# Prem House Clinic Ltd

## Quality Report

2 Park Road
Crosby
Liverpool
Merseyside
L22 3XF
Tel: 0151 949 9600
Website: newbirkdaleclinic.com

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

## Ratings

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

## Overall summary

Prem House Clinic Ltd is operated by Prem House Clinic Ltd. The clinic provides cosmetic surgery services for private fee-paying adult patients over the age of 18 years. Most patients are admitted for planned day case surgery procedures but can be accommodated overnight if required. Facilities include four consultation rooms, a ward with seven beds and one operating theatre.

The main service provided by the clinic is surgery. We inspected this service using our comprehensive inspection methodology on 30 October 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

# Summary of findings

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 rate**

This is the first time we have rated this service. We rated it as Good overall.

We found the following areas of good practice:

- Staff recognised incidents and reported them appropriately. The service had suitable premises and equipment and looked after them well.
- The service provided care and treatment based on national guidance and evidence of its effectiveness.
- Staff cared for patients with compassion. Feedback from patients confirmed staff treated them well, and with kindness. Staff provided emotional support to patients to minimise their distress.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- The service provided mandatory training in key skills to all staff and made sure everyone completed it. Staff had training on how to recognise and report abuse and they knew how to apply the required actions.
- The service made sure staff were competent for their roles. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Staff sought consent from patients prior to delivering care and treatment. The service took account of patients' individual needs.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.
- Managers promoted a positive culture and had the right skills and abilities to run a service providing high-quality sustainable care.
- There was a clear vision for the service and the mission statement and philosophy of care had been shared with and was understood by staff across the service.
- The service had effective governance systems and processes for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

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

- The incident log summary record used for identifying themes and trends was not fully complete and kept up to date.
- The risk register record had not been kept up to date.
- The service did not have a formal strategy document in place.
- The clinic did not store emergency bloods; however there was an arrangement with a neighbouring NHS acute trust for the supply of emergency blood if needed.
- The named safeguarding lead was not trained to level 4 safeguarding training, in accordance with the intercollegiate document; AdultSafeguarding: Roles and Competencies for Health Care Staff (August 2018).

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

**Ellen Armistead**

Deputy Chief Inspector of Hospitals (North Region)

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|---|---|---|
| **Surgery** | Good  | Surgery was the main activity of this service.<br>We rated this service as good because it was safe, effective, caring, responsive to people's needs and well-led. |

# Summary of findings

## Contents

Good

# Prem House Clinic Ltd

**Services we looked at:**
Surgery

# Summary of this inspection

## Background to Prem House Clinic Ltd

Prem House Clinic Ltd is operated by Prem House Clinic Ltd. The service is a private clinic based in Liverpool, Merseyside. The clinic provides cosmetic surgery services for private fee-paying adult patients over the age of 18 years.

The hospital has had a registered manager in post since February 2018. At the time of the inspection, a new manager had also recently been appointed and was registered with the CQC in October 2018. This meant there were two registered managers for this service with shared responsibilities at the time of the inspection.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. We previously carried out a comprehensive inspection of this service in July 2016 and identified regulatory breaches in relation to staffing, good governance, and safe care and treatment. We issued a warning notice to the provider following that inspection. We carried out a follow up inspection in July 2017 to check whether improvements had been made. We found that the service was meeting all standards of quality and safety it was inspected against during the follow up inspection.

The clinic is registered to provide the following regulated activities:

- Diagnostic and screening procedures
- Surgical procedures
- Treatment of disease, disorder or injury

## 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 Nicholas Smith, Head of Hospital Inspection.

## How we carried out this inspection

We inspected this service on 30 October 2018 under our comprehensive inspection methodology. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. This is the first time that we have rated this service.

During the inspection, we visited the consultation rooms and the ward and theatre areas. We spoke with eight staff including; a registered nurse, a healthcare assistant, an operating department practitioner, two administrative staff, a consultant surgeon, the registered hospital manager and the hospital director. We spoke with three patients and reviewed five sets of patient records.

## Information about Prem House Clinic Ltd

Prem House Clinic Ltd is operated by Prem House Clinic Ltd. The clinic is based in Liverpool, Merseyside and provides cosmetic surgery services for private fee-paying adult patients over the age of 18 years. Most patients are admitted for planned day case surgery procedures but can be accommodated overnight if required. Facilities include four consultation rooms, a ward with seven beds and one operating theatre.

The main service provided by the clinic is surgery. The surgical procedures offered at the clinic include include

# Summary of this inspection

breast augmentation, rhinoplasty (nose reshaping), blepharoplasty (correcting defects of the eyelids) and abdominoplasty (reduction and tightening of the abdomen).

The clinic also offers cosmetic procedures such as dermal fillers and Botox treatments. We did not inspect these services because we do not regulate these.

**Activity (July 2017 to August 2018)**

- In the reporting period between July 2017 and August 2018; there were 434 day case procedures carried out at the clinic, 34 inpatient admissions and 1,504 pre and post-operative outpatient attendances. All patients treated at the clinic were private self-funded patients over 18 years of age.
- There were 436 surgical procedures carried out during this period; the most frequent surgical procedures were: -
  - Breast augmentation (enlargement) (318 procedures – 73% of total)
  - Breast augmentation and mastopexy (raising) (37 procedures – 8% of total)
  - Breast removal and re-augmentation (32 procedures – 7% of total)

The surgical procedures are carried out by five consultant surgeons working under practicing privileges at the clinic.

**Track record on safety (July 2017 to August 2018)**

- No Never events.
- Seven clinical incidents; including three no harm, three low harm, one moderate harm, no severe harm, no death.
- No serious injuries.
- No incidences of hospital acquired meticillin-resistant staphylococcus aureus (MRSA).
- No incidences of hospital acquired meticillin-sensitive staphylococcus aureus (MSSA).
- No incidences of hospital acquired Clostridium difficile (C.diff).
- No incidences of hospital acquired E-Coli.
- Seven complaints.

**Services provided at the clinic under service level agreement:**

- Clinical and or non-clinical waste removal.
- Decontamination / Sterilisation services.
- Haematology (including transfusion).
- Pathology.
- Microbiology.
- Pharmacy services.
- Laundry.
- Maintenance of medical equipment.
- Pathology and histology.
- Resident medical officer (RMO) provision.
- Human resources and occupational health.

# 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?

Good

We rated safe as Good because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it. All staff had completed their mandatory training.
- Staff had training on how to recognise and report abuse and they knew how to apply it.
- There had been no 'never events' or serious patient safety incidents reported by the service between July 2017 and October 2018.
- Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- The service followed best practice when prescribing, giving, recording and storing medicines.
- The service had suitable premises and equipment and looked after them well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection. There had been no cases of health-care acquired infections reported between July 2017 and October 2018.
- Patients' records were clear, up-to-date and easily available to all staff providing care. Staff completed and updated risk assessments for each patient.
- The clinic had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

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

- The incident log summary record used for identifying themes and trends was not fully complete and kept up to date.
- The clinic did not store emergency bloods; however there was an arrangement with a neighbouring NHS acute trust for the supply of emergency blood if needed.
- The named safeguarding lead was not trained to level 4 safeguarding training, in accordance with the intercollegiate document; AdultSafeguarding: Roles and Competencies for Health Care Staff (August 2018).

### Are services effective?

Good

We rated effective as Good because:

# Summary of this inspection

- The service provided care and treatment based on national guidance and evidence of its effectiveness.
- The service submitted performance data to national registries such as the Private Healthcare Information Network (PHIN). Patient outcomes data was used to review individual consultant performance. Most patients experienced positive outcomes following their procedure.
- Staff assessed and monitored patients regularly to see if they were in pain.
- All staff had completed their appraisals. There were no consultants with any outstanding queries relating to their practising privileges.
- The service made sure staff were competent for their roles. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Staff sought consent from patients prior to delivering care and treatment. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

## Are services caring?

Good

We rated caring as Good because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff provided emotional support to patients to minimise their distress.
- Staff involved patients and those close to them in decisions about their care and treatment.

## Are services responsive?

Good

We rated responsive as Good because:

- Services were planned and provided in a way that met the needs of patients. The initial patient consultations allowed staff to plan the care and treatment in advance so patients did not experience delays in their treatment.
- There was sufficient capacity in the ward and theatre areas to accommodate and treat patients in a timely manner. The services were compliant with mixed-sex accommodation guidelines.
- The service took account of patients' individual needs. As part of the pre-operative assessment process, patients with certain medical conditions were excluded from receiving treatment.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

# Summary of this inspection

- The service reported that only two patients' procedures were cancelled on the day of surgery for non-clinical reasons in the last 12 months.

## Are services well-led?

Good

We rated well-led as Good because:

- Managers had the right skills and abilities to run a service providing high-quality sustainable care.
- Managers promoted a positive culture which supported and valued staff, creating a sense of common purpose based on shared values.
- There was a clear vision for the service. The mission statement and philosophy of care had been shared with and was understood by staff across the service. The service engaged well with patients, staff and the public.
- There were clear governance structures in place, which provided assurance of oversight and performance against safety measures.
- The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

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

- The risk register record had not been kept up to date.
- The service did not have a formal strategy document in place.

# Detailed findings from this inspection

## Overview of ratings

Our ratings for this location are:

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

Good

# Surgery

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

## Are surgery services safe?

Good

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

### Mandatory training

- Staff received mandatory training in areas such as children and adults safeguarding, infection control, medicines management, fire safety, food safety, nutrition awareness, health and safety, equality and diversity, dignity and respect, life support training and moving and handling training.
- The mandatory training was delivered either face-to-face or through e-learning. Records showed that 100% of eligible staff across the surgical services had completed their mandatory training.

### Safeguarding

- Staff received mandatory training in the safeguarding of vulnerable adults and children. Records showed that 100% of staff across the surgical services had completed their children and adults safeguarding training (level 2).
- Staff were aware of how to identify potential abuse and report safeguarding concerns. There was a safeguarding policy in place and information on how to report safeguarding concerns was displayed in the areas we inspected.
- The clinic had a named safeguarding lead who had completed safeguarding level 3 training in children and adults. The named safeguarding lead was not trained to level 4 adults safeguarding training, in accordance with the intercollegiate document; AdultSafeguarding: Roles and Competencies for Health Care Staff (August 2018).
- Staff were aware of how they could seek advice and support in relation to safeguarding concerns when needed.
- There had been no reported safeguarding incidents reported by the clinic between July 2017 and October 2018.
- Records showed 100% of staff had completed female genital mutilation (FGM) training and 'prevent' (anti-radicalisation) training.

### Cleanliness, infection control and hygiene

- There were no cases of meticillin-resistant staphylococcus aureus (MRSA) bacteraemia, meticillin-sensitive staphylococcus aureus (MSSA) bacteraemia, Clostridium difficile (C.diff) or Escherichia coli (E. coli) reported by the clinic between July 2017 and October 2018.
- There had been no surgical site infections reported by the clinic between July 2017 and October 2018.
- The consultation rooms, ward and theatre areas were visibly clean and tidy. Staff were aware of current infection prevention and control guidelines. Cleaning schedules and daily checklists were in place, and there were clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment. We saw the daily cleaning checklists were completed appropriately in the areas we inspected.
- There were arrangements for the handling, storage and disposal of clinical waste, including sharps. Sharps bins were appropriately stored and labelled correctly. Staff used a nationally recognised colour-coding system for

mops and buckets, and chlorine-based disinfectant was used to clean and decontaminate surfaces and equipment. The ward and consultation room areas used disposable curtains. These were replaced if contaminated or periodically every six months.

- Personal protective equipment, such as gloves and aprons, were readily available in the ward and theatre areas. There were enough hand wash sinks and hand gels. Staff we saw were compliant with hand hygiene and 'bare below the elbow' guidance.
- All patients underwent meticillin-resistant staphylococcus aureus screening prior to undergoing surgical procedures at the clinic. The hospital director told us patients with a suspected or confirmed contagious condition would not be treated at the clinic. There were side room facilities in the ward area which could be used for the isolation of patients identified with an infection risk during their treatment.
- A hand hygiene audit was carried out at least every three months to monitor staff compliance with hand washing guidelines. Audit results from April 2018 and August 2018 showed 100% compliance by staff, based on 10 staff observations during each audit. The hospital director told us if poor hand hygiene compliance was identified this was discussed with individual staff members to improve compliance.
- Infection control audits were carried out each month to check compliance against national infection prevention and control guidelines and to monitor the cleanliness of the general environment and equipment. Staff also completed cannula care audits at least every three months. Audit results showed the clinic achieved 100% compliance between April 2018 and August 2018.
- The clinic had an Infection Control Committee which held meetings every three months and involved an external infection control doctor and ward and theatre staff representatives. Meeting minutes for July 2018 and October 2018 showed discussions around infection control risks, policies and processes took place during these meetings.

**Environment and equipment**

- The consultation rooms and ward and theatre areas were well maintained and free from clutter. All the equipment we saw was visibly clean and well maintained.
- There was a service-level agreement with an external NHS acute trust for the sterilisation of reusable surgical instruments in an accredited sterilisation unit.
- We found single use sterile instruments were stored appropriately and kept within their expiry dates. Surgical instruments and implants were labelled and stored in an organised manner. Medical gas cylinders were stored securely.
- Staff told us all items of equipment were readily available and any faulty equipment was repaired or replaced in a timely manner.
- There was a planned maintenance schedule in place that listed when equipment was due for servicing. Equipment servicing was managed by the maintenance lead and the registered hospital manager who arranged for equipment to be serviced by external contractors.
- We looked at a selection of service records for equipment such as the theatre ventilation systems and anaesthetic machines and these had been serviced within the last 12 months. Service records also showed the auxiliary systems (such as gas, fire safety, electric and water supplies) were regularly tested and serviced at least annually. The maintenance lead carried out electrical safety testing and the equipment we saw was within test due dates.
- The clinic had an emergency back-up power system and we saw evidence this had been serviced within the past 12 months.
- Emergency resuscitation equipment was available across all areas. The log sheets we looked at were complete and up to date, demonstrating staff carried out daily and weekly checks on emergency equipment and anaesthetic machines.

**Assessing and responding to patient risk**

- Patients had an initial consultation to determine whether they were eligible to receive treatment at the clinic. Patients that were accepted for treatment were generally fit and healthy with a low risk of developing complications during or after surgery.
- Patients with certain medical conditions were excluded from receiving treatment. For example, patients with heart-related problems or patients with a body mass index (BMI) above 30 were considered unsuitable for certain procedures.

- Patients were assessed by an anaesthetist and surgeon on the day of surgery to identify if there had been any changes to their medical condition since their initial consultation and a decision was made whether treatment could commence.
- Patient records showed staff used an early warning score system and carried out routine monitoring observations based on the patient's individual needs to ensure any changes to their medical condition could be promptly identified.
- We looked at the patient observation audit results for May 2018 and August 2018 during the inspection. The August 2018 audit was based on a review of 38 patient records. The audit showed that there was a high level of staff compliance, with only one instance where observations were not totalled correctly and one instance where a date was omitted. Findings from the August 2018 audit were shared with staff during the monthly clinical staff meeting following the audit to raise awareness and aid staff learning.
- The clinic reported there had been no cases of unplanned transfer of a patient to another hospital between July 2017 and October 2018. Staff had guidelines to follow and understood the steps to take if a patient became unwell during or after treatment. If a patient's health deteriorated, they would be assessed by a consultant and a decision would be made to transfer the patient. There was an arrangement with a local NHS acute trust for the transfer of unwell patients.
- We were not able to observe theatre teams' use of the World Health Organization (WHO) checklist as there were no procedures taking place on the day of our inspection. However, our discussions with the theatre staff and review of patient records showed staff had a good understanding of the 'five steps to safer surgery' guidelines.
- Staff told us the theatre team carried out a safety huddle prior to commencing surgical procedures and also conducted a de-brief at the end of theatre list. We looked at the records for seven patients who had undergone treatment at the clinic and found surgical safety checklists were completed correctly.
- Staff carried out routine audits to monitor adherence to the World Health Organization (WHO) and completion of the surgical checklist record. We looked at the audit for January 2018 (sample of 36 patient records) and September 2018 (sample of 29 patient records) and 100% compliance was achieved during each audit.
- The clinic did not store emergency bloods (such as O negative blood) on site for use during medical emergencies. The clinic had an agreement in place with a neighbouring NHS acute trust for the supply of emergency blood within 30 minutes if needed. There had been no instances in the previous 12 months where emergency blood was required.
- Staff followed appropriate guidelines, pathways and the sepsis six care bundle, based on national guidelines for the management of patients with sepsis. There had been no incidents relating to the identification and management of sepsis reported by the clinic between July 2017 and October 2018.
- The clinic reported there had been one case of healthcare-acquired venous thromboembolism or pulmonary embolism (PE) during this period. This was investigated and learning was shared during clinical staff meetings and Medical Advisory Committee meetings.

**Nursing and support staffing**

- The registered hospital manager told us they did not use a recognised acuity tool to determine staffing levels. All patients were admitted for planned procedures and patient acuity was determined during pre-operative assessment. This allowed the staff to determine the staffing levels needed for the patient prior to their admission and increase staffing levels if necessary (such as for a patient requiring overnight stay).
- The clinic had a sufficient number of trained nursing and support staff with an appropriate skill mix so patients were safe and received the right level of care. The hospital director and registered hospital manager confirmed there were no outstanding nursing or support staff vacancies at the clinic.
- The service employed nine nursing staff, including two theatre nurses and two long-term bank nurses. There were five healthcare assistants, including three bank staff. There were three operating department practitioners (ODP's), and a theatre assistant.
- Staffing rotas showed the theatre staffing levels were based on nationally recognised guidelines such as the Association for Perioperative Practice (AfPP) 2014 staffing guidelines. The theatre team consisted of a minimum of five staff during surgical procedures; including the surgeon, operating department practitioner and anaesthetic or scrub nurses.

- The registered manager told us they did not routinely use external agency staff. Where agency staff were used, they underwent recruitment checks to ensure they had appropriate training and qualifications. Cover for staff sickness or leave was mostly provided by regular long-term bank staff who had completed mandatory training and were familiar with the clinic's policies and procedures. The clinic reported the shift fill rate was 100% between May 2018 and July 2018.

**Medical staffing**

- The clinic did not have any substantive medical staff based on site. Surgical procedures were carried out by a team of five consultant surgeons and one anaesthetist that were mainly employed by other organisations (such as in the NHS) in substantive posts and had practising privileges (the right to practice in the clinic).
- The consultants and anaesthetists were responsible for their individual patients during their stay at the clinic and for any subsequent post-operative follow up consultations.
- As part of their practising privileges consultants were responsible for the care and treatment of their patients at all times. The ward staff had contact details for each consultant so they could be contacted at any time for advice and guidance when required.
- There was a system for consultants to arrange appropriate alternative named cover by another consultant if they were unavailable (for example, due to sickness or leave).
- The clinic also had arrangements with an external medical agency to provide a resident medical officer (RMO) who was based on the ward if a patient was kept overnight.

**Records**

- Staff used paper based patient records and these were securely stored in each area we inspected.
- We looked at the records for five patients. These were structured, legible, complete and up to date. Patient records showed that nursing and clinical assessments were carried out before, during and after surgery and these were documented correctly.
- The records included information such as consent records, medical history reviews and risk assessments, such as for venous thromboembolism (VTE – blood clots), pressure care and nutrition and these were completed correctly.
- Patient records were kept on site and were easily accessible for follow up consultations. Medical notes made by consultants working under practising privileges were retained in the patient records.
- A monthly patient records audit was carried out to check for completeness. The audit involved a review of 10 patient records against 20 standards relating to accuracy and completeness of records. The audit results for January 2018 to October 2018 showed high levels of compliance (between 90% to 100%) across the 20 audit standards each month. Audit findings were discussed at monthly clinical team meetings to aid staff learning.

**Medicines**

- Medicines, including controlled drugs, were securely stored. Staff carried out routine checks on controlled drugs and medicine stocks to ensure medicines were reconciled correctly. We looked at a sample of controlled drugs and found the stock levels were correct, and the controlled drug registers were completed correctly.
- We found that medicines were ordered, stored and discarded safely and appropriately. Records for ordering, return and disposal of medicines were maintained by staff and we saw these were complete and up to date.
- The clinic had an arrangement with a local pharmacy provider for the supply and disposal of medicines. Staff told us they could contact the pharmacy service for advise and support if needed. They told us they had timely access to medicines needed for patients, including outside of normal working hours.
- Staff carried out scheduled controlled drugs and prescribing audits at least every three months. We looked at a sample of controlled drug and medicine audit results and these showed compliance of 100% compliance was consistently achieved over the past 12 months.
- We saw the medicines that required storage at temperatures between 2ºC and 8ºC were appropriately stored in medicine fridges. Fridge temperature logs showed these were checked daily and the medicines we checked were stored at the correct temperatures. Records showed staff monitored the room temperatures where medicines were stored on a daily basis.
- Medicines used during surgical procedures and given to patients to take home were prescribed by the consultant that carried out the surgical procedure.

Good

# Surgery

- We looked at the medicine records for seven patients. Patients were given their medicines in a timely way, as prescribed, and records were completed appropriately. The records we looked at showed patient allergy status had been documented.

**Incidents**

- There had been no 'never events' reported in relation to the surgical services at the clinic between July 2017 and October 2018. 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.
- There were no serious patient safety incidents reported by the clinic between July 2017 and October 2018. There were eight clinical incidents reported during this period; one was rated as 'moderate harm', three were rated as 'no harm' and four were 'low harm' incidents. There were no non-clinical incidents reported during this period.
- The clinical incident rated as 'moderate harm' related to a staff needle-stick injury and actions were taken to minimise the risk of harm to the member of staff, including transfer to hospital and referral to occupational health support.
- Staff were aware of the process for reporting any identified risks to patients, staff and visitors. All incidents, accidents and near misses were logged using paper-based incident reporting forms.
- Incidents were reviewed and investigated by staff with the appropriate level of seniority, such as the registered hospital manager or a consultant.
- The registered hospital manager maintained a file containing each incident report and details of remedial actions taken. A separate incidents log record was kept for use as an aid for trend analysis. However, we found the incident log record had not been maintained or kept up to date. We identified this a minor documentation issue as there had only been a small number of reported incidents with no trends or themes identified and the incident report records we looked at were complete and up to date.
- Staff told us they received feedback about incidents reported and this was used to improve practice and the service to patients. Meeting minutes showed incidents were discussed during monthly clinic meetings so shared learning could take place.
- Staff across all disciplines were aware of their responsibilities regarding duty of candour legislation. 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.
- There had been no patient deaths reported by the clinic July 2017 and October 2018. There was a process for patient deaths to be reviewed and investigated through the provider's Medical Advisory Committee (MAC).

**Safety Thermometer (or equivalent)**

- There had been no incidents relating to falls or pressure ulcers reported by the clinic between July 2017 and October 2018.
- The clinic reported that it had carried out venous thromboembolism (VTE) risk assessments for 100% of its patients between July 2017 and October 2018. We saw evidence of venous thromboembolism risk assessments completed in the patient records we looked at.

## Are surgery services effective?

Good

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

**Evidence-based care and treatment**

- Patients received care according to national guidelines such as National Institute for Health and Clinical Excellence (NICE), Royal Colleges' guidelines and General Medical Council (GMC) guidelines for doctors who offer cosmetic interventions.
- Staff used standardised care pathways such as for breast augmentation surgery and rhinoplasty (nose reshaping) procedures that were based on national guidelines.

- The care pathways were benchmarked against national guidelines and developed through the Clinical Governance Board and the Medical Advisory Committee (MAC). These were cascaded to staff at the clinic.
- Policies and procedures reflected current guidelines and staff told us they were easily accessible in electronic and paper format.

**Nutrition and hydration**

- Patients with specific nutritional needs were assessed as part of the pre-operative assessment process. Patient records showed staff used the MalnutritionUniversal Screening Tool (MUST) to assess patients and these were completed correctly in the records we looked at.
- Patients undergoing procedures were given written information about starve times prior to commencing treatment. Patients were also advised on the types of fluids or food they could take after treatment.
- Patients who were admitted for day case procedures at the clinic were provided with refreshments and a light pre-prepared meal (such as a sandwich) following their procedure. Patients staying overnight were provided with meals throughout their stay and were given a menu with a choice of food and drinks.
- Staff took into account patients with specific cultural needs and were able to provide food based on their preferences, such as vegan, halal or kosher food.
- Patients told us they were offered a choice of food and drink and spoke positively about the quality of the food offered.

**Pain relief**

- Patients were assessed pre-operatively for their preferred post-operative pain relief. Staff used a pain assessment score to assess the comfort of patients both as part of their routine observations and at a suitable interval of time after giving pain relief.
- Patient records showed patients received the required pain relief and they were treated in a way that met their needs and reduced discomfort.
- Patients were given verbal and written information to take home which provided information on how to manage pain symptoms following discharge from the clinic.
- The patients we spoke with told us they received good support from staff and their pain symptoms were appropriately managed during and after their treatment at the clinic.

**Patient outcomes**

- The services submitted patient outcomes and performance data to the Private Healthcare Information Network (PHIN) in accordance with legal requirements regulated by the Competition Markets Authority (CMA). Performance data (such as number of procedures performed) was also submitted to the Breast and Cosmetic Implant Registry.
- The services did not participate in any national audit programmes as a way to compare and benchmark patient outcomes. However, performance data was submitted for augmentation mammoplasty (breast surgery) procedures.
- The services collated performance data for each individual consultant involved in surgical procedures. The information did not specify patient outcomes but was used to compare individual consultant performance in areas such as number of procedures carried out as well as the number of complications (returns to theatre, infections and day cases converted to overnight stay) for each consultant.
- We looked at the performance data for the five consultant surgeons between July 2017 and July 2018. This showed the majority of patients experienced positive outcomes with low numbers of post-operative complications. For example, the overall post-surgery revision / correction rate was 3% (14 of 474 patients) during this period.
- There had been two cases of unplanned patient readmissions within 28 days of discharge between July 2017 and October 2018. Both cases related to patients that underwent breast surgery; one readmission was due to increased swelling and the other readmission was due to a post-surgery infection. In both cases the patients received appropriate follow up treatment and were discharged.
- The clinic reported there were two instances where patients returned to theatre following surgery during the past 12 months (out of a total of 436 surgical procedures). Both cases were due to post-operative hematoma, (discoloration of the wound edges, discomfort, and swelling) which was a known complication of the procedure and the patients received appropriate treatment prior to being discharged.
- Patient return to theatres and readmissions were discussed at routine clinical group and Medical Advisory Committee (MAC) meetings to share learning.

Good

# Surgery

### Competent staff

- Newly appointed staff underwent an induction process for up to two weeks and their competency was assessed prior to working unsupervised.
- Staff told us they received annual appraisals. The clinic reported that 100% of staff had completed their appraisals at the time of our inspection.
- Consultants working at the clinic were employed under practising privileges (authority granted to a physician or dentist by a hospital governing board to provide patient care in the hospital or clinic). There were five consultants working at the clinic under practising privileges and their practicing privileges had been reviewed. There were no consultants in the surgical services with any outstanding queries relating to their practising privileges.
- Four of the consultant surgeons also worked at other NHS hospitals and were appraised by their substantive NHS employer. One consultant was not employed within the NHS had their annual appraisal conducted with an independent appraiser.
- All eligible staff were up to date with their NursingandMidwifery Council (NMC) and General Medical Council (GMC) revalidation dates.
- Records showed that 100% of nursing, theatre and healthcare staff had received immediate life support (ILS) training. All the medical staff had completed advanced life support (ALS) training. An anaesthetist trained in advanced life support was present in the theatre area when surgical procedures were undertaken.
- Staff were positive about on-the-job learning and development opportunities and told us they were supported well by their line managers.
- We looked at three staff files and these showed evidence of competency-based training, such as for cannulation or use of specialist theatre equipment.

### Multidisciplinary working

- There was effective daily communication between multidisciplinary teams within the clinic. Patient records showed that there was routine input from nursing and medical staff.
- Nursing and healthcare staff told us they had a good relationship with consultants working under practicing privileges.
- There was daily communication between the patient ward manager, registered manager and consultant surgeons so patient care could be coordinated and delivered effectively.
- There were service level agreements with a number of external organisations to support processes such as equipment maintenance, laundry services, domestic services, sterilisation of medical devices and laboratory support for meticillin-resistant staphylococcus aureus screening and blood tests.

### Seven-day services

- The clinic did not operate over seven days. Normal operating days were Monday, with some activities on Wednesday and alternative weekends between 7am and 6pm. Pre and post-operative follow up consultations took place during routine working hours on weekdays.
- Patients were provided with an emergency contact number so they could contact the clinic at any time in case of a medical emergency or complication following discharge.

### Health promotion

- Medical and nursing staff told us they routinely discussed health promotion and lifestyle choices as these could impact on their ability to receive treatment at the clinic. For example, patients identified as being overweight or patients that were smokers were given advice and support during their initial consultation.

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had the appropriate skills and knowledge to seek verbal informed consent and written consent before providing care and treatment to patients.
- The consultants sought written consent from patients undergoing surgery during the initial consultation process. Written consent was also obtained a second time before the patient underwent surgical treatment.
- Written consent was also obtained from patients for the use of digital images.
- All patients were allowed a minimum ‘cooling off’ period of two weeks before undergoing surgery. This was in line with the Royal College of Surgeons; Professional Standards for Cosmetic Surgery guidelines.

Good

# Surgery

- Patient records showed that written and verbal consent had been obtained from patients and the planned care was delivered with their agreement. Consent forms showed the risks and benefits were discussed with the patient prior to carrying out surgical procedures.
- Records showed 100% of staff working at the clinic had completed mandatory training in the Mental Capacity Act (MCA) 2005 and Deprivation of Liberties Safeguards (DoLS).
- Where patients lacked the capacity to provide informed consent, the consultants made decisions about whether treatment could be provided and sought input from other healthcare professionals, such as the patient's general practitioner (GP).
- Staff told us they sought input from a patient's GP if they identified any psychological concerns (such as plastic surgery addiction). Patients with certain mental health conditions (such as depression, anxiety or risk of self-harm) were excluded for treatment at the clinic.

## Are surgery services caring?

Good

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

### Compassionate care

- There were no surgical procedures taking place on the day of the inspection so we were unable to observe care in the ward and theatre areas. However, a post-operative wound dressing clinic took place on the day of our inspection and we observed staff interacting with patients in a polite, courteous and respectful manner.
- We saw the privacy and dignity of patients attending the dressing clinic was maintained and staff spoke discreetly with patients to maintain confidentiality.
- Staff told us they maintained patients' privacy and dignity during their surgical treatment by providing dressing gowns and blankets when transferring patients between the ward and theatre areas. Bed curtains were also in place to maintain privacy.
- We spoke with three patients. They all said they thought staff were kind and caring and gave us positive feedback about ways in which staff showed them respect and ensured their dignity was maintained. The comments received included: "brilliant service, haven't had any problems" and "staff were lovely, it was a really good experience".
- Staff carried out routine patient satisfaction surveys and the feedback was used to look for improvements to the service.
- The patient satisfaction survey for the period between July 2018 and September 2018 showed 100% of patients surveyed rated the clinic as good or excellent. The survey was based on feedback from 29 patients and covered areas such as staff attitude, meeting patient needs, food and cleanliness.

### Emotional support

- Patients told us the staff were calm, reassuring and supportive and helped them to relax prior to undergoing treatment. Patients commented that a member of staff met them on the day of surgery and accompanied them throughout their procedure; this helped to reassure them and calm their nerves.
- During consultations patients were offered a chaperone or patients were encouraged to have a friend or relative present.
- The consultants reviewed patients' emotional state as part of the pre-operative assessment process. Where patients were identified as needing counselling support, they were referred to their general practitioner (GP) so they could access the appropriate support or treatment needed.

### Understanding and involvement of patients and those close to them

- Patient records included pre-admission and pre-operative assessments that took into account individual patient preferences.
- Patients we spoke with told us they were kept informed about their treatment and staff were clear at explaining their treatment to them in a way they could understand. They told us the risks and benefits of their procedure were clearly explained to them so they could make an informed decision.
- Patients also spoke positively about the verbal information and support they received from staff before, during and after their procedure.

## Are surgery services responsive?

Good

# Surgery

Good

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

**Service delivery to meet the needs of local people**

- Initial patient consultations took place at the clinic and also as outpatient clinics across a number of areas to allow patients outside of the local area easier access to services.
- The initial consultation process allowed staff to plan for the patient in advance so they did not experience delays in their treatment when admitted to the clinic.
- The clinic only provided cosmetic services for private fee-paying adult patients over the age of 18 years. Most patients were admitted for planned day case procedures. The service provided overnight accommodation for patients following certain procedures or if it was identified as part of their pre-operative assessment.
- As part of the pre-operative assessment process, patients with certain medical conditions were excluded from receiving treatment at the clinic.This included patients that were pregnant, had mental health problems (such as depression, anxiety or self-harm history) or had other underlying health issues (such as heart disease, stroke, diabetes or cancer).
- There were four consultation rooms and the ward could accommodate up to seven patients. The services were compliant with mixed-sex accommodation guidelines.
- Staff used an electronic system to manage patient appointments and follow up visits. There was regular communication between the ward and theatre staff, pre-admission staff and the surgeons so the required resources (such as staff and equipment) could be arranged in advance.

**Meeting people's individual needs**

- Information leaflets about the services were readily available in all the areas we visited. Staff told us they could provide leaflets in different languages or other formats, such as braille if requested.
- All staff at the clinic had completed training in conflict resolution and equality and diversity. Staff could access a language interpreter if needed.
- The pre-operative assessment process identified patients with dementia or learning difficulties and this allowed the staff to determine if they could accommodate these patients' needs or whether they should refer them to another service that could meet their needs.
- The clinic was accessible for patients with limited mobility. The consultation rooms, ward and theatre areas were located on the ground floor of the premises and there was an operational lift in the building to allow wheelchair access to the first floor.

**Access and flow**

- Most patients accessed the services via self-referral. When a patient made an initial enquiry about the services offered at the clinic, a consultation appointment was made with a patient coordinator. Patients were given verbal and written information about the types of treatments offered.
- There was sufficient capacity to provide care and treatment for patients undergoing surgery. The clinic had one operating theatre, with one recovery bay and only one patient was present in the theatre and recovery area at one time. The next patient was not called to theatre until the previous patient had been transferred to the ward from the recovery area.
- Patients were then reviewed by the surgeon responsible for carrying out the procedure. As part of this consultation, a review of the patient's medical history was carried out to determine whether they were suitable to undergo surgical treatment at the clinic.
- Patients that were eligible and had agreed to undergo surgery at the clinic received a further consultation where they were provided with information about the procedure and relevant fees and to discuss the patient's individual preferences.
- Most patients underwent surgery within four to six weeks of their initial consultation. Patients undergoing varicose vein or liposuction procedures were routinely admitted and discharged within four hours on the day of surgery.
- The clinic reported one instance where they had cancelled procedures on the day of surgery for a non-clinical reason in the last 12 months. The incident was due to an equipment issue that resulted in the theatre list over running and two patients' procedures had to be cancelled. This was discussed during de-brief,

clinical staff meetings and Medical Advisory Committee meetings to discuss and share lessons learned. The affected patients were offered an alternative date within 28 days of the cancellation.

- Patient records showed staff completed a discharge checklist, which covered areas such as medication given to the patient to take home. Discharge letters were not routinely sent to a patient's GP unless patient permission had been obtained.
- Patients who were discharged from the clinic were given an emergency contact number so they could speak with a member of staff as part of the aftercare process.
- Patients that had undergone surgery received a follow up phone call from a nurse within two days of discharge to discuss any concerns the patient may have. Patients were given a follow up wound dressing clinic appointments within two to three weeks following their discharge.
- Patients were also given a post-operative follow up appointment with the consultant at routine intervals. Patient records showed patients had been offered follow up appointments and they were regularly seen by a consultant after their procedure.
- Where a patient did not attend their planned appointment, staff contacted the patient to arrange an alternative date. In most cases patients did not attend these appointments through their own personal choice.

**Learning from complaints and concerns**

- Information leaflets describing how to raise complaints about the service were visibly displayed in the main reception and waiting area.
- Patients told us they had been given information on how to raise a complaint. Staff we spoke with understood the process for receiving and handling complaints. Complaints were managed by the complaints coordinator with oversight from the registered manager.
- The complaints policy stated that complaints would be acknowledged within two working days and investigated and responded to within 20 working days for routine complaints.
- Where the complaint investigation had not been completed within 20 working days, staff were required to notify the complainant in writing explaining the reasons for the delay.
- The service was not registered with an independent complaints adjudicator, such as Independent Sector Complaints Adjudication Service (ISCAS). Where patients were not satisfied with the response to their complaint, the complaint was escalated for review By the Medical Advisory Committee and further escalated to the overall director of the service for review and resolution.
- The clinic received seven complaints between July 2017 and August 2018; four complaints were for clinical reasons (such as patient not satisfied with procedure), one complaint related to an appointment cancellation and two complaints related to staff behaviour / attitude.
- We looked at the records for four complaints during the inspection. These showed the complaint investigations and response letters were completed appropriately. All four complaints were acknowledged and responded to within the clinic's specified timelines. Two of the four complaints we reviewed had been resolved and two remained on-going. We saw that holding letters had been sent to patients to keep them up to date about the complaint investigation progress.
- Staff told us that information about complaints was discussed during routine clinical staff meetings and medical advisory committee meetings to raise staff awareness and aid future learning. We saw evidence of this in the meeting minutes we looked at.

## Are surgery services well-led?

Good

This is the first time we have rated this service. We rated well-led as good.

**Leadership**

- The overall lead for the services was the hospital director, who was also a registered manager since February 2018. A registered hospital manager was also in place and their application to become registered manager was approved by the Care Quality Commission on 18 October 2018.
- This meant there were two registered managers with shared responsibilities at the time of the inspection. This was an interim arrangement and the hospital director planned to deregister in the near future to allow the registered hospital manager to take on the role going forward.

- The registered hospital manager was supported by an assistant hospital manager, who was responsible for overseeing ward area. The registered hospital manager was also involved in theatre activities and oversaw the theatre area.
- Staff told us they understood their reporting structures clearly and described the hospital director and registered hospital manager as approachable, visible and who provided them with good support.

**Vision and strategy**

- The provider's mission statement was: -
  - To be recognised; at all levels, for our high standards of professionalism, service, and quality of care provided within appropriate safe and therapeutic environments.
  - To nurture a working environment which will attract, motivate, develop and retain the very best people in our sector.
  - To be clear, open, honest, fair, and transparent in all our undertakings.
  - To be the leading independent provider of healthcare services.
- This was underpinned by a 'philosophy of care' which was based on a commitment to provide every patient with individual, holistic, personalised care and attention in a safe and warm environment.
- The mission statement and philosophy of care were clearly displayed in the areas we inspected and the staff working at the clinic had a good understanding of these.
- There was no formal strategy document in place. However the hospital director was able to articulate the strategy for the services. The hospital director told us the strategy for the service was to increase the number of patients receiving treatment at the clinic and to maintain good clinical standards.

**Culture**

- All the staff we spoke with were highly motivated and positive about their work. They told us there was a friendly and open culture and that they received good support from the their colleagues and managers.
- The clinic reported the overall staff sickness rate of 3.3% between August 2017 and July 2018. The staff turnover rate was 0% during this period.
- There was a whistle blower policy in place and staff were aware of the process to follow if they wished to raise any concerns.

**Governance**

- There were clear governance structures which provided assurance of oversight and performance against safety measures. There were a number of groups and committees that held meetings either monthly or every three months and reported to the Clinical Governance Board and senior management team.
- The Infection Control Committee and the complaints and patient experience group reported to the Medical Advisory Committee (MAC). The Medical Advisory Committee and Health and Safety Committee reported to the Clinical Governance Board, and there was also an information governance / Caldicott Guardian group.
- There were monthly clinical staff meetings which included most of the staff working at the clinic. Meeting minutes showed that discussions around workforce, performance and governance issues and key risks took place during the staff meetings and committees.
- The Medical Advisory Committee had oversight of clinical activities and held meetings every three months. The committee was chaired by a consultant surgeon and attended by the consultant surgeons, the hospital director and the registered hospital manager.
- There were five consultants working at the clinic under practising privileges and their practicing privileges were reviewed every two years by the Medical Advisory Committee. This included a review of appraisals and scope of practice and checks for any reported incidents related to the individual consultant.
- We looked three consultant files and these contained up to date appraisal records, General Medical Council (GMC) revalidation, indemnity certificates and Disclosure and Barring Service (DBS) checks. We spoke with one consultant who told us they were required to submit this information to the clinic on an annual basis.
- We looked at three staff files and these showed evidence that appropriate pre-employment checks had been carried out. This included identification checks, qualifications, Hepatitis B inoculation certificates, at least two employment references and Disclosure and Barring Service (DBS) checks.
- The provider had one executive director who was also the nominated individual. We saw evidence that appropriate recruitment checks had been carried out to

confirm the executive director was of good character and able to perform their role in line with the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014).

**Managing risks, issues and performance**

- There was a risk management policy which outlined the process for identifying, assessing and mitigating risks to the services.
- We looked at a risk assessment file that contained up to date risk assessments in relation to health and safety risks and Control of Substances Hazardous to Health (COSHH) assessments.
- The risk file also contained risk assessments relating to organisational risks, such as equipment or workforce risks. Meeting minutes showed key risks had been reviewed and discussed at routine clinical staff meetings and Medical Advisory Committee meetings.
- The service had a separate risk register record but this had not been maintained and kept up to date. We identified this as a documentation issue as we found key risks were documented in individual risk assessment records and these were up to date. We saw evidence that organisational risks (such as staffing and equipment-related risks) were discussed and reviewed at routine meetings.
- Routine staff meetings took place to discuss day-to-day issues and to share information on complaints, incidents and audit results.
- We saw routine audit and monitoring of key processes took place to monitor performance against patient safety standards and organisational objectives. There was a structured programme of audit covering key processes such as infection control, patient records and medicines management. Information relating to performance against key quality, safety and performance objectives was monitored and cascaded to staff through routine team meetings.
- There was a system in place to ensure safety alerts relating to patient safety, medicines and medical devices were cascaded to staff and responded to in a timely manner.

**Managing information**

- Staff completed data protection training and information governance training every three years as part of their mandatory training. Records showed 100% of staff at the clinic had completed this training.
- Staff used paper based patient records that contained detailed patient information from admission and surgery through to discharge. This meant staff could access all the information needed about the patient at any time.
- Electronic systems (such as to manage patient appointments) required password access.
- Staff could access information such as policies and procedures in paper and electronic format. The policies we looked at were version-controlled, up to date and had periodic review dates. Staff told us they could access up to date national best practice guidelines and prescribing formularies when needed.

**Engagement**

- Staff routinely engaged with patients to gain feedback about the services. This was also done formally through routine patient satisfaction surveys. Survey responses showed patients were very positive about the care and treatment they received.
- The services also engaged with the public though public events and open evenings. An open event was planned to take place in early 2019 to promote the services provided.
- Staff told us they received good support and regular communication from the management team. Staff engagement took place through daily communication, routine clinic meetings and through other general information and correspondence that was displayed on notice boards and in staff rooms.

**Learning, continuous improvement and innovation**

- The service reported a number of improvements had been made following feedback from patients and audit findings. This included the implementation of an updated process for checking emergency equipment, and a system where patients were escorted into theatre with a member of ward staff to provide support and reassurance to the patient and also a familiar face.
- The hospital director told us the clinic was financially viable and sustainable as a result of well-maintained

Good

# Surgery

premises and a stable workforce. A business development manager had recently been appointed to develop and promote the business to help future expansion.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the provider SHOULD take to improve

- The provider should ensure incident log sheet records are routinely maintained and kept up to date.
- The provider should ensure risk register records are routinely maintained and kept up to date.
- The provider should consider developing a formal documented strategy for the service.
- The provider should consider storing emergency blood on site.
- The provider should consider the training requirements specified in the intercollegiate adult safeguarding 2018 guidelines for the named safeguarding lead.