Alexandra Health Care Limited

Alexandra Private Hospital

Inspection report

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Date of inspection visit: 22 February and 7 March 2023
Date of publication: 16/06/2023

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

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Insufficient evidence to rate
Are services well-led?	Inadequate

Summary of findings

Overall summary

Alexandra Private Hospital is an independent hospital which provides cosmetic surgery to self-funding patients.

We carried out an unannounced focused inspection to follow up on concerns we found at our last inspection when we rated the cosmetic surgery core service overall as inadequate.

We only inspected the key questions of safe, effective, and well led as this is where the breaches of regulation were found for our previous inspection, published on 7 December 2022. We did not inspect the safe, effective, and well led key questions in full; instead, we focused on the key lines of enquiry where serious concerns had been previously identified to see if improvement had been made.

We collated enough evidence to rate both safe and well led key questions.

We did not rate the effective key question as we did not collect sufficient evidence to rate this key question.

We did not inspect the service for the caring and responsive key questions during this inspection.

Our rating of this location stayed the same. We rated it as inadequate because:

- The service did not have oversight if staff were compliant with mandatory training and competence requirements for their roles. Staff did not have adequate training on how to recognise and report abuse. The service did not control infection risk well. Equipment and premises were not visibly clean. Staff used out-of-date products to wash their hands. Staff did not monitor the effectiveness of infection prevention and control measures. The design, maintenance and use of facilities, premises and equipment were not sufficient to keep patients safe. Staff did not always complete risk assessments for each patient. Staff did not identify or quickly act upon patients at risk of deterioration. The service could not evidence that patients knew who to contact to discuss complications or concerns following their surgery. Staff did not keep detailed records of patients' care and treatment. Records were not comprehensively and consistently completed and did not follow best practice guidance. The service did not consistently use systems and processes to safely manage medicines.
- The service did not monitor the effectiveness of care and treatment. Therefore, they did not use findings to make required improvements to the service to ensure patients received safe care.
- Leaders did not have the necessary skills and abilities to run the service in relation to governance and managing performance and risk. They did not understand or effectively manage all the priorities and issues the service faced. They were not always visible and approachable in the service for patients and staff. They did not always support staff to develop their skills. Leaders did not operate effective governance processes, throughout the service and with partner organisations. Some staff were not clear about their roles and accountabilities and some non-clinical staff were asked to work outside of their competency level. Staff did not have regular opportunities to meet, for example at team meetings, to discuss and learn from the performance of the service. Leaders and teams did not use systems to manage performance effectively. They did not identify or escalate relevant risks and issues and therefore were unable to identify actions to reduce their impact. The service did not collect enough data in easily accessible formats, to understand performance, make decisions and improvements. The information systems at the service did not always support the delivery of the business.

However:

Summary of findings

- Staff managed clinical waste well.
- Controlled drugs were safely secured.
- The service had a vision for what it wanted to achieve.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Inadequate	

Summary of findings

Contents

Summary of this inspection

Background to Alexandra Private Hospital

The Alexandra Private Hospital is operated by Alexandra Health Care Limited. It is a private hospital located in Chesterfield. The hospital facilities include 21 beds which are split between 2 floors; however, the service mainly utilise the beds that are located on the first floor. There are also 2 theatres on the lower ground floor, 1 of which is mainly used by a third party for their procedures. There are also consultation rooms on the ground floor where patients will receive their pre-operative consultations.

The hospital provides cosmetic surgery for self-funding patients. The hospital also offers cosmetic dental procedures. We did not inspect these services.

The service currently has 3 registered managers, 2 of which have been in this position since the service registered with the CQC in October 2010.

The Alexandra Private Hospital has been inspected by CQC 6 times since they were registered. The most recent inspection was a comprehensive inspection on 11 October 2022. Following this inspection, the service was rated inadequate overall.

The service is registered to provide the following regulated activities:

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

At our previous inspection we found the following breaches of regulation:

Regulation 12: Safe care and treatment

- Patients were exposed to the risk of harm due to out-of-date equipment (consumable items) which was found during the inspection which had been available to use during recent episodes of patient care and treatment.
- Patients were exposed to the risk of harm due to the presence of out-of-date medications which were available for staff to use on patients.
- Patients were exposed to risk as standards of documentation were not always sufficient to provide assurance that all risks were suitably identified and acted upon. Some of the risk assessments were not tailored to the needs of the patients who attended the service. We also found there was minimal evidence of any discharge instructions given to patients when they left the service. This meant that there was a risk of patients not identifying if further medical advice or support needed in case of complications.

Regulation 17: Good Governance:

- Systems and processes in place did not identify that patient safety was being compromised.
- Systems and processes in place failed to identify that the service level agreements were no longer adequately covering the needs of the service.
- Systems and processes in place failed to identify that documentation did not meet the needs of the patients when reducing their risk of harm.
- The service did not report on patient outcomes. We are therefore not assured they are collecting, reviewing and using patient outcome data to ensure patients are getting the best outcomes.

Summary of this inspection

- There was no process to record and review risks to the service.

Regulation 18: Staffing:

- The service did not record staff compliance with required training.

We also found the following areas where the service needed to improve although a breach of regulation had not occurred:

- The service should ensure that staff follow appropriate infection prevention and control practices to minimise the risk of infection to patients.
- The service should ensure their systems and processes are robust enough to identify when service level agreements are no longer meeting the needs of the service and update accordingly.
- The service should ensure that staff consistently record accurate NEWS scores when performing observations on patients.
- The service should consider improving processes for identifying and managing patients who may be experiencing toxicity because of local anaesthetic.
- The service should consider how they assure themselves that patients consenting for cosmetic surgery are in line with the Royal College of Surgeons recommendations.

How we carried out this inspection

We completed onsite visits to the service on 22 February 2023 and 7 March 2023. The inspection team consisted of 2 CQC inspectors and was overseen by an inspection manager.

On both days of inspection, there were no theatre lists running or patient appointments. However, we still visited the ward and theatres. The last surgical procedure list had taken place on 15 February 2023; 1 week prior to our first inspection visit.

We spoke with 3 staff and 2 registered managers. We reviewed 22 sets of patient records.

Following this inspection, we requested the service take urgent action to mitigate serious risk of harm to patients. We reinspected the service on the 7 March 2023 to follow up on these actions; to review staff records, governance documentation and inspect medicines management.

After the second inspection we placed an urgent condition on the registration of the location to not undertake any regulated activities from the Alexandra Private Hospital location without the prior written consent of the CQC due to the serious concerns and associated risk to patients found again.

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

Areas for improvement

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

Summary of this inspection

Action the service MUST take to improve:

- The service must ensure that they display the current CQC rating at the hospital location and on their website. (Regulation 20A (1, 2, 3): Requirement as to display of performance assessments Health and Social Care Act (2008) Regulated Activities).
- The service must ensure they support patients to give informed consent for revision or return surgery following the original procedures. (Regulation 11 (1): Need for Consent).
- The service must ensure electrical items are safety tested and safe to use. (Regulation 15 (1c, e): Premises and equipment).
- The service must ensure governance processes are effective to enable sufficient oversight of performance, quality and risk. (Regulation 17(1, 2): Good Governance).
- The service must ensure all patient and staff information is stored as per General Data Protection Regulations. (Regulation 17(2d): Good Governance),
- The service must ensure patients are able to access appropriate and timely clinical advice following surgical procedures. (Regulation 12 (2b, c, i): Safe Care and Treatment).
- The service must ensure they have oversight of staff training and competency levels. (Regulation 18 (2a): Staffing).
- The service must ensure they are reporting outcome measures to external agencies in line with legal requirements. (Regulation 17 (1,2a): Good Governance).

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Inadequate	Insufficient evidence to rate	Not inspected	Not inspected	Inadequate	Inadequate
Overall	Inadequate	Insufficient evidence to rate	Not inspected	Not inspected	Inadequate	Inadequate

Inadequate

Surgery

Safe	Inadequate
Effective	Insufficient evidence to rate
Well-led	Inadequate

Is the service safe?

Inadequate

Our rating of safe stayed the same. We rated it as inadequate.

Mandatory training

Not all staff were compliant with mandatory training requirements and the service had no way to monitor this. The service provided mandatory training in key skills to some staff however, this was not in a timely way.

The service was unable to easily or clearly demonstrate that staff received or kept up to date with their mandatory training. During our inspection, registered managers at the service were unable to provide policies or procedures which outlined what mandatory training staff needed to complete and how often each staff member should complete this. We requested this information after the inspection and were sent a generic undated document entitled 'training for clinical personal' which outlined required training for this service, although clinical staff groups were not specified. The title of this document indicated non clinical staff were not considered with regards to mandatory training needs. The list of training topics was brief; and did not contain enough information for some training modules to reflect statutory requirements. In addition, this document was not dated and did not show evidence of being version controlled, reviewed or who the author was. The mandatory modules were listed as:

- Life support
- Equality and diversity
- Fire safety
- Health and safety
- IPC
- Information governance and GDPR
- Mental capacity
- Moving and handling
- Safeguarding

Managers provided an electronic document containing various training information for the following 11 staff: 1 HCA, 4 ODPs and 6 nurses. Managers did not provide any data relating to training compliance for medical staff, including plastic surgeons and anaesthetists, non-clinical staff or the leaders of the service. Where data was sent; this showed most staff listed had completed their training in other healthcare organisations. Not all the training modules were dated or showed a clear date of training with a date of the training expiry. Some training documents did not contain a name of the individual who had completed the training. As the service did not keep any staff training records which provided quick oversight of staff training compliance, managers would not be able to easily track staff training compliance be able to prompt staff when training was due.

Due to the way the data was presented, we were unable to ascertain if the training documents provided matched what was required for the role staff were employed for at this service. For example, 'life support training' was listed; but we saw no detail around what level each staff group required. Clinicians working in theatres require advanced life support (ALS) to be completed regularly but non-clinical staff only require basic life support. The data sent from the trust showed 1 staff member (out of 11 names given which excluded medical staff, non-clinical staff or management) was trained in ALS. All listed staff had received either level 1 or level 2 resuscitation training from other organisations which was the equivalent of basic life support training (BLS). Only 2 staff were trained to level 3 which was equivalent to immediate life support (ILS).

All staff listed were trained in equality and diversity.

All staff listed were trained in fire safety; however, we were not assured this included local fire safety training.

Out of 11 named staff (not including managers); 8 were trained in Health and Safety. Three staff were out of date with this.

All named staff had completed some form of training around infection prevention and control within the past 12 months.

Ten out of 11 listed staff were compliant with information governance training.

Nine out of 11 listed staff were compliant with some form of mental capacity training.

All listed staff had received moving and handling training over 2 years prior to this inspection.

All listed staff had received some form of adult safeguarding training over the preceding 2 years; this varied for staff members between level 1 and level 3. Four out of 11 staff had completed training in safeguarding children over the preceding 2 years.

We saw training and core competencies which are considered essential in other healthcare services offering surgical procedures to ensure patients are treated safely were not specified. For example, managing deteriorating patients, sepsis and medicines management.

Non-clinical staff were given a booklet which outlined an induction programme. However, at the time of our inspection, none of the non-clinical staff had completed this. Non-clinical staff were expected to learn their role themselves with little guidance or supervision. The reason for this was due to a substantive member of the administrative team being out of the business for a long time. However, the senior team had not arranged any alternative provision to ensure new staff were trained, monitored, or supported to undertake their role competently and safely.

The nominated individual for the service was the responsible officer for medical staff who did not have substantive employment at NHS organisations. This meant they completed their appraisals with the surgeons and anaesthetists which involved reviewing their completion of training. The nominated individual reviewed training as part of the appraisal process however there were no training completion dates.

Managers did not identify all staff training needs accurately. Staff used an assessment tool called the National Early Warning Score (NEWS) to assess patients who may deteriorate whilst undergoing care and treatment at the service. During our inspection, we found staff did not complete these assessments accurately which meant they may not be able to quickly identify when a patient was deteriorating and take the appropriate action. Managers told us staff who used this tool undertook training for NEWS at their substantive workplace within the NHS. However, NHS organisations use an updated version of this tool called NEWS2, introduced in 2017 to replace NEWS. NEWS2 is not measured or scored in the

same way as NEWS. Therefore, staff trained in NEWS2, would not necessarily be competent to undertake NEWS assessments and would not have undertaken any recent training in the original tool. However, we acknowledged one clinical team member employed solely by the service had undertaken NEWS training in 2021; however we also saw this staff member had undertaken many of the NEWS assessments for patients which were recorded inaccurately indicating this training was not embedded.

Managers did not monitor mandatory training or alert staff when they needed to update their training. Staff who were employed in a substantive role with another organisation, for example an NHS hospital, were expected to undertake the mandatory training offered there. Whilst managers said staff would be expected to share completion records to demonstrate compliance, as above, there was no governance arrangements to ensure this was done. This meant staff may be working with patients who were not up to date with their mandatory training requirements including life support.

Senior staff asked staff who were employed solely by The Alexandra Private Hospital to complete online training modules which was sourced by the registered managers. Two staff we spoke with had not completed any locally arranged training at the point of inspection including safeguarding training. However, at the time of our inspection, managers told us they had scheduled local safeguarding training for these staff

Non-clinical staff were expected to work outside of their competency and training levels. For example, undertaking pre-assessment appointments with prospective patients. We saw the forms clearly stated that a nurse should undertake these appointments. This meant patients may be at risk of not having their medical history and risk factors adequately assessed.

Safeguarding

Not all staff had adequate training on how to recognise and report abuse.

Managers had no oversight of staff safeguarding training requirements or compliance. Managers did not have oversight of the required safeguarding training levels staff were required to complete in line with 'The Intercollegiate Document for safeguarding children and young people: roles and competencies for healthcare staff (2019)' and 'The Intercollegiate Document for safeguarding adults: roles and competencies for healthcare staff (2019)'. This meant the service could not be assured all staff were trained to protect vulnerable people from abuse.

The service had an in date safeguarding policy however, this did not detail the level of training staff were required to be trained to or how staff would make a referral to the local authority. In addition, this policy did not reference responsibilities for children. Although we acknowledge children did not attend the location, the Intercollegiate Document for safeguarding children and young people: roles and competencies for healthcare staff (2019) states that all staff (including non-clinical) who work in a healthcare setting should receive training. Where staff work in an adult only setting; this training is still important as adult patients may have access to at risk children.

The training documents submitted showed some staff were trained and in date for both safeguarding adults and children however, this was not the case for all staff. A document provided which detailed a brief list of required training for the service did list safeguarding training. However, the type and levels of safeguarding training for staff groups was not specified.

Inadequate

Surgery

From our analysis of the data provided we saw, for 11 staff where training data was provided, all these staff had received some form of adult safeguarding training over the preceding 2 years; this varied for staff members between level 1 and level 3. Four out of 11 staff had completed training in safeguarding children over the preceding 2 years. As reported in mandatory training, managers did not provide any training data for any medical staff, non-clinical staff or senior leadership.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff told us they knew how to manage a safeguarding concern however this was from learning in previous roles.

The primary registered manager was trained to level 3 in safeguarding adults and children which was required as the designated safeguarding lead for the service.

Staff had a Disclosure and Barring Check (DBS) completed as part of the recruitment process to identify concerns that may put patients at risk. We checked a range of personnel files for medical staff and found 2 DBS checks had been undertaken over 4 years ago. Registered managers told us that there was no written or ratified policy around how often they renewed staff DBS checks although they would expect it to be done every 3 years. This meant the service could not assure themselves they were undertaking all checks to ensure staff were safe to work with patients.

Cleanliness, infection control and hygiene

The service did not control infection risk well. Equipment and premises were not visibly clean. Staff used out of date products to wash their hands. Staff monitored the effectiveness of infection prevention measures; however, we were not assured the actions in response outlined in action plans were fully implemented.

Not all ward areas were clean. We visited the ward office, 3 patient rooms, the ward cleaning area and the kitchen during our inspection. Whilst the patient rooms were visibly clean; the ward office was cluttered. We found dirty items which indicated the room had not been deep cleaned or checked for cleanliness recently. The ward clearing area had re-usable mop heads which were unsuitably stored. The re-usable mop heads were visibly dirty, and we noted an offensive odour in this area. During our second inspection visit, staff had improved the cleaning area on the ward had been organised with the buckets emptied and used mop heads disposed of. We saw the cleaning area in theatres was similarly organised and suitable for purpose.

The service had a cleaning policy. However, this did not contain any specific local process for staff to follow or information which outlined what clinical areas staff should clean, how these should be cleaned and how often.

The service had a cleaning tick sheet for the theatres and ward to guide cleaning staff. Cleaners were employed directly by the service.

We requested a copy of a policy which covered deep cleans in terms of frequency and expectations for this task. The service did not provide a policy or standard operating procedure; but records showed that deep cleans were undertaken on 2 occasions; October 2022 and January 2023 by internal staff.

The service had a COVID-19 policy which was regularly reviewed and updated in line with current government guidance and with local decisions around protective measures to take.

Inadequate

Surgery

Not all theatre areas were clean, and furnishings were not all clean and well-maintained. Equipment and stored items were dusty in some areas. We found damaged equipment such as a patient couch mattress in an operating theatre which had tape over ripped areas. This had been highlighted during our previous inspection in October 2022 as a risk to effective infection prevention and control. We also found a blood pressure cuff which was ripped and visibly dirty. Some sinks were visibly stained. Both the patient couch mattress and the blood pressure cuff had been removed by our return visit.

Documentation from the service reported the theatres were cleaned weekly, with the last clean undertaken on 15 February 2023. This was contrary to our findings. For example, 1 area which was marked as completed was 'all clinical and general waste disposed' however we found general rubbish on both our inspection visits.

Monthly audits of infection prevention and control practices within theatres were conducted although the dates these took place were not specified and the auditor had not recorded their name. We saw the issue of stained sinks was identified in the February 2023 audit indicating this had not been acted upon by our inspection visit. Managers told us they had scheduled the stained sinks be replaced after our inspection. These sinks were porcelain which had been stained by chemical waste, but were not otherwise visibly unclean. Although the audit directed the reviewer to check items such as antibacterial hand gel; the out-of-date hand gel was not identified.

Action plans did not drive improvement. An action plan covering the period July 2022 to January 2023 was provided for theatres, the ward and for hand hygiene. However, we did not see audits for the ward to support the action plan for this area. In the ward action plan clutter from the nurses' station was identified as a concern. This had not been rectified by our February 2023 visit. The action plans did not specify who was responsible for what tasks or provide any timeframes for completion.

All of the audits we reviewed showed high compliance to infection prevention and control. We did not see staff working clinically during our inspection and therefore cannot determine if staff used appropriate hand hygiene methods; our findings on general cleanliness in theatres, the ward cleaning area and the ward office did not support the high audit scores.

One bottle of antibacterial hand gel for staff use and an almost full box of surgical nail scrubbing brushes mounted above the scrub sink for staff use were out-of-date. We found a used nail brush on top on the clean brushes. These items had been removed by our return visit.

Staff had access to personal protective equipment (PPE). This was stored in easy to access areas within the theatres.

The service audited hand hygiene practices monthly although as above the date these audits were undertaken was not recorded.

Not all reusable surgical equipment was safe to use. The service had an agreement with the local acute hospital for decontamination of surgical equipment which was reusable. We found unwrapped equipment in a trolley in the first theatre which should be packaged in sterile packaging after decontamination. This indicated the equipment needed to be decontaminated. We found these items in the same place in our second visit indicating they had not yet been removed. Some equipment packaging was compromised and therefore staff could not ensure it was safe to prevent patients from acquiring infections.

The service had 1 surgical site infection from October 2022 to February 2023 which was identified post procedure.

Inadequate

Surgery

Environment and equipment

The design, maintenance and use of facilities, premises and equipment were not sufficient to keep patients safe. Staff managed clinical waste well.

Staff did not ensure consumable equipment was safe for use. We found over 60 items which were past their expiry date as part of a sample check across all areas we checked. Some of this had been expired for a number of years for example equipment used to aid intubation in emergency which expired in 2016 was found in the recovery room. This meant patients could be exposed to a risk of harm if staff used expired items. Following our first visit, the registered managers told us action had been taken to rectify this risk. When we returned for our second inspection visit we saw that the expired items identified by us had mostly been removed although we saw some items still left in one clinical room within theatres. We also found a further 46 individual items and 2 boxes of sutures, all of which had expired. The out-of-date items expiry ranged from 2015 to the month prior to our inspection.

Staff did not follow a system to dispose of out-of-date or damaged items. We saw a piece of reusable equipment left in the storage room, despite a note attached to it from 2022 advising this instrument could not be effectively decontaminated.

The design of the environment did not always follow national guidance.For example, Health Building Note 26 (HBN26): 'Facilities for surgical procedures: Volume 1' outlines standards for operating theatres. HBN26 states that security measures are needed to prevent unauthorised access to the theatres. We found the theatre areas were not locked or secured meaning anyone in the building such as contractors, patients or visitors or non-clinical staff could enter any of the theatre areas at any time. On the day of our first visit' external contractors were working in this area. However, on our return visit keypad locks had been fitted to the 2 doors at either end of the theatre area and were locked on arrival demonstrating some improvement had been made. Senior staff confirmed further locks were on order to secure each individual clinical and storage area within theatres.

Not all patient windows on the first floor were fitted with restrictors. On 1 side of the corridor, windows were fitted with suitable restrictors although managers were not aware of the correct restriction measurement. However, all patient rooms on the other side were unrestricted. The non-restricted floor to ceiling windows opened onto a balcony area from which a patient could potentially walk out onto and fall into the car park or through the glass atrium below. The service did not have a risk assessment in place for these windows as specified as a requirement in Health Building Note 00:10 Part D: Windows and associated hardware. Managers told us that the fire service had advised these should be used by ward-based patients as an emergency exit in the event of a fire. We reviewed the most recent fire assessment conducted in June 2022 and found no reference of this advice. In addition, this was not listed as an emergency fire escape route in the service policy entitled 'fire safety policy and procedure' last updated in June 2022 which was the same month as the fire risk assessment. Following the inspection, managers told us window restrictors had been fitted; however we were not sent any risk assessment completed prior to this being done; indicating managers did not fully understand the requirements of HBN 00:10 Part D.

Some aspects of clinical areas followed national guidance for example flooring was easy to clean and continued partially up the wall in line with infection prevention and control guidance and HBN26. Sinks in all areas enabled staff to operate the taps using their elbows although as above some sinks were visibly stained.

Theatre 1 was fitted with laminar flow ventilation as per Health Technical Memorandum (HTM) 03-01: 'Ventilation in healthcare premises'. This meant air flow was optimised to reduce the risk of surgical site infection.

Staff carried out safety checks of specialist equipment. The period in between maintenance for medical equipment, with the exception of anaesthetic equipment which still required yearly servicing, had been extended to 2 years. The service had a device management policy and kept a record of specialist clinical equipment and maintenance.

Staff checked the resuscitation/ difficult airway trolley using a check sheet which promoted staff to complete this task before every surgical list. We saw checks were also completed for days when the service did not have planned procedures. On 2 out of 6 checks (22 November 2022 and 15 February 2023), we saw recorded that the anaesthetic machine had been checked. We did not see evidence this had been checked on the other 4 days. This meant the service could not be assured the trolley was fully equipped, free from tampering and safe to use in an emergency.

The service did not provide us with evidence the resuscitation trolley on the wards was checked.

The service had enough suitable equipment to help them to safely care for patients. For example, they had adequate anaesthetic machines and relevant theatre consumables to undertake procedures.

Staff disposed of clinical waste safely using a third-party provider. Sharps bins were labelled and not overfilled. Staff had access to an up-to-date policy which provided an overview of what clinical waste was, and where to dispose of this.

Not all fire risks were mitigated as per a fire risk assessment completed in June 2022. We saw a number of full and empty medical gas cylinders stored within a general storage room. The majority of these were stored safely in dedicated racks; 4 empty cannisters were leant against the wall. There was no sign on the door of this room to indicate potential fire hazards despite a statement in the fire risk assessment stating signs were present in any areas containing fire hazards at the time that assessment was conducted. However, we acknowledge that maintenance staff were painting the corridor into which this door opened. Managers told us the sign had been removed for the purpose of painting and would be replaced when this was completed.

We found a small quantity of non-clinical electrical equipment out-of-date for safety testing; or not tested at all. This presented a fire hazard and was outside of the requirements of the fire safety risk assessment. For example, we found a radio in theatre 1 which was due for testing in February 2014.

The fire safety policy and procedure was specific to this location and clearly outlined what actions to take in the event of a fire and stated where fire exits were located.

Fire extinguishers were inspected in August 2022 and were within the date for their next inspection.

Assessing and responding to patient risk

Staff did not always complete risk assessments for each patient. Staff did not identify or quickly act upon patients at risk of deterioration. The service could not evidence that patients knew who to contact to discuss post-surgical complications or concerns.

Staff did not effectively use a nationally recognised tool to identify deteriorating patients or escalate them appropriately. We saw that the original National Early Warning Score (NEWS) was used, rather than the updated NEWS2 to assess patient's physiological observations and detect and respond to clinical deterioration in patients. In all 22 records we checked, the NEWS scores were either not calculated at all; or were calculated incorrectly. This meant that deteriorating patients were not identified, and no action was taken in response which exposed patients to a risk of harm.

Where patients NEWS scores did rise indicating deterioration; staff did not identify this. For example, for 1 patient; we calculated that the patient's NEWS score increased from a '0' to a '2' whilst in recovery post procedure from 14.30 to 15.05; with 6 sets of observations being done in this time. This meant they had shown some deterioration. Despite this, the patient was moved to the ward and there was no evidence in this patient record to show staff identified, considered, or acted upon this deterioration.

The registered managers told us that nurses who completed patient observations using NEWS all completed their mandatory training within the local NHS trust where they worked substantively. The local NHS trust used a modified version of this tool NEWS2 which meant staff were trained on a different tool to the one used at The Alexandra Private Hospital. The registered managers acknowledged this risk and stated their intent to commence using NEWS2 as soon as it was possible to obtain the assessment paperwork.

Staff did not always complete risk assessments for each patient or review these regularly. We saw venous thromboembolism assessments (VTE) were not completed consistently and did not always reflect prophylaxis used (such as compression stockings).

We saw 3 World Health Organisation (WHO) safer surgery checklists were not completed fully; and in 1 case for a patient who returned for an internal suture removal procedure, the checklist was not completed at all. This meant that national safety guidance for surgery was not always followed, exposing patients to a risk of harm or a never event through errors which may be made when not following a systematic process. A never event is a serious incident or error that should not occur if proper safety procedures are followed. The service had previously had a never event in 2021.

The service kept a record of each patient's journey within theatre; for example, the positioning of the patient, if the patient was high risk, the patients' American Society of anaesthesiologists (ASA) score which indicated the anaesthetic risk level and if the surgical trolley had been checked. We saw staff consistently recorded that correct steps were taken within theatre to keep patients safe.

Staff did not always identify mental health conditions as part of the assessment process. The service completed self-reporting screening tools for depression and anxiety as a way of identifying potential mental health symptoms which might indicate cosmetic surgery was not suitable for some patients. However, we did not see evidence that staff considered this information in a meaningful way. Two patient's records indicated patients were prescribed antidepressant medication at the time of their consultation and pre-operative assessment. We saw pre-operative questions relating to mental health, as completed by the nurse, indicated patients did not have any mental health concerns despite their prescribed medicine. In 1 record this contrasted with what the consultant had recorded at the time of the initial consultation for surgery.

Staff did not follow one patient up who did not return for post-operative checks. Staff emailed the patient and asked them to contact the service. We found no evidence to indicate any additional contact had been attempted by staff or that the patient had returned for an appointment. This presented a missed opportunity to identify harm.

The service had a process to communicate histology findings to patients or their GPs if results indicated further investigation was required as per an up-to-date policy entitled 'Pathology Reports Protocol'. Staff at the service could not evidence they fully completed their own documentation when managing results from histology samples sent off for testing. Staff clearly recorded when they sent off samples; but did not record evidence that results were received and acted upon if necessary. Managers at the service told us they had not received any results which required follow up with the GP.

Inadequate

Surgery

Staff did not consistently complete the discharge notes page within patient records. This meant it was not possible to see what advice had been given to patients on discharge, at what time they were discharged and if they had been given any specific medicines to take home. Managers told us they did record when results were returned; however, were unable to provide evidence to support this.

The hospital did not sufficiently complete patient records to show some follow-up support for patients was effectively managed.We asked the service about their discharge and aftercare process. The service told us at discharge, patients are given an aftercare advice leaflet that included postoperative instructions, information on post operative complications such as infections, and an instruction to contact the hospital in the event of any concern. We saw these leaflets were available at the service during our inspection. Following discharge, any advice requests were answered by a nurse via telephone and patients were offered face-to-face appointments if necessary. The relevant surgeon would be informed; and would provide instructions to hospital staff regarding management of the concerns raised. We asked for evidence of advice requests and subsequent recommendations; the service sent a patient record whereby a nurse had communicated with a patient about suture concerns. An appointment was made for 2 weeks' time. Another example showed an email sent to a consultant whereby a patient had twice contacted the service about concerns. We did not see the original concerns, the date these were received, or the consultant's response. Therefore, it was not possible to identify if this patient received a timely response.

The service told us for emergency treatment during surgery, such as a major haemorrhage, patients would be sent via ambulance to the local NHS trust. Where patients at this service had required an urgent return to theatre; this had always occurred before patients were discharged and had been due to hematomas. A haematoma is *pool of mostly clotted blood that forms in an organ, tissue, or body space*

Records

Staff did not keep detailed records of patients' care and treatment. Records were not comprehensive, inconsistent and did not follow best practice guidance. Records were mostly stored securely and easily available to staff providing care however did not include all information to keep patients safe. Staff recorded all cosmetic implants on the Breast and Cosmetic Implant Registry (BCIR).

Patient notes were not comprehensive. We reviewed 22 patient records during our inspection and found none of these contained enough accurate information to keep patients safe. For example, staff did not calculate physiological observation scores therefore were not able to easily identify patient deterioration.

We noted inaccuracies in patient records; and 2 patient records did not clearly document what clinical care the patient had received.

We found numerous areas of patient records where forms had not been fully completed. For example, not all discharge notes were completed.

We saw 'not applicable' written in a WHO safer surgery checklist has the 'has the [surgical] site been marked' section. This surgery was addressing 1 specific area of the body therefore it would have been appropriate to mark this to avoid a never event. A never event is a serious incident or error that should not occur if proper safety procedures are followed.

Medical and nursing staff did not always follow good clinical note taking principles. For example, nursing notes were signed but the signature could not be read. No printed name was provided therefore it was not possible to see who had made these entries. Medical notes were illegible at times. Medical staff did not always print their name either. Consent forms to share outcome information with The Private Healthcare Information Network (PHIN) were either not completed

at all or crossed through indicating staff did not talk these through with patients or submit information to PHIN. PHIN is an independent, government mandated organisation that publishes performance data for private hospitals and consultants. Staff did not complete consent forms for revision surgery or follow up surgeries such as internal suture removal under anaesthetic.

Records were stored securely. The records were paper based and stored in locked cabinets behind the reception desk. All staff could access patient records easily.

However, we found both patient and staff identifiable personal and sensitive information in areas accessible to contractors and visitors. Some of this documentation was over 12 months old indicating it had been in place for a long time without being destroyed or securely stored.

Medicines

The service did not consistently use systems and processes to safely manage medicines.

The service used a numbered prescription pad to write prescriptions which was kept securely.

The service had a medicines policy in place; however, this only referred to the management of controlled drugs. There was no policy or guidance to support staff to manage non-controlled drugs. The service did have an in date antibiotic prescribing policy in place which described best practice with regards to antimicrobial use.

Staff did not record advice to patients about medicines after surgery. Therefore, we were not assured patients had enough information to safely take their medicines outside of the hospital setting.

Staff did not complete medicines records accurately. On medicine administration pages within patient records, staff did not print their name or consistently include all information to indicate what medicines had been given at what time.

Staff did not store or manage all medicines safely. We found unsecured medicines in areas easily accessible to non-clinical staff, as the doors to the operating theatres, storeroom, recovery room or anaesthetic room were unlocked. We found it was not possible for them to be locked. This presented a safety risk as there was the potential for medicines to be accessed, taken or tampered with by unauthorised persons. During our inspection, we saw people who were not directly linked to the service had access such as external contractors working in the theatre areas.

We also found a number of out-of-date medicines. For example, in the ward office we found 2 expired medicines which were different types of intravenous infusion liquid (both expired 01/23). In the anaesthetic room we found1 bottle of sterile intravenous solution which expired in 2022. This was still present when we revisited the service on 7 March.

We also found a collection of part used medicines kept in drawers. These included co-codomol, ibroprofen, and paracetamol. 1 packet had been prescribed but the patients name had been crossed out; indicating this may have been given to other patients. Many of these medicines were not in their original packet which meant the expiry date was not easily observable.

Controlled drugs were safely secured as per the policy. The controlled drugs register accurately reflected stock levels. However, we noticed 1 controlled drug strip had been cut and therefore the expiry date was not present. The service reported no incidents related to controlled drugs for October to December 2022.

Inadequate

Surgery

Data from the service reported managers shared national and local patient safety alerts with clinical staff, in addition to any relevant updates from the local NHS trust.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Managers reported there had been no incidents reported since our last inspection in October 2022. Staff we spoke with told us they informed the managers of any incidents.

The service had no never events since our previous inspection.

The service had in date incident reporting and duty of candour policies. The incident reporting policy contained instructions to complete the incident reporting form and for what sort of incidents.

Staff did not always receive feedback to look at improvements to patient care. However, Information provided post inspection showed changes were made because of staff and patient feedback; particularly with regards to upgrading specialist medical equipment.

Is the service effective?

Insufficient evidence to rate

We did not rate the effective key question as there was insufficient evidence to rate.

Patient outcomes

The service did not monitor the effectiveness of care and treatment. Therefore, they did not effectively use findings from audits to make required improvements to the service.

The service did not submit performance data to participate in relevant national organisations that publish performance results. This was identified on our previous inspection in October 2022. From 2018, the Competition and Markets Authority (CMA) required every operator of a private healthcare facility that admits patients including cosmetic surgery patients to collect performance data and to supply this to the Private Healthcare Information Network (PHIN).

The service did not collect clinical quality indicator data; specifically, Q-PROMS (patient reported outcome measures) for cosmetic surgery. These are self-reported pre- and post-surgery questionnaires which seek to measure patient satisfaction on the quality of their surgery. Q-PROMS data can be collected for the following types of surgery which are undertaken at The Alexandra Private Hospital:

- BREAST-Q – Augmentation mammoplasty
- FACE-Q – Rhinoplasty
- FACE-Q – Blepharoplasty
- FACE-Q – Rhytidectomy
- BODY-Q – Abdominoplasty

Inadequate

Surgery

- BODY-Q – Liposuction

Managers at the service told us they had issued 4 Q-PROMS questionnaires to patients since October 2022, but the patients had not completed these. We did not see any evidence of this in patient records; and within patient records saw that consent forms to submit information to PHIN were either not completed or crossed through.

The Royal College of Surgeons (RCS) states 'All services that provide cosmetic surgical care within the UK should be working towards collecting these data items.

As performance data was not collated; managers and staff did not drive improvement to outcomes.

Managers and staff did not carry out a programme of repeated audits to check improvement over time. Since our last inspection in October 2022, no audits had been undertaken for any performance area including clinical audits despite this being identified as an action to be undertaken following urgent enforcement taken at that time. Managers told us this was due to 1 member of staff being on long term unplanned absence. As no audits were undertaken, we saw no improvements since our last inspection in terms of care and treatment.

Is the service well-led?

Inadequate

Our rating of well-led stayed the same. We rated it as inadequate.

Leadership

Leaders did not demonstrate the skills and abilities to run the service in relation to governance and managing performance and risk. They did not demonstrate understanding or manage all the priorities and issues the service faced. They were not always visible and approachable in the service for patients and staff. They did not always support staff to develop their skills.

Leaders did not understand or manage the priorities and issues the service faced. They were not aware of significant risks to the service including patient safety risks and therefore did not act to address them. Leaders did not have oversight of clinical quality and performance, specific legal requirements or staff performance.

Leaders were not always visible for patients and staff. Whilst a registered manager was on site for some patient activity; this was not consistent and often administrative staff were left to manage the patient facing aspect of the service with little input from leaders.

Staff were complimentary about leaders in respect of being generally caring. However, leaders did not support all staff to develop their skills; new staff were given induction booklets, but staff were not supported to complete these; nor were they offered mandatory training until almost a year after commencing in the role.

Staff were not provided with policies or processes which contained enough specific detail to enable them to effectively carry out their roles.

Vision and Strategy

The service had a vision for what it wanted to achieve.

Inadequate

Surgery

Leaders at the service wanted to increase engagement with patients in the future; and to address concerns raised following CQC inspections conducted in 2022 and 2023. At the time of our current inspection, the service did not have a specific action plan to achieve this.

Governance

Leaders did not operate effective governance processes, throughout the service and with partner organisations. Staff were not clear about their roles and accountabilities and non-clinical staff were asked to work outside of their competency level. Staff did not have regular opportunities to meet, discuss and learn from the performance of the service.

The service did not have effective structures, processes and systems of accountability to support the delivery of safe and good quality, sustainable services.

Not all policies and processes at the service supported effective governance and performance.

Managers were unable to provide policies or procedures which clearly outlined what mandatory training was required per staff member and how often each staff member should complete this.

The service did not keep any form of accessible record which provided quick oversight of staff training compliance. This meant even if a list of required training was available, managers would not be able to easily track training and prompt staff when training was due.

Although a 'cleaning, disinfection and sterilisation' policy was available, the service did not have a policy or process which outlined how often cleaning needed to be done in clinical areas. This meant there was no process to ensure staff who cleaned were clear on their roles and responsibilities. Not all audits reflected what we saw on inspection. Action plans around infection prevention and control did not drive improvement. The action plans did not specify who was responsible for what tasks or provide any timeframes for completion.

The service had a medicines policy in place; however, this only referred to the management of controlled drugs. There was no policy or guidance to support staff to manage non-controlled drugs.

There was no stock control process to ensure all stock was monitored and rotated effectively to avoid expired items being used.

There was no process in place to assess the health and safety of the building and environment. However, following our first inspection visit in February 2023; managers did install locks on the outer theatre area doors following feedback.

There was no process in place to collect patient outcomes.

No audits had been completed since our last inspection; despite this forming part of the post enforcement action plan in October 2022. This meant no improvement was identified at our current inspection despite a warning notice being issued at that time which meant urgent improvement was required. In addition, the service did not have a process to review the quality of patient records.

We saw the service did have a comprehensive service level agreement to support sterilisation of surgical instruments with a third-party provider.

The service had a device management policy and kept a record of specialist clinical equipment and maintenance.

Managers did not hold any team meetings with staff. Most of the communication was through a shared messaging service; however, this was not always adequate to provide required support to staff located at the service. This also meant staff who raised issues through this communication method did not always receive feedback. Senior leaders told us they fed back positive patient feedback to the relevant staff.

The service held medical advisory committee meetings. We saw the minutes of a meeting held in January 2023; however, we were not assured that these meetings were effective as a governance process to share information, drive change or monitor performance. For example, in the agenda item 'clinical governance items'; the minutes record agreement in improving areas of risk identified in the last CQC inspection including removing expired items, ensuring quality medical notes and improving governance. However, our findings from the current inspection show none of this was actioned including an action of direct engagement with staff to achieve outcomes. We also noted there was no discussion of clinical performance including updates to practising privileges. We saw 1 consultant file did not have a practising privileges contract.

Management of risk, issues and performance

Leaders and teams did not use systems to manage performance effectively. They did not identify or escalate relevant risks and issues and therefore were unable to identify actions to reduce their impact.

The service did not have an up-to-date risk register at the time of the site inspection dates. However, managers sent an updated risk register after the inspection which had the additions of out-of-date stock, incomplete or inaccurate patient records and the risk of non-compliance with legal and regulatory requirements. We saw not all risks to the service had been captured at this stage. For example, the non-completion of an agreed audit programme due to the unplanned long term absence of key personnel.

Managers of the service had limited oversight of compliance with safety requirements at the time of our inspection. For example, they were not aware of the number of expired items present in all areas of the service or the poor completion of patient notes.

Service leaders had not ensured concerns raised in our previous inspection had been addressed in a timely way and took no personal responsibility in line with their roles, as we found the same risks on the current inspection. Managers did not take responsibility for reviewing work undertaken by delegated individuals, or for finding alternative staff to undertake urgent audits.

Managers told us they had recruited 2 external staff to work on a part time basis to ensure improvements were made to the service with regards to findings from our current inspection. However, 1 of these staff had not been provided with a specific remit or job plan for this task and were therefore not sited on what actions specifically needed to be taken, by when, or how they or the management team would measure or monitor this.

Despite the service having a fire risk assessment and comprehensive policy, they did not demonstrate compliance with required actions identified in the risk assessment to reduce risk to patients and staff.

The service did have a comprehensive risk-based approach to managing COVID-19 which was clearly outlined to patients and staff.

Inadequate

Surgery

Information Management

The service did not collect enough data in easily accessible formats to understand performance, make decisions and improvements. The information systems in place did not always support the effective and safe delivery of the business.

On our first visit to the service in February 2023, we found the service was not displaying their CQC rating as per Regulation 20A: Requirement as to display of performance assessments (Health and Social Care Act (2008) Regulated Activities. We informed the registered managers of this finding; this was subsequently displayed in the waiting area on our second inspection visit in March 2023. However, we noted this was still not displayed on the service's website as required by this regulation.

The service did not collect data to drive improvements or understand improvements. No audits had been undertaken since our previous inspection.

The service did not always provide all required information to external bodies. The service did not collect performance data as required by the Competition and Markets Authority (CMA) or as recommended by the Royal College of Surgeons.

However, the service had submitted their latest quarterly report to CQC under the Controlled Drugs Regulations 2013 to be included in the Controlled Drugs Accountable Officer (CDAO) Register.

The service did record the number of surgical site infections and revision surgery following patient procedures.

The service had moved to storing some information electronically; however due to ongoing external problems with the server they had started to move back to a paper-based approach. This meant managers were not able to easily find documentation to demonstrate compliance with regulations. This had been an on-going issue since our previous inspection. Leaders were in the process of reviewing alternative options to move back to an electronic system.

We found both patient and staff identifiable personal and sensitive information in areas accessible to contractors and visitors which meant this was at risk of patient information security breaches. Some of this documentation was over 12 months old indicating it had been insecurely stored for a long time without being destroyed or securely stored.