Liverpool Skin Clinic Limited

Liverpool Skin Clinic

Inspection report

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

Ratings

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

Summary of findings

Overall summary

Liverpool Skin Clinic is operated by Liverpool Skin Clinic Limited. The service is based in Mossley Hill, Liverpool and provides hair transplant cosmetic surgery and platelet-rich plasma hair restoration therapy for private fee-paying adults.

The clinic facilities are on the ground floor, which include a reception and office area, a waiting room, a consultation room, a bathroom, a kitchen, two treatment rooms and a stock room. There is a washroom with a backwash sink unit that is used to shave and wash patients' hair before procedures and an additional surgical wash area used for after care. Treatment rooms and waiting rooms are easily accessible with a ramp if required for the two steps leading to the washroom.

We rated it as inadequate because:

- Mandatory training did not cover all key skills and the service did not monitor compliance. Staff did not always complete training on how to recognise and report abuse. Not all staff had been safely recruited through pre-employment checks. The service did not always control infection risk well and did not have a process to monitor surgical site infections. Staff did not ensure equipment was maintained to keep people safe. They did not manage clinical waste well. Staff did not always complete documented risk assessments or record follow up discussions to identify or minimise any risks. The service did not always follow their own processes to manage medicines and could not be sure that staff knew how to store and dispose of medicines safely
- The service did not always provide care and treatment based on national guidance and evidence-based practice. The service did not carry out an audit for patient outcomes to evidence good outcomes or use the findings to make improvements. Not all staff had an appraisal or supervision meetings to measure staff competency and provide support and development. The service did not always have clear documentation to evidence that consent was in line with national guidance or that patients gave consent in a two-stage process with a cooling off period of at least 14 days between stages.
- The complaints procedure was not displayed or explained to patients as to how they could give feedback and raise concerns about care received. The service did not have an effective complaints policy in place to respond to concerns and complaints appropriately.
- Leaders did not demonstrate the necessary skills and abilities to run the service. They did not always understand and manage priorities and issues the service faced. The service did not have a formally documented vision for what it wanted to achieve and a strategy to turn it into action. Leaders did not operate effective governance processes. Staff did not have regular opportunities to meet, discuss and learn from the performance of the service. The service did not use systems to manage risk, issues, or performance effectively. They did not have clear plans to cope with unexpected events. The service did not collect and analyse data to understand performance or make decisions and improvements. The service did not have clear plans for learning, continuous improvement or innovation.

However:

- Equipment and the premises were visibly clean and the service had suitable premises and facilities to meet the needs of patients. The service had a process to identify and quickly act upon patients at risk of deterioration.
- Staff gave patients enough food and drink to meet their needs. Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. All staff worked together as a team to benefit patients. They supported each other to provide good care. Patients could contact the service seven days a week for advice and support after their surgery. Staff gave patients practical support and advice.

Summary of findings

- The service planned and provided care in a way that met the needs of local people. The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. People could access the service when they needed it and received the care in a timely way.
- Staff we spoke with felt respected, supported and valued. Staff told us they were focused on the needs of patients receiving care. The information systems were secure.

Following our inspection, we issued the provider with one section 29 Warning Notice for Regulation 17 HSCA (RA) Regulations 2014 Good governance. We also issued the provider with a requirement notice for Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Inadequate 	We rated this service inadequate. See the summary above for details.

Summary of findings

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Summary of this inspection

Background to Liverpool Skin Clinic

Liverpool Skin Clinic is operated by Liverpool Skin Clinic Limited and has been registered with the Care Quality Commission (CQC) since 2013. The service has been monitored through our engagement and transitional monitoring approach.

The service provides hair transplant cosmetic surgery and platelet-rich plasma hair restoration therapy for private fee-paying adults and is registered to provide surgical procedures and the treatment of disease, disorder or injury.

The service uses the follicular unit excision method of hair transplant cosmetic surgery. In follicular unit excision, individual hair follicles are extracted and then implanted into small incisions in the patient's scalp. We do not regulate or inspect cosmetic procedures that do not involve cutting or inserting instruments or equipment into the body. The service provides platelet-rich plasma hair restoration therapy as a stand-alone treatment or alongside hair transplant procedures. The therapy involves extracting plasma from the patient's blood and injecting it into the scalp to promote hair growth.

There is currently no mandatory accredited qualification for hair transplant surgery in the United Kingdom. However, the surgical steps of the procedure should only be performed by a General Medical Council (GMC) licenced doctor. The service has one hair transplant surgeon, who is also the registered manager, a hair transplant technician, and a client relations lead.

Treatments are provided for adults aged 18 and over. The service is open flexibly on a pre-bookable appointment only basis. Patients can book directly online or by phone. The service website can be accessed at: https://theskinandhairclinic.co.uk)

The service had a registered manager in place since initial registration until February 2022. An application for a new registered manager was not submitted until September 2022 and approved in November 2022. This meant the service did not have a registered manager in place for 9 months and breached requirements of Regulation 7 HSCA (RA) Regulations 2014 Requirements relating to registered managers.

We have not previously inspected Liverpool Skin Clinic.

How we carried out this inspection

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 19 December 2022 and an announced follow up visit on 23 January 2023.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate. Due to a low number of patients consenting to speak with us the caring key question could not be rated.

Summary of this inspection

During our inspection we interviewed all three staff who were based at the service, including the registered manager. We spoke to one patient who attended the service on the day of inspection, and we reviewed some comments from patients that the service had received online. We also looked at six patient records.

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

Areas for improvement

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

Action the service MUST take to improve:

- The service must have processes in place to ensure that staff are suitably qualified, competent, skilled and experienced to provide a safe service (Regulation 12(2)(c)).
- The provider must have processes that assess the risk of, and prevent, detect, and control the spread of, infections, including those that are health care associated (Regulation 12(2)(h)).
- The service must ensure that equipment is maintained and serviced in accordance with manufacturer's guidelines (Regulation 12(2)(e)).
- The service must ensure the safe and proper management of medicines (Regulation 12(2)(g)).
- The service must ensure there are relevant, service specific policies in place using the latest best practice guidance. This should include but not be limited to adapting the complaints policy to respond to concerns and complaints appropriately (Regulation 17(2)(a)).
- The service must ensure that robust procedures are in place to record all decisions taken in relation to care and treatment and make reference to discussion with people who use the service and record their consent (Regulation 17(2)(b)(c)).
- The service provider must have systems and processes such as regular audits of the service and must assess, monitor and improve the quality and safety of the service (Regulation 17(2)(a)).
- The service must ensure that robust recruitment processes are in place and ensure that all staff undergo an up to date disclosure and barring service prior to employment (Regulation 17(2)(d)).
- The service must ensure that appropriate policies, systems and processes are in place to govern the service, support staff to do their roles safely and manage the risks to patients (Regulation 17(2)(a)(b)).

Action the service SHOULD take to improve:

- The service should develop a mandatory training matrix appropriate for each role and in line with recommendations and monitor staff training to ensure they are up to date in mandatory key skills.
- The service should develop a risk assessment template that can be clearly documented in patient records to demonstrate the actions taken to mitigate risks.
- The service should clearly display information on how to raise a complaint.
- The service should consider adapting documentation to inform patients of the 14 day cooling off period and to clearly evidence the cooling off period in patient records.
- The service should continue to implement the use of patient surveys and use these to make any improvements identified.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Inadequate	Inadequate	Insufficient evidence to rate	Requires Improvement	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Insufficient evidence to rate	Requires Improvement	Inadequate	Inadequate

Inadequate

Surgery

Safe	Inadequate
Effective	Inadequate
Caring	Insufficient evidence to rate
Responsive	Requires Improvement
Well-led	Inadequate

Is the service safe?

Inadequate

Mandatory training

The service provided mandatory training to all staff. However, the training did not cover all key skills and the service did not monitor mandatory training. This meant the provider could not be assured staff training was up to date.

The service did not have a set list of mandatory training required for each staff role and did not monitor compliance to alert staff when they needed to update it. One staff member had infection control and information governance training that should be completed annually and had expired in July 2022. Staff training records showed that two staff members had completed paediatric basic life support (BLS) level two training. However, the service did not treat children.

The registered manager could not be sure that all staff had completed the training required to perform their roles safely and reduce the risks to patients. We looked at staff training records and no staff members had completed resuscitation as part of their mandatory training. This was not in line with the Health Education England core skills training framework.

No staff had valid first aid training. The registered manager had completed emergency first aid at work training in February 2015 which was only valid for three years and they did not provide evidence they had completed adult Basic Life Support training (BLS).

However, all staff had received training in key areas such as fire safety, moving and handling and equality and diversity.

From 1 July 2022, all registered health care providers were required to ensure their staff received training in learning disability and autism, including how to interact appropriately with autistic people and people who have a learning disability. This training should be at a level appropriate to their role. At the time of the inspection, two of three staff members had completed autism awareness training. This meant some staff had the skills and knowledge to communicate effectively and provide safe care to these patient groups.

Safeguarding

Staff did not always complete training on how to recognise and report abuse. Not all staff had been safely recruited through pre-employment checks.

Inadequate

Surgery

All staff had completed adult safeguarding training up to level three. However, two of three staff had not completed any child safeguarding training. This was not in line with the recommendations of the Intercollegiate Guidelines for Safeguarding Children and Young People. It is recommended that all staff working in healthcare services should complete level one training. This meant that not all staff had received safeguarding training to the specific level required for their role.

The service had a safeguarding policy which covered all aspects of potential abuse such as physical abuse and neglect. It described what actions to take such as phoning the local authority safeguarding team. However, there was no phone number provided on the policy and staff told us they would search for the local authority details online. The service treated patients who resided in areas outside of Liverpool. The registered manager described the actions they would take to locate the relevant authority, but the policy did not outline these steps for staff. This was not in line with best practice.

The service required all staff to have pre-employment checks such as a Disclosure and Barring Service (DBS) check as part of their recruitment. We saw that one staff member had a DBS check completed within the last three years. Post inspection, the service provided evidence of DBS checks for the other two remaining staff members. However, one was dated February 2023 (after our inspection) and ten months after they had commenced employment. This meant that staff had not always been recruited safely.

However, the service had guidance about the level of adult safeguarding training required for each staff role.

Staff were able to verbally describe that they would contact social services or the patients' GP if they had identified a safeguarding concern.

Cleanliness, infection control and hygiene

The service did not always control infection risk well or have a process to monitor surgical site infections. However, equipment and the premises were visibly clean.

The service had an infection control and sharps policy that was not always adhered to. For example, the storeroom was cluttered and not well organised. The policy stated that products and supplies should be used within the expiry date. We looked at storage for supplies and found a small number of sterile swabs, dressings and infiltration tubing were the past expiry dates. In one of the treatment rooms there were some syringes for needles past the expiry date. These were removed and the registered manager told us that they were not used. This meant the service did not follow a process for monitoring expiry dates for clinical supplies and expired items might no longer be sterile and be ineffective.

We found no evidence to confirm that any regular audits were taking place for managing and monitoring infection control practices or the cleanliness of the environment. The registered manager told us they had just started to do this. We observed a blank infection control audit document that covered areas such as hand hygiene, personal protective equipment (PPE) and cleanliness of the environment.

The registered manager told us that all surgical instruments are single use and that a desktop steriliser was used approximately once a month to decontaminate some instruments. During our inspection we observed a surgical bowl inside the steriliser. The Department of Health Technical Memorandum 01-01: management of surgical instruments (medical devices) recommends that desktop sterilisers should only be used as a last resort. If used, there 'should be measures in place to audit each use of the steriliser and identify which cycles are for the steriliser's routine validation and which are for surgical decontamination'. This audit should ensure that the steriliser is only used for instrument decontamination in exceptional circumstances. The service did not have the records described; this increased the risk to patients from infection.

Inadequate

Surgery

The service did not have a policy that outlined the process to monitor surgical site infections, review or make the necessary changes to avoid further infections should they occur. The registered manager told us that one or two previously reported infections had been reviewed and documented in patient files. They told us that a common theme had been patients not following aftercare instructions.

However, the equipment and the premises were visibly clean with no dust present. Flooring was tiled throughout the clinic and chairs were easily wipeable. Staff told us that the clinic was cleaned regularly by a cleaner and the service had a daily cleaning checklist that outlined what should be cleaned. The service provided evidence that the checklist had recently been completed and showed dates and the areas cleaned.

Staff told us that they cleaned treatment areas before and after each procedure and followed a treatment room daily cleaning and disinfection schedule. During the inspection we saw evidence that staff completed the schedule to evidence this.

Staff followed infection control principles relating to the use of personal protective equipment (PPE) and hand hygiene. The surgical bed was covered in disposable roll and replaced after each patient and all handheld equipment was cleaned and covered with a disposable glove before and after each procedure.

Environment and equipment

The service did not ensure equipment was maintained to keep people safe. They did not manage clinical waste well. However, the service had suitable premises and facilities to meet the needs of patients.

At the time of our inspection, the examination due date sticker for the desktop steriliser stated June 2022. Staff told us the equipment had been serviced on this date and was not overdue. We asked for evidence of this, but the service did not provide it. Following our inspection, we saw evidence that the desktop steriliser had been subsequently serviced in January 2023 which was seven months after the due date. This meant there had been a lack of assurance around the performance of the steriliser and could place patients at risk of infection.

Safety checks for electrical equipment throughout the clinic and treatment rooms were one month overdue. The equipment had electrical appliance testing stickers on dated November 2021. Staff told us there had been delays with the contracted company and the safety checks would be completed the following month. During the inspection, the service provided a document that listed all equipment had been tested in January 2023. However, we observed that the electrical appliance testing stickers were still dated November 2021. Staff told us the equipment had not been tested yet and subsequently sent another document showing equipment had been tested after our inspection. This meant that staff were not keeping a true record of safety checks and the provider could not be assured that the equipment worked as it should to keep patients safe.

The service had a Control of Substances Hazardous to Health 2002 (COSHH) policy. However, the service had not followed all the recommendations within it. The policy stated that hazardous substances must have a risk assessment and be kept in a lockable facility. We observed cleaning products and a flammable substance containing hazardous symbols that had no risk assessments and were not stored securely in a locked cupboard.

The treatment rooms had clinical waste bins for staff to use and the contents were then moved to large clinical waste bins in the back yard. However, the service had not disposed of clinical waste safely from the back yard for a significant time period. Staff could not recall when the waste had last been removed. At the time of inspection there were two large clinical waste bins in the back yard of the premises that had overflowed and could not be closed or locked. The back door was broken and could not be secured which made the area accessible to local residents. Staff told us they had told the

landlord of the premises about the broken door but at the time of inspection this had not been resolved. The registered manager told us that they had issues with the previous waste disposal company which had led to a long delay in the removal of the clinical waste. Staff provided evidence of a contract with a new company, and we observed that the clinal waste was removed on 20 January 2023.

The service had a risk assessment checklist that had recently been completed and assessed areas such as physical hazards, lifting and handling, stress, and the general work environment.

Assessing and responding to patient risk

The service had a process to identify and quickly act upon patients at risk of deterioration. The service made sure patients knew who to contact to discuss complications or concerns. However, staff did not always complete documented risk assessments or record follow up discussions to identify or minimise any risks prior to surgery.

The service identified patient risks through a pre-operative questionnaire completed by each patient before their consultation. It included an emergency contact, GP details, medical history, allergies, and current medicines. It also covered alcohol use, family history of diseases, recent medical examinations, and psychological history.

Staff shared key information to keep patients safe when handing over their care to others. Patients gave for the service to contact their GP for the confirmation of medical history and to share information about the procedure and developments with their GP. Patients also consented to confirm that the medical history they had provided was accurate and complete. The registered manager told us that if they had any concerns, they would contact the patients' GP for assurance before proceeding with surgery. They gave an example of when they had contacted a patients' cardiologist to verify their medical history in order to assess risk. They told us that sometimes the information received from GP's had excluded patients from surgery.

Staff had the knowledge to recognise and deal with patient deterioration. The service had a medical emergency policy which outlined possible medical emergencies such as anaphylactic reaction to medicines, hypotension, and cardiac arrest. The policy described actions that should be taken such as phoning the emergency services, administering first aid, and using the emergency medicines kit. We observed that the emergency kit included antihistamine medicine, adrenaline for severe allergic reactions, and steroid medicine to reduce swelling and was kept in the treatment room. Staff told us they checked the emergency stock regularly and were able to verbally describe the actions they would take to manage the deterioration of patients.

The service made sure patients knew who to contact to discuss complications or concerns. Patients were given the contact number for both the service and the emergency contact number for the hair transplant surgeon in the aftercare pack. Staff told us they could be contacted seven days a week.

However, we did not see any documented risk assessments for patients. We looked at six patient records and three patients' pre-operative questionnaires collectively recorded penicillin allergies, mild asthma, past cancer, hay fever and a previous operation. These patient records did not document any follow up discussions to show these areas had been explored further to identify or mitigate any risks prior to surgery.

The service did not have a process to record vital observations during the hair transplant procedure which could take eight to ten hours. Staff recorded patients' vital observations at the start of each procedure and recorded these again after the procedure. The service did not use a nationally recognised tool and the registered manager told us that based on the presentation of the patient during surgery they would take vital observations when required.

Inadequate

Surgery

The service did not have a standard set of exclusion criteria to inform patients what risks would prevent them from being able to access treatment. The registered manager verbally described some conditions that would exclude patients from being able to have the procedures. However, there was a risk that the exclusion criteria were not clear to patients prior to booking a consultation.

Staffing

The service had enough staff with the right qualifications. However, the service employed one person to undertake both the registered manager and hair transplant surgeon role. This meant that some tasks and duties expected of a registered manager were not completed.

The service employed a small team of staff made up of one hair transplant surgeon, who was also the registered manager, a hair transplant technician, and a client relations lead. The hair transplant surgeon was the business owner and a registered doctor. They had worked at the service for over ten years and had been the registered manager since November 2022. Staff arranged procedures in line with patient needs and preferences as well as staff availability.

The hair transplant surgeon was suitably qualified and performed the surgical steps of the procedures. The hair transplant technician had worked at the service for a year and performed non-surgical steps of the procedure. The client relations lead worked at the clinic part time and managed appointments and clinic arrangements. There was also a part time cleaner who the service booked in advance to support staff with cleaning the premises.

The registered manager told us that they had surgery procedures booked in daily for the next month and each procedure took eight to ten hours. This meant there was limited time to complete tasks assigned to the registered manager role. Some duties had not been done such as the completion of audits, the maintenance of equipment and having oversight of mandatory training.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Patient records were all in paper form, stored securely in a locked cabinet and easily available. Staff were able to easily locate the relevant documents for each patient and the hair transplant surgeon had access to patient records on the day of the procedure.

We looked at six patient records. These were detailed and included the pre-operative questionnaire, consent forms, patients' weight and height, allergies, the benefits and risks of surgery. There was also an operative report for every patient which included pre-operative blood pressure and pulse, anaesthesia details and the amount given, blade size, total number of hairs used, fluid intake and medicine given. We also observed that every patient had post-operative blood pressure and pulse recorded.

However, not all patient records we looked at documented information regarding the 14 day cooling off period or any follow up discussion to show medical information had been explored further.

Medicines

The service did not always follow their own processes to manage medicines and could not be sure that staff knew how to store and dispose of medicines safely. However, the service used systems and processes to prescribe, administer and record medicines for patient use.

Inadequate

Surgery

The service did not dispose of unwanted medicines in accordance with regulations. The service had a medicines management policy that included guidance for prescribing, storage, administration, managing and reporting adverse reactions. However, the policy did not include the process for disposing of medicines. The registered manager told us they did not return unwanted or expired medicines to the pharmacy and disposed of them with the general waste or the clinical waste bin where possible.

Staff did not always store medicines in accordance with the manufacturer's recommendations. The medicines management policy stated that the temperature of the fridge should be monitored daily using a maximum and minimum thermometer.

Staff told us the fridge temperature ranged between 2°c and 14°c. We looked at temperature records for the refrigerator and checks had not been completed daily since March 2022. On the first day of inspection there had been no temperature recorded for over a month. Between August 2022 to January 2023, refrigerator checks had only been recorded once or twice a month. Actual temperature readings ranged from 10°c to 13.8°c over this time period with no maximum or minimum readings. This meant that it was not possible to be sure that medicines needing cold storage had been kept within the manufacturers recommended temperature range to assure efficacy of the medicine.

At the time of inspection, the service stored two small bottles of liquid anaesthetic in the refrigerator. Staff did not know the recommended storage temperature of this medicine and therefore could not be sure of its effectiveness. This meant that patients were at risk of receiving inadequate medicines.

Not all medicines were stored appropriately. The service had an additional emergency medicine kit that included antihistamine medicine, adrenaline, and steroid medicine. This was kept on a table in the main clinic area. There was saline in the staff food fridge that had expired in April 2019.

The medicine cupboard used to store medicines was in line with British standards relating to the storage of medicines in healthcare premises. As the medicine's management lead, only the registered manager had accessible keys to this cupboard.

The service used red wristbands for patients who were allergic to certain medicines which made the identification and administration of medicines safer for patients with allergies.

The registered manager was a registered doctor and prescribed and ordered medicines in advance of patient procedures. The service had a form to record which medicines a patient had received on the day of their procedure and what medicines they had taken home such as antibiotics and pain relief. The form listed the registered manager as a prescriber option and patients took home an aftercare booklet. This included the name and information about the medicine, strength, dosage, and duration.

Incidents

The service had systems and processes to identify and report incidents.

The service had an incident and accident policy that included a process for reporting and investigating incidents. It also included a process to learn from incidents to improve quality and an incident reporting form.

The incident and accident policy provided information on incidents that are reportable to CQC such as death of a service user, incidents reported to or investigated by the police and how to report them.

Inadequate

Surgery

The registered manager told us that no incidents had occurred for a few years and therefore had no incidents recorded. The registered manager gave examples of what incidents they would report and knew how to report them. The service also had an accident book but had not needed to report any accidents.

The service had a duty of candour policy. Duty of candour is a legal obligation for healthcare workers to be open and honest with patients when something goes wrong with their treatment or care. The policy guided staff on what steps they should take should a notifiable safety incident occur. The registered manager told us that they would apologise to a patient should any mistakes happen during or after treatment.

However, the registered manager did not receive patient safety alerts from the Central Alerting System (CAS). CAS alerts include important safety information from the Medicines and Healthcare products Regulatory Agency (MHRA). The registered manager told us they used the Alliance Healthcare website to keep updated on MHRA medicines alerts.

Is the service effective?

Inadequate

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence-based practice. The service did not evidence how they met cosmetic surgery standards published by the Royal College of Surgeons.

The service had a number of policies in place to govern the service. However, the policies did not reference national guidance relevant to cosmetic surgery or hair transplant surgery. For example, no policies we looked at referenced the Royal College of Surgeons (RCS) professional standards for cosmetic surgery or the Cosmetic Practice Standards Authority (CPSA) hair transplant surgery standards.

The service had not instigated a process to evidence and record that staff had read and understood all policies.

The hair transplant surgeon told us they received updated guidance and journals through their registration with the General Medical Council (GMC) and membership with the International Society of Hair Restoration Surgery (ISHRS). However, the provider did not have assurance that care and treatment was based on national guidance and evidence-based practice. The hair transplant surgeon told us that they did not follow guidance for the number of follicles that should be planted during surgery. They told us that when following this recommended guidance then patients would not get the best results. They had implemented their own technique to include more density and more follicles based on their own experience.

The service used the follicular unit excision method of hair transplant cosmetic surgery. Experts regard the follicular unit excision method as one of the two main, and most effective, methods of hair transplant treatments.

All staff we spoke with were aware of how to access policies in use at the service and where the policies were located.

Nutrition and hydration

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

Inadequate

Surgery

As procedures could last over prolonged periods, patients were given a break during treatment for food and drink. Patients or their contact usually brought food and drink with them. On the day of our inspection a staff member went to the local shop to purchase food and drink for a patient.

Patients received information around what they can eat and drink on the day of surgery. We spoke with one patient that told us this information was given in the pre-operative information pack and received a text message a few days before surgery around nutrition and hydration.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Staff told us that they regularly asked patients if they were in pain during their procedure and that doctors would provide pain relief if it was safe to do so.

All patient records reviewed during inspection evidenced that staff had recorded the administration of local anaesthetic detailing type, batch number, amount, expiry date and site of administration.

Each patient was given a post-op pack containing detailed ongoing care advice specific to the procedure they had, medicines and contact telephone numbers if they had any concerns.

We spoke with one patient who told us they were never in pain and staff regularly monitored this throughout the procedure.

Patient outcomes

The service did not carry out an audit for patient outcomes to evidence good outcomes or use the findings to make improvements. The service monitored the effectiveness of care and treatment through regular follow up appointments. However, this was not always documented in patient records.

The service did not carry out an audit for patient outcomes to evidence good outcomes or use the findings to make improvements. We did not see evidence the service held meetings with staff to discuss audits or review performance. The service provided two team meeting minutes that showed medicines and recruitment had been discussed.

The service monitored patient outcomes by patient follow up appointments on the day after treatment, at two weeks and then every three months until 18 months. Photographs of pre and post treatment were taken to make comparisons and with permission shared on social media. Reviews left online described regular follow up meetings and video calls. However, this was not always evidenced in patient files. From the six patient records we reviewed, clear documentation of follow up conversations was not recorded.

Patients were encouraged to provide feedback, which they could do on a patient feedback form or leave reviews online. At the time of inspection there were 86 online reviews of which 93% were positive about the outcome of their hair transplant surgery.

Competent staff

The service did not ensure all staff were competent for their roles. Not all staff had an appraisal or supervision meetings to measure staff competency and provide support and development.

Inadequate

Surgery

The service did not provide any evidence that all staff had an appraisal for work performance or supervision meetings to measure staff competency, provide support or development. The registered manager told us that they gave staff feedback through informal discussions on a regular basis but did not document this.

At the time of our inspection, there was no mandatory accredited training requirement for hair transplant surgery in the UK. However, a General Medical Council (GMC) licensed doctor must have performed the surgical steps of the procedures. The hair transplant surgeon at the clinic was GMC registered with the necessary qualifications and experience relevant to their role. They had not applied to be added to the GMC specialist register which was recommended by the Cosmetic Practice Standards Authority (CPSA). However, they were registered with the International Society of Hair Restoration Surgery (ISHRS) to maintain up to date knowledge and training to perform their role well.

The hair transplant surgeon had regular appraisals by their responsible officer as part of their continued GMC registration. Continuing professional development (CPD) was related to the field of hair restoration. The CPSA hair transplant surgery standards outline that hair transplant surgeons should complete at least 25 CPD points related to hair restoration surgery on average per year. We looked at the most recent CPD records and found they were compliant with this.

The British Association of Hair Restoration Surgery (BAHRS) does not outline any recognised training or formal qualifications required for hair transplant technicians. The hair transplant technician at the service was trained, supervised and monitored by the hair transplant surgeon.

The service had a fit and proper person requirement (FPPR) policy in place which outlined what recruitment checks should be carried out for the role of registered manager. Most requirements had been met such as evidence of employment history, valid DBS check, qualifications, and health information. However, there was only one reference provided instead of two.

The service provided evidence that all staff had completed an induction as part of their employment process.

Multidisciplinary working

All staff worked together as a team to benefit patients. They supported each other to provide good care.

We saw evidence that staff worked well together in the best interest of patients. All members of staff we spoke with told us that team working was well established within the service, and they had no issues working with their colleagues.

Seven-day services

Patients could contact the service seven days a week for advice and support after their surgery.

The service was open for hair transplant procedures Monday to Friday and at weekends to accommodate follow up appointments. The clinic opened at varying times depending on patient's needs. The hair transplant surgeon told us that they could be contacted out of hours seven days a week for advice and support.

Health promotion

Staff gave patients practical support and advice.

The service provided patients with good post-operative care information to help promote hair growth and get the most out of their procedure. Online patient reviews we looked at reflected this.

Inadequate

Surgery

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

The service did always have clear documentation to evidence that consent was in line with national guidance or that patients gave consent in a two-stage process with a cooling off period of at least 14 days between stages. However, staff gave patients information to make informed decisions about their care and treatment.

Consent was not always obtained in line with the Royal College of Surgeons (RCS) Professional Standards for Cosmetic Surgery (April 2016) which states that, consent should be gained by the doctor who will be delivering treatment, 14 days prior to treatment, to ensure the patient has a cooling-off period. However, of the six patient records we reviewed; no records included any information about the 14-day cooling off period. Two records showed dates on consent forms and dates of the procedures had less than 14 days in between. There was no client disclaimer form to say that the patient was happy to proceed with surgery within the 14 days.

Staff told us that they always kept a strict 14 day gap between consent and procedure and that the forms did not always show a true reflection. For example, if a patient was sent the pre-operative booklet and consent forms by post they might take a few days to sign it.

During the inspection, we looked at the records for a patient currently having a procedure. The patient had implied consent when they booked their appointment, but we did not see that informed consent was gained after this. The records showed that the consent for medical history and sharing of medical information form was signed but not dated. The patient contract/consent form and the additional informed consent form had not been signed. Staff told us that the patient consent forms had been sent in the post, completed at home and the patient had forgotten to bring them to the clinic.

All patients had an initial consultation with the hair transplant surgeon and received a pre-operative booklet that contained detailed information about the risks. Staff understood the importance of checking patients' understanding of their treatment and ensuring that patients did not have any unrealistic expectations of the outcomes. Information was given about what to expect on the day and after their procedure.

Is the service caring?

Insufficient evidence to rate

Due to a low number of patients consenting to speak with us the caring key question could not be rated.

Is the service responsive?

Requires Improvement

Service delivery to meet the needs of local people.

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

Patients did not have to be local to access the service if they are willing to travel to appointments.

Staff arranged appointments in line with patient needs and preferences as well as staff availability.

Inadequate

Surgery

Facilities and premises were appropriate for the services being delivered. The clinic was located in an area with parking nearby and good transport links. The main entrance and clinic were located on the ground floor with a large reception, two treatment rooms, a toilet facility, consultation room, and a waiting room. All rooms were easily accessible with a ramp if required for two steps leading to a washroom.

Patients booked follow up appointments on the day of their procedure and staff understood the importance of contacting patients if they missed them. The service's pre-operative booklet included the importance of attending follow up appointments

Patients were provided with post-discharge care information, which included clinic contact details for post-operative advice and specific instructions about hair care.

Meeting people's individual needs

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

The service worked with a wide variety of patients and staff said that there were no adult groups or protected characteristics that they would not consider for treatment. All staff had completed equality and diversity, learning disabilities or autism training.

Patients brought their own food and drink to meet their cultural and religious preferences.

Wheelchair users could access the building and all rooms were easily accessible with a ramp if required for two steps leading to a washroom.

Staff could speak different languages and told us they would use online translation services or family or friends to translate information if needed.

Patients could arrange an appointment by telephone or make an enquiry using the clinic's website.

We looked at online reviews and one patient said that the length of procedure had been adapted to meet their own individual needs.

The pre-operative questionnaire did not directly ask patients if they had a learning disability or were autistic. The registered manager told us that they would add this question to their questionnaire. They said patients with additional needs could attend the clinic with a family member or friend and they would use eye masks if patients were sensitive to light.

We did not see evidence of a hearing loop available within the clinic.

Access and flow

People could access the service when they needed it and received the care in a timely way.

People could access the service within agreed timeframes. One patient told us they had waited four weeks and that the process from booking an appointment to having the procedure was positive. Staff arranged procedures in line with patient needs and preferences as well as staff availability. The registered manager told us that they would rearrange appointments straight away if staff were sick and they would apologise to patients.

Inadequate

Surgery

The service provided regular follow up appointments that included the day after surgery and quarterly appointments up to 18 months. The service offered video call consultations to patients, but these did not replace the required face to face appointments.

We spoke with one patient who described regular contact between appointments and that they felt fully supported throughout their treatment journey. Online patient reviews also reflected this.

Learning from complaints and concerns

The complaints procedure was not displayed or explained to patients as to how they could give feedback and raise concerns about care received. **The service did not have an effective complaints policy in place to respond to concerns and complaints appropriately.**

The service had a complaints policy that outlined the process patients and staff should follow when raising and dealing with a complaint. However, not all information was relevant to the service. For example, the policy referenced the Parliamentary and Health Service Ombudsman (PHSO) which is for NHS patients and not appropriate for people who use their service.

The service was not registered with Independent Sector Complaints Adjudication Service (ISCAS) which provides independent adjudication on complaints for independent healthcare providers registered with them. The complaints policy informed people that they could raise their concerns with the GMC and CQC if they were not happy with the response they received from the service.

It was unclear if staff followed their own process for dealing with complaints. The registered manager told us that if a complaint was not resolved locally, they would pass the complaint onto their legal team and insurance company. This was not in line with their complaints policy.

The service did not display information about how to raise a concern in any of the clinic areas. Post-inspection, the registered manager told us that this information had recently been taken off the wall but was now displayed again. It was not easy for people to find information on how to complain because it was not displayed on the website or in any leaflets or information booklets. One patient we spoke with told us the complaints process had not been explained to them, but they would know to make a complaint directly with the service.

We asked to see evidence of any complaint investigations and responses from the past 12 months. The registered manager told us there had been no formal or informal complaints received into the service during this time frame.

However, the service had a complaint letter template that staff could use to acknowledge complaints. The policy outlined that the service would acknowledge the complaint within three working days, investigate and write to the patient with the outcome within 28 days.

Staff could give examples of how they had used patient feedback to improve daily practice.

Inadequate

Surgery

Is the service well-led?

Inadequate

Leadership

Leaders did not demonstrate the necessary skills and abilities to run the service. They did not always understand and manage priorities and issues the service faced.

The leadership team consisted of the registered manager who was also the business owner. The registered manager was responsible for ensuring compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During and post inspection the registered manager did not demonstrate an understanding of the obligations placed on them by their role as registered manager, and, how compliance with the fundamental standards of care helped to ensure maintenance of quality at the location and continuous improvement.

However, the registered manager was new in post, and they welcomed feedback to support them to improve systems and processes to ensure the service met regulatory requirements.

Vision and Strategy

The service did not have a formally documented vision for what it wanted to achieve and a strategy to turn it into action.

The service did not have a formally documented vision that incorporated future plans or objectives relating to the service.

The registered manager told us they had a vision to expand the clinic and move to a larger building which would provide more storage space. At the time of inspection, they were following the process for planning permission. However, there was no business plan or service strategy to measure progress.

Culture

Staff we spoke with felt respected, supported and valued. Staff told us they were focused on the needs of patients receiving care.

Staff said that they felt respected and valued by their colleagues and manager.

Staff spoke passionately about giving the best care to meet the needs of patients and they made regular contact to check their wellbeing.

Staff appeared happy and content in their roles. Staff we spoke with said they enjoyed their roles and felt well supported by their colleagues.

The registered manager described the culture as honest and open to change and recommendation.

Staff did not receive formal supervision or appraisals therefore plans for their development or career progression were unclear.

Inadequate

Surgery

Governance

Leaders did not operate effective governance processes. Staff did not have regular opportunities to meet, discuss and learn from the performance of the service.

The service did not have the expected processes to govern the service. Some policies had not been adapted or revised to ensure it fitted the scope of the service and some information was more relevant to a hospital setting. The recruitment policy did not specify that all staff required pre-employment checks and not all policies referenced appropriate national guidance. This meant there were gaps in the processes that are expected in a health and social care setting to support governance and ensure compliance with legislation.

The service had a governance framework that documented that audits should be carried out and analysed to ensure the framework was meeting its principles. However, they did not implement this. There was no clear system for auditing the service or patient outcomes to improve the quality and safety of care. For example, the service did not have a process to measure how many patients developed an infection after their treatment. The lack of audit processes meant the service lacked assurance and oversight in terms of the quality of care for patients.

The service did not evidence how staff employed to carry out the regulated activity met all expected parts of the regulations. The service did not have a list of mandatory training for each role or oversight of expired training. Not all staff had formal supervision or appraisals to measure staff competency and provide support and development.

We did not see evidence that all staff had the opportunity to meet, discuss and learn from the performance of the service. The registered manager told us they held weekly team meetings which were minuted. We saw two sets of recent meeting minutes that showed there were discussions regarding recruitment of a new cleaner and medication orders. We did not see evidence of any other team meetings throughout the previous year.

As an independent regulator it is not our role to tell providers specifically what should be in their policies, systems, and processes. These are specific to the location and the types of care and treatment that it delivers. We evaluate these to assess their compliance with the Health and Social Care Act 2008 (Regulated Activities) and performance against best practice guidance.

Management of risk, issues and performance

The service did not use systems to manage risk, issues or performance effectively. They did not have clear plans to cope with unexpected events.

We saw limited evidence that the service used systems to manage performance effectively. Leaders of the service did not demonstrate they had the knowledge or experience to fully embed systems to manage performance.

The registered manager was also the only hair transplant surgeon at the clinic. The service did not have a business continuity plan in place should they be absent for a prolonged period of time.

The registered manager had not developed a defined risk register with risks that were rated or graded in terms of impact or likelihood. Therefore, appropriate mitigations and reviews for any risks were not documented. The registered manager verbally identified risks such as the economy having an impact on the business and staffing issues. However, no issues relating to clinical risks were identified as a risk and they did not reflect the concerns found during the on-site inspection.

Inadequate

Surgery

Information Management

The service did not collect and analyse data to understand performance or make decisions and improvements. Although the information systems were secure not all staff had valid information governance training.

The service did not do audits to ensure compliance with policies and procedures or best practice guidance.

The service did not have a set process for collecting information about patient outcomes and experiences to improve the service.

Not all staff had information governance training that was in date.

However, the service had a record keeping storage of records policy, a data protection policy, and a data breach incident form. There had been no data breaches reportable in the previous 12 months.

Patient records including completed consent forms were stored in a locked filing cabinet in the reception. The computer we saw in use was password protected and locked when not in use.

Engagement

Engagement with patients and staff was informal. However, the service had plans to use a more formal process in future.

The service did not have a formal process for engaging with patients or staff. The registered manager provided a copy of a blank staff satisfaction survey. There was no evidence that this had been completed with staff, but the registered manager told us this would be used in the future.

The service did not have formal supervision and appraisal processes in place for staff, however staff told us that they felt supported and valued by the registered manager.

Staff maintained open lines of communication through text messaging, phone calls, and face-to-face or virtual follow up appointments. Patients were encouraged verbally to provide feedback on their experience via online reviews. We saw evidence in the reviews and from one patient that staff contacted them regularly to see how they were and kept them up to date about their treatment plans.

The registered manager told us that customer satisfaction was monitored using online and social media reviews and via a patient survey. They provided evidence that one patient survey had recently been completed with plans to use these more in the future.

The service had a public website which provided the public with information about what the service offered.

The service proactively used social media to engage with existing and new patients.

Learning, continuous improvement and innovation

The service did not have an embedded approach for continuous improvement.

At the time of inspection, the service did not carry out any audits to drive improvements and performance data was not collected to enable them to change or improve practice.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service did not ensure that staff were suitably qualified, competent, skilled and experienced to provide a safe service. The service did not assess the risk of, and prevent, detect, and control the spread of, infections, including those that are health care associated. The service did not ensure that equipment was maintained and serviced in accordance with manufacturer's guidelines. The service did not ensure the safe and proper management of medicines.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service did not have the expected processes to govern the service or procedures that are expected in a health and social care setting to support governance and ensure compliance with legislation and support staff to perform their roles safely. The service did not have records available to the commission regarding the persons employed to carry out the regulated activity meeting all expected parts of the regulations.