The Belvedere Private Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Belvedere Private Hospital is operated by Pemberdeen Laser and Cosmetic Surgery Clinic Ltd.

The hospital has eight in-patient beds, and the facilities include one operating theatre, anaesthetic room and a recovery room. There are three consultation rooms.

The Belvedere Private Hospital provides cosmetic surgery, mainly breast augmentation, but also abdominoplasty, blepharoplasty and liposuction. We inspected surgery services only using our comprehensive inspection methodology. We carried out an unannounced inspection on 11 June 2019, which we followed up with a further unannounced inspection on 2 July 2019.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

The main service provided by this hospital was cosmetic surgery including breast augmentation.

Services we rate

This was the first time we have rated this service. We rated it as **Requires improvement** overall.

- Staff understood how to identify patients who may be being abused. Staff had training on how to recognise and report abuse, and they knew when it applied**.** However, staff did not recognise or report situations where individuals may have been at risk of self-harm. There was no clear process for reporting suspected abuse or avoidable harm.
- The service had suitable premises. However, it was unclear due to the way the service stored their equipment whether the equipment was in use or out of action.
- The service did not manage patient safety incidents well. Staff did not always recognise and report incidents and near misses. There was no evidence the manager had fully investigated incidents and of learning from the process having been shared with the whole team. There was no evidence that the manager ensured that actions from patient safety alerts were implemented and monitored.
- The service could not demonstrate it provided care and treatment based on national guidance and evidence-based practice. There was no evidence managers checked to make sure staff followed professional guidance or its own policies and procedures.
- It was easy for people to give feedback and raise concerns about care received. However, the service could not demonstrate they treated concerns and complaints seriously or investigated them sufficiently and shared lessons learned with all staff.
- Leaders of the service did not have the necessary skills and knowledge to run a service providing high-quality sustainable care. They did not understand what was required to manage the priorities and issues the service faced.
- The service did not have a documented vision, strategy or values; however, the owner of the service had a vision for development of the service.

Summary of findings

- Opportunities for career development were not provided by the service. The service provided the opportunity for patients, their families and staff to raise concerns without fear, however there was no robust system to investigate those concerns.
- The service did not have a systematic approach to improving service quality and safeguarding high standards of care. There was a lack of overarching governance.
- There were no effective systems in place for managing risks, and there was no evidence risks and their mitigating actions were discussed with the team.

However, we found areas of good practice:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- The service controlled infection risks well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- When things went wrong, staff apologised and gave patients honest information and suitable support.
- Staff completed and updated risk assessments for each patient. They kept clear records of assessments.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. Staff gave patients enough food and drink to meet their needs.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff felt supported and valued.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We issued the provider with one warning notice that affected the service. Details are at the end of the report.

Dr Nigel Acheson

Deputy Chief Inspector of Hospitals (London and South East)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	**Requires improvement** 	Surgery was the main activity of the hospital. The service was rated requires improvement because there were areas that needed to improve, including understanding safeguarding, reporting and investigating incidents, complaints handling, updating policies and procedures and governance for the service.

Summary of findings

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Background to The Belvedere Private Hospital

Belvedere Private Hospital is operated by Pemberdeen Laser and Cosmetic Surgery Clinic Ltd.

The hospital opened in 1985. It is a private hospital in south east London. The hospital primarily serves the communities of the London and North Kent areas but also accepts patient referrals from the whole country.

The inspection was an unannounced inspection, which took place on 11 June 2019. We returned for a follow up unannounced inspection on 2 July 2019, after which we received two separate whistle-blower concerns about changes in practice. This led to an additional visit on 26 July 2019.

At the time of the inspection, a new manager had recently been appointed and had applied to the CQC on 27 May 2019 to be the registered manager. Following the inspection on 11 June 2019, we were informed the new manager had left the hospital. At the time of the unannounced follow up inspection on 2 July 2019, the service did not have a manager in post but were recruiting for a replacement.

The hospital also offers cosmetic procedures such as dermal fillers. We did not inspect these services, as they do not come under the requirements of current regulations.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two other CQC inspectors, and two specialist advisors with expertise in surgery. The inspection team was overseen by Amanda Williams, Interim Head of Hospital Inspection south London.

Information about The Belvedere Private Hospital

The hospital had one ward, one theatre, a recovery area and anaesthetic room and was registered to provide the following regulated activity:

Surgical procedures.

During the inspection visits, we visited the ward and the theatre. We spoke with nine staff members including; the manager, deputy matron, registered nurses and medical staff. We spoke with two patients and reviewed eight sets of patient treatment and care records. The provider sent information to us following the inspection, which we considered in making our judgement.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital has been inspected five times; the most recent inspection took place in April 2018.

Four surgeons worked at the hospital under practising privileges, this is where a medical practitioner is granted permission to work in a private hospital or clinic in independent private practice, or within the provision of community services. Three regular resident medical officer (RMO) worked on an as required basis. There was one employed registered nurse. All of the rest of the clinical staff bank staff and only worked on days that surgery was taking place. All administration staff and reception staff were self-employed. The accountable officer for controlled drugs (CDs) would be the registered manager.

Track record on safety

- two Never Event
- Clinical incidents zero no harm, zero low harm, zero moderate harm, zero severe harm, zero death
- zero serious injuries

Summary of this inspection

zero incidences of hospital acquired meticillin-resistant Staphylococcus aureus (MRSA),

zero incidences of hospital acquired meticillin-sensitive Staphylococcus aureus (MSSA)

zero incidences of hospital acquired Clostridium difficile (c.diff)

zero incidences of hospital acquired E-Coli

29 complaints

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal
- Laundry
- Maintenance of medical equipment
- Pathology and histology
- RMO provision

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We have not previously rated this service. At this inspection we rated it as **Requires improvement** because:

- Staff understood how to identify patients who may being abused. Staff had training on how to recognise and report abuse, and they knew when it applied. However, there was no clear process for reporting suspected abuse.
- The service did not manage patient safety incidents well. Incidents and near misses were not recognised and reported by staff, which meant the manager was not always aware of incidents and did not always have the opportunity to investigate them.
- There was limited evidence to demonstrate that the manager had fully investigated incidents and that lessons learned from the outcome of the investigation was shared with the whole team. When things went wrong, staff apologised and gave patients honest information and suitable support.
- There was no evidence that managers ensured that actions from patient safety alerts were implemented and monitored.
- The service mostly used systems and processes to safely prescribe, administer, record medicines, however, expiry dates of medicines were not always monitored.

Are services effective?

Requires improvement

We have not previously rated this service. At this inspection we rated it as **Requires improvement** because:

- The service could not demonstrate it provided care and treatment based on national guidance and evidence-based practice.
- There was no evidence of auditing or other procedures to check that staff followed professional practice standards, guidance or the services own policies and procedures.
- There was no monitoring of patient's outcomes by speciality or surgery type.

However,

- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Summary of this inspection

Are services caring?

Good

We have not previously rated this service. At this inspection we rated it as **Good** because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress.
- Staff supported and involved patients, families and carers to understand their surgery and make informed decisions about their care and treatment.

Are services responsive?

Requires improvement

We have not previously rated this service. At this inspection we rated it as **Requires improvement** because:

- It was easy for people to give feedback and raise concerns about care received. However, the service could not demonstrate they treated concerns and complaints seriously or investigated them sufficiently. Lessons learned from complaints were not shared with all staff**.**

However,

- The service planned and provided care in a way that met the needs of their patients and the communities it served.

Are services well-led?

Inadequate

We have not previously rated this service. At this inspection we rated it as **Inadequate** because:

- Leaders of the service did not have the necessary skills and knowledge to run a service providing high-quality sustainable care. They did not understand what was required to manage the priorities and issues the service faced or which were required to meet their regulatory responsibilities.
- The service did not have a documented vision, strategy or values; however, the owner of the service had a vision for development of the service.
- Opportunities for career development were not provided by the service.
- The service provided the opportunity for patients, their families and staff could raise concerns without fear, however there was not a robust system of investigation of those concerns**.**
- There were no effective systems in place for managing risks, and there was no evidence risks and their mitigating actions were discussed with the team.

Summary of this inspection

- The service did not collect, analyse, manage, and use information well to support all its activities.

However

- Staff felt supported and valued.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Requires improvement	Requires improvement	Good	Requires improvement	Inadequate	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Inadequate	Requires improvement

Requires improvement

Surgery

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Requires improvement
Well-led	Inadequate

Are surgery services safe?

Requires improvement

We have not previously rated this service. At this inspection, we rated safe as **requires improvement.**

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

- Staff received and kept up to date with their mandatory training. Training subjects included: infection prevention and control levels one and two, information governance, fire safety, moving and handling level one and two, adult resuscitation levels one, two and three. We saw evidence staff had completed NHS conflict resolution training, paediatric resuscitation levels two and three and new born resuscitation levels two and three.
- We viewed five human resource records (HR) of staff which showed in-date mandatory training certificates.
- Training was provided by an external company annually and staff were given the time to attend the one-day classroom-based session.
- Management staff provided us with a spreadsheet which had details of mandatory training expiry dates for four members of theatre staff and five members of ward staff. This was not a complete list of training for all bank staff. There was not sufficient oversight of training needs for all bank staff by management staff.
- One member of the clinical staff, the deputy matron had been certified in basic life support (BLS) and was always available when patients were in the hospital.
- The resident medical officer (RMO) and anaesthetist used by the service had been certified intermediate life support (ILS). The RMO was on site at all times when patients were recovering from surgery were in the service.

Safeguarding

Staff understood how to identify patients who may being abused by others, but did not make consideration of possible safeguarding concerns where individuals may self-harm. However, there was no clear process for reporting suspected abuse. Staff had training on how to recognise and report abuse, and they knew when it applied.

- We viewed five human resource records (HR) of staff which showed in-date mandatory training relating to safeguarding adults' level one and two. We also noted staff had valid and recent criminal records checks.
- Staff were not provided with training regarding female genital mutilation (FGM) or PREVENT which is the Government's counter-terrorism strategy. It aims to stop people becoming terrorists or supporting terrorism.
- During our inspection we reviewed a safeguarding adult's policy which gave an overview of safeguarding, types of abuse and how to recognise abuse and who to make a referral to at the local safeguarding authority. However, the policy did not state how to make a referral to the local safeguarding authority. Further, the policy was not easily accessible to staff.

- The service had a safeguarding children in an adult setting policy, which included much of the same information as was contained within the safeguarding adults policy**.** The local authority safeguarding team contact number was included. The policy was limited in that it did not reflect the latest guidance as outlined in the intercollegiate document: Safeguarding children and young people: roles and competences for health care staff, (2014). There was no indication as to the level of safeguarding children's training, or the frequency of training. Guidance recommends level 2, as a minimum level required for non-clinical and clinical staff who have some degree of contact with children and young people and/or parents/carers. Further, the policy did not mention such matters as 'PREVENT', which is the government's response to the terrorist threat in the UK.
- We asked three members of staff how they would raise a safeguarding alert and all three told us they would report their concerns to the registered manager (RM). The RM was always on duty when consultations or surgery was taking place at the hospital. When asked if they had raised a concern, we were told no they had not had to do that. During our follow up visit staff told us about a patient who they had suspected had self harmed, the staff when asked said they did not raise a safeguarding alert as they "did not get involved with that" but they 'kept an eye' on the patient. We were not assured patients were being safeguarded by this service.
- Nursing, medical and administrative staff we spoke with had an understanding of safeguarding for adults and children, although they had not yet needed to raise a safeguarding concern. Management staff told us they were unable to provide us with any information relating to any previously raised safeguarding concern.
- We asked the nominated individual to provide us with any safeguarding concerns raised since the last inspection. The service had not reported any safeguarding concerns in the period since the last inspection. We asked the deputy matron how they would raise a concern and they could explain to us what they would do if they were concerned about a patient.
- We were not assured the service had a full understanding of the safeguarding process. There was no clear referral making process, including who would make the referral, how the referral would be made and what documentation the referral would be made on.

Cleanliness, infection control and hygiene

The service controlled infection risks well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

- The service conducted MRSA screening for all patients. This was in line with best practice guidance.
- All clinical and non-clinical areas we observed were visibly clean and tidy. We saw evidence of daily cleaning schedules. Theatre and clinic rooms were deep cleaned regularly.
- Staff had access to personal protective equipment (PPE) including gloves and aprons. We observed staff using PPE whilst in contact with patients. We observed that all staff adhered to the bare below the elbow guidance when in a clinical environment.
- We found adequate handwashing facilities and hand-gels available. We observed staff utilising these facilities during our inspection.
- The service had a hand hygiene and infection prevention and control policy which was dated, authored and had a review date. However, we were concerned that the accessibility for staff to access the policy was restricted as it was kept in the administration annex, which was in a separate building away from the main hospital block.
- The service carried out infection control audits. However, from the audits we reviewed it was unclear how often these were being conducted and the thoroughness of these audits. There was no information such as actions plans to show how the results of the audit were used to change or improve practice.
- The service had developed a proforma used by the surgeons at the patient's six week follow up appointment to talk to the patient about whether there had been any surgical site infection, whether the patient had had to see their GP or had been given antibiotics. We looked at the completed proformas in the patient files we reviewed and found they had been completed

in all the files viewed. This information was used to track the numbers of surgical site infections if there were any; however, we did not see any action plans or learning from this information.

Environment and equipment

The service had suitable premises. However, it was unclear if some equipment was in use or out of action.

- Clinical areas we observed were generally suitable for their use. However, the anaesthetic room had limited space and out-of-use equipment stored in it. We found coats, jackets and handbags were left in this room untidily, although these were removed when brought to the attention of staff.
- We found that all relevant equipment had valid electrical safety testing.
- We noted two sharps boxes which had commencement dates of 2017. The boxes were not full which suggested they were used for extended periods of time until they reached the full level.
- Staff told us they carried out Legionella risk assessments and checks on water supplies. However, we asked the service to provide documented audits or evidence this had been carried out, the frequency of such checks and any results. The service did not provide this information to us following the inspection.
- The service had two emergency resuscitation trolleys, which included a defibrillator. We found a number of out-of-date equipment items, including medicines. A box of Adrenaline 1:10,000 had expired in 2017. This may have posed a risk to a patient if an emergency situation required staff to use this medicine. We noted other out of date, single use items for example syringes in both trolleys. This suggests the routine checks which were completed on the days that surgery was taking place were not being undertaken as expected. The checklists we reviewed indicated the trolleys had been check but we were not assured of the thoroughness of this checking process due the out of date items we found. This issue had been identified during our previous inspection. Following the inspection the provider confirmed these issues had been addressed.
- Arrangements were in place for the handling, storage and safe disposal of clinical and domestic waste. This was handled by an external company.
- We observed working emergency call bells in every clinical area and inpatient toilets.
- Patients accommodation was a mixture of private room or two bedded rooms, which were located off the main ward corridors. All rooms were equipped with a nurse call bell and emergency buzzers.Windows all had safety opening restrictors fitted since our last inspection.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records of assessments.

- We were told the lead clinician would assess and discuss every patients psychiatric and emotional health to determine if a patient was suitable for surgery. The lead clinician would write to the patient's GP asking for information relating to any previous psychiatric history. We saw evidence of this in each of the eight patient records we viewed.
- Consultations for procedures were held face to face with the lead clinician who would assessed and examine the patient and explain a number of treatment options to them.
- There was an admissions acceptance criteria. This was used to ensure only those individuals who were suitable to receive treatment at the service were accepted for surgery.
- In the eight patient records we viewed, we saw evidence that a mental capacity assessment had taken place. However, we had concerns around the informative nature of the 'capacity to consent' policy which did not make it clear how capacity should be assessed.
- All patients had preoperative blood tests in line with NICE guidance.
- We reviewed eight patient records and saw evidence venous thromboembolism (VTE) assessments had been completed.
- Nursing staff regularly reviewed patients post operatively, and observations were recorded; since the last inspection the service now used an early warning score to determine when patient needed further escalation which was in line with the National Institute for Health and Care Excellence (NICE) guidance CG50.

Requires improvement

Surgery

- The service used the World Health Organisation (WHO) surgical safety checklist. We saw evidence this was being used on all patient records we viewed.
- As we observed during our previous inspection we found the RMO was required to have Intermediate Life Support (ILS) training but nursing staff still only received basic life support training. In the event of a cardiac arrest, the anaesthetist, who had ILS training, would be required to leave theatre. If the anaesthetist was called out of theatre, a patient would be left on the operating table, which would be a safety risk to them.
- Patients were provided with a three day post surgery phone call from the deputy matron. We saw documented evidence of advice given.
- Although clinicians we spoke with were able to tell us how they kept themselves updated on latest clinical guidance, we were not assured management staff had an oversight of staffs' clinical competence. The service was unable to provide us with information which had been disseminated to staff relating to latest clinical best practice.
- The service was unable to care for a deteriorating patient and would therefore stabilise and transfer to a local NHS hospital via 999 ambulance. Staff were trained in adult resuscitation.
- It was very rare that patients needed to stay at the hospital overnight. If a patient did need to stay overnight the RMO and a nurse were on the ward. The practising privileges agreement required the designated consultant to be contactable at all times when they had a patient in the hospital. They needed to be available to attend within an appropriate timescale according to the level of risk of medical or surgical emergency usually within 30 minutes.
- During our last inspection we highlighted concerns regarding the lack of use of pregnancy testing for patients undergoing surgery. On this inspection we found the service had amended their policy and all patients between the age of 18 and 55 years are asked if there might be a possibility they were pregnant? If there was any doubt, a pregnancy test was conducted, and results were saved in the patient care record.

Nursing and support staffing

The service had enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

- At the time of the inspection, the service employed one full time deputy matron who oversaw nursing requirements and one full time manager to oversee the running of the service. Other staff were hired through self-employment or through an internal staff bank. Following the first inspection, the manager left the service. The service was in the process of registering a new manager, who we met on our third visit.
- Although staff were self-employed or working through the bank, the staff working there were familiar with the service and worked there frequently.
- We viewed staffing rotas and saw evidence of sufficient quantity of staff on days surgery was taking place.
- The service did not use any staffing tool to identify staffing requirements. The amount of staff required was dependant on the number of operations or consultations being conducted. The registered manager and the deputy matron worked at the service five days per week and were available to chaperone patients during consultations. The manager at the time was responsible for overseeing staffing arrangements.

Medical staffing

The service had enough medical staff to provide the right care and treatment.

- Medical staff were employed on a self-employment contract and were not directly employed by the service. All consultants held roles in the NHS; however, the RMO on duty on the day of the inspection did not work in the NHS and worked solely in the capacity as RMO within the private sector.
- There were four surgeons with practising privileges at the time of our inspection. The anaesthetists and RMO were provided through an agency.Medical staff were granted practising privileges through the service. We viewed three staff records which showed practising privileges had been granted to staff working there. However, we were not assured of the practising privileges process as management staff were unable to provide us with a practising privilege document.

- In cases where a patient required an overnight stay, the manager booked the RMO for a 24-hour shift.
- The vast majority of the surgery undertaken was carried out as day cases.
- As we found during our previous inspection, the manager had the contact details of all the surgeons and were able to contact them for advice anytime. Surgeons at the clinic would review patients for each other, when an urgent review was required for a patient post operatively and the patient's surgeon was not available for review.
- Surgeons were contactable 24 hours a day by telephone and were required as part of their contract be able to return to the hospital within 30 minutes should an emergency require them.

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.

- The hospital used a paper-based record system to record all aspects of patients care. Patient records contained information of the patient's journey through the service including pre-assessment, investigations, test results and treatment and care provided.
- Patient pathways and care plans were detailed and contained risks assessments such as manual handling, bed rails and pressure ulcers. We saw all care plans and risks assessments were completed in the eight records we reviewed.
- We saw evidence World Health Organisation (WHO) surgical checklist were completed.
- Care records were held on site in the administration annex.
- Notes were held securely in the nurses' office on the ward when in use to prevent unauthorised access to confidential patient data. We examined the records for eight patients and found a good standard of documentation in most areas.
- The theatre register, and implant book were stored in the theatre. They weren't locked away, but patients would not be able to access these documents easily.
- As we found on our previous inspection, staff kept a record of all breast implants in the patient notes and in the hospital's breast implant register. Patients also received a card with details of the size and make of the implant. The clinic also contributed data to the National Breast Implant Register.

Medicines

The service mostly used systems and processes to safely prescribe, administer, record medicines, however, expiry dates were not always monitored.

- In line with what we saw during our last inspection, the controlled drugs (CD) were still stored in a separate locked cupboard and checked twice daily. There was a clear process for administration of controlled drugs, which staff were aware of and followed. We reviewed the contents of the CD cupboard against the CD book and did not find any discrepancies.
- If patients required any medications post-operatively, they were prescribed under private prescription.
- As noted on our previous inspection, the oxygen cylinders in the patient rooms were available at each bed space and were appropriately stored in a wall mounted stand.
- During the previous inspection we found out of date emergency medications on the resuscitation trolleys; both on the ward and in theatre expired. On this inspection we found out of date medications in the resuscitation trolley on the ward.There was a prefilled syringe of adrenaline which expired in 2017. This was immediately removed by staff when you highlighted it to them. We were not assured the service had the resuscitation trolleys were being checked because the daily checklists had been completed but we found an out of date medication.
- During the previous inspection we found a cylinder of nitrous oxide which was out of date. During this inspection we also found three cylinders of nitrous oxide which were out of date. The manager informed us that the nitrous oxide was no longer being used and they would call the company to collect the cylinders. We did however see many cylinders of nitrous oxide that were in date.
- We saw patient's allergies were noted on the care reports we reviewed.

Requires improvement

Surgery

Incidents

The service did not managed patient safety incidents well. Staff did not always recognise and report incidents and near misses. We saw no evidence the manager fully investigated incidents. There was no evidence of lessons learned being shared with the whole team. There was no evidence that managers ensured that actions from patient safety alerts were implemented and monitored.

- The service informed us there had been one never event during the period June 2018 to May 2019. The never event was a diathermy burn to a patient. A diathermy is a surgical technique involving the production of heat in a part of the body by high-frequency electric currents, to stimulate the circulation, relieve pain, destroy unhealthy tissue, or cause bleeding vessels to clot. The service provided us with a copy of the incident reporting form which detailed the incident; however, they did not provide any evidence of an investigation having been completed following the never event. The staff we spoke with were aware of the incident but there had not been any lessons learnt or required actions shared with them.
- We were told by the nominated individual on the follow up inspection that there had been two separate diathermy burn incidents. Following the inspection, the service provided us with two the incident reports which describes two diathermy burn. However they could not provide evidence that any formal investigations had taken place. They could not provide evidence other than telling us that the same surgeon had been involved in both incidents and they had been spoken to regarding the incidents, however, there was no written evidence of this conversation.
- The service had a proforma which should be completed to report all incidents or near misses. We spoke with staff who told us they would report incidents to the RM and they would complete the form. Staff told us they did not get feedback from incidents they reported. There was no shared learning from incidents.
- The services incident reporting process was very poorly development and needed urgent improvement, to ensure patients were protected from harm.

Are surgery services effective?

Requires improvement

We have not previously rated this service. At this inspection, we rated effective as **requires improvement.**

Evidence-based care and treatment

The service could not demonstrate it provided care and treatment based on national guidance and evidence-based practice. There was no evidence managers checked to make sure staff followed guidance.

- The service had policies and procedures, however the vast majority of these were well past their review date by at least two years. Staff did not have easy access to policies and procedures. They were stored away from the theatre and ward area in the administration annex building. We saw no evidence policies had been updated in line with changing national guidance.
- Some audits had been undertaken for example world health organisation safer surgery checklists, hand hygiene and infection prevention and control audits, however when we reviewed them we were unsure of the outcome of the audits. There were no action plans and information regarding the audit results was not disseminated to staff.

Nutrition and hydration

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

- Staff provided light refreshment including hot and cold drinks and sandwiches for patients post operatively.
- Patients very rarely stayed overnight in the service with the vast majority of patients leaving the service on the day of surgery. If a patient stayed over night the service provided hot food for them. There was a kitchen located on the ground floor where ward staff could prepare food.

Pain relief

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

- As we saw on our last inspection the prescribing of post-operative pain relief was still done by the anaesthetist and included regular and as required painkillers. The RMO the still reviewed patients whose pain was not controlled.
- Patient's pain assessed regularly using a patient reported scoring system of 0-3, where 0 was no pain and 3 was severe pain. We saw evidence of pain scores in all the care records we reviewed.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients

- Between June 2018 and May 2019, there were no incidents of unplanned transfers of inpatients to another hospital because their condition had deteriorated.
- There was no unplanned return to the operating theatre between June 2018 and May 2019.
- The service now reviewed surgical site infection data using a proforma which the surgeon's completed during the six to 10 weeks post-operative consultation. There had been no surgical site infection in the period June 2018 and May 2019.
- As we reported in our previous inspection, the hospital continues to not contribute to any cosmetic services databases other than the national breast implant register.

Competent staff

The service made sure most staff were competent for their roles.

- Consultants who worked in the NHS were required to submit evidence of their appraisal. Consultants were expected to have an up to date appraisal as part of their practising privileges. Their appraisals were conducted by the NHS trust they worked at. Records of appraisals were kept on the consultants HR files.
- The theatre staff received appraisals and supervision at the NHS trust they worked for. They provided a copy of their NHS appraisals for the staff files. The one member of nursing staff we spoke with who did not work for an NHS trust had not had an appraisal since 2017. Their appraisal should have been completed by the registered manager. The one member of bank staff who did not work for the NHS had not had an appraisal for the last three years. This was the responsibility of the registered manager.
- Administration staff were self-employed. We did not see any evidence they received appraisals or had opportunities to discuss their development. Following the inspection we were informed the administration staff had meetings with a team leader but they did not keep formal written minutes of these meetings.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

- Theatre teams met for 'sign in' prior to commencement of the surgery list, which we observed, and performance was in accordance with policy.
- Pre-operatively the nurses worked closely with individual consultants to ensure any issues identified was clearly communicated and necessary actions.
- All the staff we spoke with said the team worked well together.

Seven-day services

- The service was not provided across seven-days. The service operated Monday to Friday with some consultations taking place on Saturday mornings.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

- Consent was taken from patients during their pre-operative consultation and reconfirmed on the morning of their surgery by the consultant.
- We saw consent forms signed by the patient and the surgeon in all eight care records we reviewed. The consent forms detailed the risks and benefits of the surgery.

Requires improvement

Surgery

- Patients were given information verbally and in written format regarding the surgery they were having.
- In the eight care records we reviewed we saw the two-week cooling off period had been adhered to. This is two weeks between agreeing to the surgery and the surgery taking place. This enabled patients to have time to fully consider the risks of the surgery.
- The hospital provided training in the Mental Capacity Act 2005 (MCA). The staff we spoke with understood their responsibility under the MCA.

Are surgery services caring?

Good

We have not previously rated this service. At this inspection, we rated caring as **good.**

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

- We observed ward and theatre staff being polite and courteous to patients. .
- Patients we spoke with told us they felt "well cared for" and staff were "very friendly and kind".
- Patient feedback was good generally good across the areas we visited.
- Staff knocked on doors before entering the patient rooms, they introduced themselves and asked permission before commencing any task.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

- We saw staff in theatres providing emotional support to patients who were worried or anxious. For example, we saw a member of staff holding a patient's hand before a procedure to provide comfort and reassurance.
- Patients were given appropriate and timely support and information to cope emotionally with their care and treatment. Patients we spoke with informed us staff were supportive and reassuring and gave them and their family the reassurance to ease their anxiety before and after their procedure.
- Patients were given a number they could ring 24 hours a day following their surgery. The RM or the deputy manager was available to provide advice and reassurance when patients called.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their surgery and make informed decisions about their care and treatment.

- In all interactions we observed, staff were being caring and respectful to patients and their loved ones. They explained procedures in ways patients could understand and kept them informed about their care. Patients told us they felt well supported and were given appropriate and timely information to participate in their care right from their first meeting with the consultant to discharge.
- Costs of treatment were discussed fully with patients, including what was covered within the cost including follow up visits should they be required.
- Patients were offered the opportunity to have a friend or relative present during consultations and examinations. There were signs in the reception area that indicated to patients that a chaperone could be provided if required.
- All patients were asked to complete a patient satisfaction questionnaire prior to discharge and again at their first follow up appointment. The questionnaires we viewed were fully completed and patients were satisfied with the service they received.

Are surgery services responsive?

Requires improvement

We have not previously rated this service. At this inspection, we rated responsive as **requires improvement.**

Service delivery to meet the needs of local people

Requires improvement

Surgery

The service planned and provided care in a way that met the needs of their patients and the communities it served.

- All surgery carried out at the hospital was elective and staff reported it was easy to plan the workload.
- The hospital provided cosmetic procedures to adults over the age of 18 years.
- There was a patient co-ordinator based at the hospital, who responded to enquiries made via the hospital's website, through social media or by patients who called the hospital directly.
- Operating theatre lists for surgery were scheduled in advance and patients could select times and dates to suit their family and work commitments. The hospital conducted surgery lists on average two to three days per week, depending on availability of surgeons.
- The hospital pre-planned all admissions to allow staff to assess patients' needs prior to surgery. They accepted patients for treatments with low risks of complication, and who's post-operative needs were met through ward-based nursing.
- We saw the facilities in theatre were appropriate for the services provided. For example, there were enough equipment and recovery space for the number and type of surgeries undertaken.
- There were no facilities for emergency admissions.

Meeting people's individual needs

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

- Staff had access to a telephone based translation service to assist communication with non-English speaking patients. Staff we spoke with were aware of this service but reported they had not had to use it.
- All the patients we spoke with felt staff had given them enough information about their procedure and were able to discuss it with their consultant and nursing staff. Staff gave patients information about their procedure at pre-assessment. This included procedure specific information leaflets and information about their stay. Staff discussed their care in detail and explained what to expect post-operatively and involved patients in their plans for discharge.
- Due the nature of the procedures undertaken at the hospital, the hospital did not accept any patients who were living with dementia or had a learning disability.
- Staff gave patients clear instructions about managing their surgical wounds and any follow up appointments that were required.
- There was still no training for staff on cultural needs. Staff we spoke with had a clear understanding of equality and diversity, they understood cultural needs with regards to food but patients didn't stay at the service for long periods of time so they did not have a special menu reflecting this.

Access and flow

People could access the service when they wanted it and received care promptly.

- On arrival at the hospital, staff showed patients to their room on the ward. Patients changed and prepared for surgery in their room. The consultant and a nurse visited the patient in their room to reconfirm consent and answer any questions the patient may have. Staff then escorted patients to the theatre for their operation.
- Immediately after surgery, staff cared for patients in the recovery room. Once patients were stable and pain-free, staff took them back to the ward to continue recovering.
- Patients designated a responsible adult to collect and escort them home from the ward after discharge. The vast majority of patients were day cases and went home the same day.
- We asked the RM to provide details of the number of cancelled operations in the period June 2018 and May 2019, the service was unable to provide this information at the time of our request or following the inspection.
- The majority of patients were usually seen within two weeks of a request for a consultation. Surgery was then planned at a time and date convenient to the patient which was at least two weeks after the consultation. This allowed for a cooling off period of two weeks.

Learning from complaints and concerns

Requires improvement

Surgery

It was easy for people to give feedback and raise concerns about care received. However, the service could not demonstrate they treated concerns and complaints seriously or investigated them sufficiently or shared lessons learned with all staff.

- The hospital told us they had received 29 complaints during the period June 2018 to May 2019.
- The hospital was not able to demonstrate to us a robust complaint investigation process. We were not able to ascertain what training the previous RM had received to be able to investigate complaints. The service had a complaints spreadsheet, which detailed the name of the complainant, date the complaint was received, whether it was a valid complaint and notes of correspondence with the complainant. There was no information regarding resolution of the complaint. The patient did not receive a resolution letter or written apology as far as we could see from the patient files viewed.
- The service did not share learning from complaints within the team.
- The service did not analyse complaints information to identify trends.

Are surgery services well-led?

Inadequate

We have not previously rated this service. At this inspection, we rated well-led as **inadequate.**

Leadership

Leaders of the service did not have the necessary skills and knowledge to run a service providing high-quality sustainable care. They did not understand what was required to manage the priorities and issues the service faced.

- The service was privately owned, and one individual was the sole director, company secretary and nominated individual.
- The former RM had not put in place sufficient arrangements around governance and the monitoring of the service. The handover and induction to the new manager was not sufficiently detailed, which meant the individual taking over the role was not briefed on important systems and processes or where to find such information.
- The service had a manager who at the time of the inspection was awaiting registration with CQC. They had been in post for seven working days, and their role was to provide day to day management of the service. Following the inspection, the new manager left the service.
- We were not assured the new manager or the previous registered manager had all the appropriate knowledge or skills to provide leadership of the governance within the service. For example, managers did not have an appropriate system to identify risks or review and implement policies and procedures. We were not assured the managers understood what information was required within the policies and procedures to ensure the safe and effective delivery of the regulated activity. For example, following our post inspection feedback, the nominated individual arranged for an external consultant to review and rewrite the service's policies and procedures.
- The previous registered manager had not established a well-developed and embedded system to evidence that appropriate governance processes were in place. For example, we were told that audits were completed; however, there was no system to demonstrate the outcome of the audits or use the findings to drive service improvements.
- The nominated individual did not have oversight of the work the registered manager had been tasked with doing. The nominated individual was not aware that the majority of the service's policies and procedures were out of date.
- At the time of the inspection, staff said the new manager was visible and approachable. Staff said that both the new and former managers were friendly and approachable, and they felt confident to discuss any concerns they had with them.

Vision and strategy

The service did not have a documented vision, strategy or values; however, the owner of the service had a vision for development of the service.

- The owner of the service wanted the service to be the leading service for cosmetic surgery in south east London. They intended to expand the locations to include two more theatres and 18 more patient beds.
- The service could not provide us when requested with a documented strategy or values.
- The staff we spoke with could not describe the values or strategy for the service. Staff commented they were happy to do their job and were not concerned with the service strategy. This was possibly because staff were not contracted and mainly held substantive posts outside of the service.

Culture

Staff felt supported and valued. Opportunities for career development were not provided by the service. The service provided the opportunity for patients, their families and staff could raise concerns without fear, however there was not a robust system of investigation of those concerns.

- Staff fed back they felt supported by the new manager and previous registered managers. We observed positive interactions between staff and manager.
- The vast majority of the staff were bank staff or self-employed, which did not provide an opportunity for the staff to feel fully connected to the organisation and did not ensure they were as fully committed to the organisational values. Staff we spoke to did tell us they enjoyed working for the hospital.
- The staff we spoke to were able to tell us what duty of candour was. Staff were able to tell us how important it was to be open and honest with patients and to apologise when things went wrong. However, the service was unable to show us documented evidence that duty of candour process had been completed. The service could not provide us with copies of letter sent to patient when duty of candour had been required.
- Our observations and discussion with staff indicated a disinterest with regards to reporting concerns, incidents or errors. Staff told us that the manager dealt with all concerns or incidents. Once staff had reported the concern to the manager they did not hear about the concern again.

Governance

The service did not have a systematic approach to improving service quality and safeguarding high standards of care. There was a lack of overarching governance.

- There were limited formal governance arrangements in place to promote the safety and quality of care. We found there was a reliance on a non-structured approach across the service. We were told the medical advisory committee (MAC) meetings were held quarterly. We requested copies of the MAC agendas and meeting minutes from the service, we received one set of minutes from a meeting which took place in May 2018.The service could not provide us with any agendas or other minutes from the MAC meetings that had taken place this year.
- The MAC chair was a consultant from the hospital. We were told the registered manager and the MAC chair would attend every meeting and the nominated individual attended when they were available. Other consultants from the hospital very rarely attended the meetings. The meetings were held over the phone in the majority of cases and it was not clear what information was provided prior to the meeting and what was considered during the discussion.
- There was no formal process in place for reviewing, updating and ratifying policies and procedures. The vast majority of the policies and procedures were reviewed during the inspection were past their review date by at least two years. We did not see any evidence they had been amended in line with latest changes to guidance.
- In addition, the process for publishing policies was unclear and we did not see evidence that staff were made aware of changes when policies were updated. At our follow up inspection, we were told by the nominated individual that they were using an external consultancy to review the policies. We were told this process would take about a month, however, we were not assured that this there was an effective plan with timescales for completion. Furthermore, we were not assured managers had considered the on-going process for reviewing policies and procedures or how they would ensure staff understanding and compliance.

- We found policies and procedures to support staff lacked detail; for example, the safeguarding adult's policy did not have information about how to make a referral.
- There was no effective system for recording, handling, responding to, and learning from complaints. For example, there was no evidence of complaints being investigated and there was no evidence of learning and sharing lessons learnt.
- There were no processes in place for learning lessons from incidents, complaints and audits. Whilst the new manager told us they would ensure learning would be directed to the individual, we were not assured learning would be or was shared with other staff to improve quality and safety across the service.
- Due to the majority of the clinical staff being bank staff, there were limited opportunities for those staff to be updated on performance, complaints, incidents, policies, patient feedback and clinical issues. Staff told us they had not met all staff working within the service and there were no regular structured team meetings.
- The service did not minute meetings that did take place between staff. Therefore, we were unable to gain assurance that both quality and safety were given sufficient coverage within such meetings, and staff were engaged in improving quality and safety across the service.
- Mechanisms for reviewing and improving the quality of the service were limited. There was an audit schedule in place, but we did not see evidence of infection control audits or any quality and outcome audits. Whilst the service completed peer review audits, there was no system in place for documenting the audit and the outcomes of the audits. Furthermore, there was no evidence the findings were discussed with staff or service improvements being made. During the inspection it was unclear what the schedule for audits was and who was responsible for them.
- Staff underwent appropriate recruitment checks prior to employment to ensure they had the skills, competence and experience needed for their roles. We reviewed the personnel records for staff and found all required information was available, such as employment reference, disclosure and barring service (DBS) checks, full employment history, evidence of qualifications and professional registration.

Managing risks, issues and performance

There were no effective systems in place for managing risks, and there was no evidence risks and their mitigating actions were discussed with the team.

- The service did not have a formalised approach to identify and manage risks within the service. Service had a document which they called a risk register, however this document was a list of issues that had arisen within the service. For example, breakdown of equipment in theatre was listed. There were no action plan or assessment of what the risk would be to patients should equipment break down in the theatre. There were no mitigations put in place should equipment break down in theatre.
- We asked the clinical staff what the main risks were within the service; however, the staff we spoke with could not confidently explain the main risks for the service and what, if any, mitigation had been put in place. They said the registered manager dealt with the risks.
- There was no formal process in place to demonstrate the service used patient feedback, feedback from complaints and audit results to help identify any necessary improvements needed to ensure they provided a high-quality, effective, safe service. For example, the information provided by patients when they complained was not investigated and feedback was not passed on to the staff.

Managing information

The service did not collect, analyse, manage, and use information well to support all its activities.

- The service collected a limited amount of information to improve performance of the service. During the inspection, we asked for information on numbers of cancelled operations. This information was not readily available; therefore, we were not assured the service was using information effectively to improve outcomes.

Requires improvement

Surgery

- Staff we spoke to knew how to access policies and procedures, but they were not stored where the clinical staff worked. The policies were stored in the administration annex in a folder. There was no evidence to show that staff had read the policies or procedures.
- Patient records were managed in a way that kept them secure and patient's confidentiality was maintained.

Engagement

The service engaged generally well with patients, however engagement was not used systematically to improve the service. There was limited staff engagement.

- Patient satisfaction surveys were given to patients prior to discharge and patients were asked to complete them before they left the hospital. We asked the new manager for information regarding how patient's feedback was used to review and improve the service. The service was unable to provide us with this information during or post inspection. We were not assured the feedback patients were giving the service was used to monitor and improve quality.
- The hospital used social media to promote the services it provided.
- Staff engagement was limited. Staff fed back they enjoyed working for the service, however did not have many opportunities for team meetings.

Learning, continuous improvement and innovation

The service did not demonstrate it had a systematic approach to learning from when things went wrong and continuously improving.

- The service did not have sufficient or robust systems in place for the reporting, monitoring, investigation of safeguarding, incidents, risks or complaints.
- The service did not have an adequate audit schedule in place.
- We did not see any examples of development or innovation.
- During the inspection the new manager did demonstrate a commitment to improve, however following the inspection they informed us they were leaving the service. During the follow up inspection the nominated individual felt that the improvements that were required would be completed by the person they employed next as the manager. We met the new manager on the third inspection visit, they recognised there was a lot of work required to improve the service.
- We were not assured that the service had an action plan in place to ensure continuous improvement would be made in a timely manner.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure policies and procedures are up to date, reflect current national guidance, are reviewed in a timely manner and are accessible to staff.
- The provider must ensure that the incidents management process is development to enable effective incident management.
- The provider must ensure that risks to patients are identified, assessed, mitigated and monitored. That staff are aware of their responsibilities relating to risk.
- The provider must ensure that complaints are recorded and investigated fully. Correspondence with the complaint is documented. Learning is identified, and action plans are developed

Action the provider SHOULD take to improve

- The provider should ensure equipment is stored in a suitable area and clearly display which equipment is not working. that all patients are given enough support and opportunity to be fully involved in the planning of their own care.
- The provider should develop a vision and strategy for the service.
- The provider should investigate and carry out further analysis to understand the reasons for high staff turnover.

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 Policies and procedures were not easily accessible for staff as they were kept in an annex of the building. We found no electronic copy of policies were available to staff and paper copies in the theatre area were not updated and reviewed in line with the stated review date. In the event of access to policies being required for safe care and treatment, policies and procedures were not updated and were not easily accessible to staff. Regulation 17 (2)(a) The incidents management process was not sufficiently developed to enable effective incident management. Risk identification, mitigations and managements systems were not sufficiently developed to provide reasonable assurance of managerial oversight. Regulation 17 (2) (b) Complaints systems were not sufficiently developed to provide assurance. Regulation 17 (2) (e)