Transform (Riverside)

Quality Report

Address: Abbey Riverside Hospital, 3 Brentside Executive Park,
Great West Road, Brentford,
Middlesex,
TW8 9HE
Tel: 02082326300
Website: info@transform-medical.co.uk

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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

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

Summary of findings

Letter from the Chief Inspector of Hospitals

Transform Riverside is an independent hospital that is located in a purpose built facility in West London and was opened in 2009, to meet the needs of patients from the Midlands to the South of England. The hospital has a 14 bedded in-patient ward and a five bedded day care unit. Facilities include two operating theatres and a five bedded recovery unit. The hospital solely provides cosmetic and bariatric surgery for adults ages 18-74 years old. The hospital offers a range of surgical cosmetic procedures for day case and inpatients. The most common procedure performed at this hospital include breast augmentation, rhinoplasty and lipoplasty. The service also offers gastric band surgery to patients with a body mass index of up to 45. This is higher than the standard threshold and therefore a greater proportion of bariatric patients are able to access this service

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 29 November 2016, along with an unannounced visit to the hospital on 09 June 2017.

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

Services we do not rate

We regulate, cosmetic surgery service's but we do not currently have a legal duty to rate them. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

We found the following areas of good practice:

- Robust reporting procedures in place for incident reporting and for raising safeguarding concerns. Staff knew how to report incidents and the provider displayed clear and easy to read flowcharts on how to report incidents.
- We were told by patients that nurses were kind and friendly and frequently checked their wellbeing.
- Positive patient feedback was often reported on patient feedback forms and results proved to be consistent.
- The service provided a late clinic on either a Monday or Tuesday finishing at 8pm, this meant that the service could provide appointments for patients working between 9am to 5pm.
- The hospital offered laparoscopic gastric band surgery for patients with a body mass index (BMI) of up to 45. This was a higher threshold than other centres offered, which meant a greater proportion of bariatric patients were able to access the service.
- Clinical governance meetings were held in conjunction with the provider's other hospital. Meeting minutes showed governance issues across both hospitals were discussed.
- Staff reported that they were happy to work for Riverside and reported an optimistic culture and environment to work in.

However we found the following areas of improvement:

- The shower room in the ward was not suitable for ease of wheelchair access.
- We saw no action plans from patient record summary audits and were not assured any learning had taken place.

Summary of findings

Professor Sir Mike Richards
Chief Inspector of Hospitals

Overall summary

- Incidents were regularly reviewed in detail at quality assurance meetings and actions were set to avoid repeat incidents. However we were not convinced that learning from incidents were effective as needle stick injuries were increasing.
- Staff were kept updated on national guidelines via emails from the ward sister, and the hospital encouraged all staff participation in local audits. However we saw no action plans from patient record summary audits which meant that improvements could not be made.
- Patients we spoke to were happy with the service and we observed positive care from the nurses. The hospital was responsive to patients needs and we found no evidence that contradicts this.
- We saw that patients used discharge questionnaires to provide feedback for the service.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery		• Incidents were regularly reviewed in detail at quality assurance meetings and actions were set to avoid repeat incidents. However we were not convinced that learning from incidents were effective as needle stick injuries were increasing. • Staff were kept updated on national guidelines via emails from the ward sister, and the hospital encouraged all staff participation in local audits. However we saw no action plans from patient record summary audits which meant that improvements could not be made. • Patients we spoke to were happy with the service and we observed positive care from the nurses. The hospital was responsive to patients needs and we found no evidence that contradicts this. We saw that patients used discharge questionnaires to provide feedback for the service.

Summary of findings

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Riverside

Services we looked at Surgery

Summary of this inspection

Background to Transform (Riverside)

Riverside is operated by Transform. The hospital opened in 2009. It is a private hospital in West London. The hospital primarily serves the population between the Midlands and the South of the UK. It also accepts patient from outside this area.

The hospital has had a registered manager in post since 19 March 2015. Since the initial inspection in November 2016, the registered manager has left. At the time of the unannounced inspection the clinical services manager was acting up as registered manager. The post is yet to be filled by the provider.

The hospital is registered to provide the following regulated activities:

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

Our inspection team

The team that inspected the service comprised of a CQC lead inspector; Monisha Parmar other CQC inspectors, and a specialist advisor who is a consultant urological surgeon. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection.

How we carried out this inspection

During the inspection, we visited the inpatient ward, the day care unit and the recovery unit. We spoke with 14 members of staff including; registered nurses, health care assistants, reception staff, chaperones, medical staff, operating department practitioners, and senior managers. We spoke with four patients and three relative. During our inspection, we reviewed five sets of patient records.

There were no special reviews or investigations of the hospital ongoing by CQC at any time during the 12 months before this inspection. This was the hospital's first inspection since registration with CQC.

Information about Transform (Riverside)

Activity (July 2015 to June 2016)

- In the reporting period July 2015 to June 2016 there were 1940 inpatients, 1553 day cases and 4859 outpatient spells of care.
- The most common surgical procedures were breast augmentation and rhinoplasty procedures.

There were 21 Doctors with practicing privileges who had more than six months in post. 12 doctors had been revalidated in the last 12 months. Forty five consultants had practicing privileges for cosmetic surgery (there were 40 on GMC specialist register, the five remaining were asked to apply to be on this register before operating). No consultant had had their practicing privilege revoked in the last 12 months. There were no directly employed

Summary of this inspection

resident medical officers (RMO's). These were provided by a different healthcare organisation. RMO's work a week long rota. Relevant certificates were reviewed and approved by hospital staff before an RMO was employed.

Track record on safety between July 2016- June 2017.

- One never event
- There were 226 Clinical incidents 134 no harm, 112 low harm, 19 moderate harm, and no incidents that led to severe harm or death
- There were no serious incident during this period.

There were no incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA).

There were no incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA).

There were no incidences of hospital acquired Clostridium difficile (C.diff).

There were no incidences of hospital acquired E-Coli.

There were 31 complaints received within the reporting period.

Services accredited by a national body:

- ISCAS (Independent Healthcare Sector Complaints Adjudication Service)

Services provided at a service level agreement by other providers or companies:

- Medical equipment servicing.
- Maintenance agreement.
- Pharmacy cover.
- Ambulance services.
- Resident medical officers (RMO).
- Pathology processes.
- Sterilisation of medical equipment.
- Fire alarm maintenance.
- Fire and security.
- British Oxygen Company.
- Diagnostic procedures.
- High dependency unit.

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?

Services we do not rate

We do not currently have a legal duty to rate cosmetic surgery service.

We found the following areas of good practice:

- The service had included and recognised the importance of a duty of candour in their incident policy.
- The service had clear advice on hand hygiene for patients and visitors.
- Rooms and sleeping areas were free from dust and were visibly clean.
- Wards were single sex.
- Medicines were appropriately stored.
- Records had individual bar codes for easy storage and identification.
- Audits were regularly undertaken in patient records and in hand hygiene.
- Patient notes were well documented and legible.
- 100% of patients had a thromboembolism risk assessment completed on admission.

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

- We found poor infection prevention control from staff and lack of clinical waste bins.
- Carpets were seen in some clinical areas, which is not compliant with the Department of Health, Health Building Note.
- The shower room in the ward was not suitable for ease of wheelchair access.
- Patients' names were printed on each page in patient notes but no other identifiable information was printed, for example the patient's hospital number.

Are services effective?

Services we do not rate

We do not currently have a legal duty to rate cosmetic surgery service.

We found the following areas of good practice:

Summary of this inspection

- The hospital submitted data to the Private Healthcare Information Network (PHIN), via an automated data upload computer software.
- Training in wound care and intravenous cannulations was organised for staff when the time was available.
- Patients told us that their pain was well managed and controlled after surgery.
- All staff had received an annual appraisal.
- Consultants had to demonstrate revalidation and annual appraisals to maintain their practicing privileges.
- RMOs were provided by an external organisation that completed relevant employment checks, such as DBS and General Medical Council registration
- There was a range of information leaflets on all different procedures which were differed according to consultants.
- Consent forms were given to patients at their pre-operative appointment by a clinic nurse. This allowed patients the opportunity to read the form before having their surgery.

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

- We saw no action plans from patient record summary audits and were not assured any learning had taken place.

Are services caring?

Are services caring?

Services we do not rate

We do not currently have a legal duty to rate cosmetic surgery services.

We found the following areas of good practice:

- We were told by patients that nurses were very kind and friendly and frequently checked their wellbeing.
- We observed patients being kept warm during bed transfers.
- Patients reported feeling safe and confident, and were happy with their surgeon who was very open and honest with the risks and the procedures.
- Friends and families reported that they were kept up to date and informed of any updates while their loved ones were in theatre.

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

We observed some occasions where patient privacy and dignity was not fully maintained

Summary of this inspection

Are services responsive?

Are services responsive?

Services we do not rate

We do not currently have a legal duty to rate cosmetic surgery service.

We found the following areas of good practice:

- Patients had a two week cooling off period after deciding to go ahead with their procedure.
- Patients attended their preoperative consultation and assessments at a range of clinics across the country.
- The service provided a late clinic on either a Monday or Tuesday finishing at 8pm, this meant that the service could provide appointments for patients working between 9am to 5pm.
- The services used the same RMO for consecutive months at a time, which meant that patients were able to have continuity of care.
- Patients could access the hospital by contacting the provider to organise a consultation at their local clinic.
- Patients told us they did not have to wait long for their procedure and that their procedure date had been scheduled around their own commitments, such as childcare and work.
- After being discharged from hospital, patients received a follow up telephone call within 24 hours to check their progress.
- Senior staff told us the hospital could accommodate patient requests to have an entirely female care team, including the surgeon and theatre team, as well as nurses on the ward.
- The hospital offered laparoscopic gastric band surgery for patients with a body mass index (BMI) of up to 45. This was a higher threshold than other centres offered, which meant a greater proportion of bariatric patients were able to access the service.
- The service had introduced a new vegan menu, there was also an option to highlight specific allergens when ordering food.
- Complaints data we reviewed showed the hospital complaints policy was adhered to.

Are services well-led?

Are services well-led?

Services we do not rate

We do not currently have a legal duty to rate cosmetic surgery service.

We found the following areas of good practice:

Summary of this inspection

- Clinical governance meetings were held in conjunction with the provider's other hospital. Meeting minutes showed governance issues across both hospitals were discussed.
- The risk register was reviewed every three months with mitigating actions.
- The manager reported confidence in all her staff and staff reported a good working atmosphere.
- There were opportunities for patients to provide feedback post operatively.
- We saw evidence of medical advisory committee (MAC) meetings taking place quarterly.

Surgery

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are surgery services safe?

We regulate this service but we do not currently have a legal duty to rate it. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

Incidents

- Reviewing incidents was a standard agenda item on the quarterly quality assurance meetings. This ensured that any themes of incidents were highlighted and new incidents were discussed. In each meeting up to five incidents were discussed. These incidents all had an action recorded and outcomes discussed. Typically incidents discussed included patients being booked in for the correct treatment but wrong procedure, and pharmaceutical issues regarding incorrect labelling of medicines.
- Staff were encouraged to report all incidents, and to also inform the manager of any incidents verbally as well recording the incident on the correct form.
- The most common incident reported was haematoma (a solid swelling of clotted blood within the tissue) the second most commonly reported incident was haemorrhage (an escape of blood from a ruptured blood vessel).
- The incident policy stated that incidents should be reported via an incident reporting (paper based) form. Master copies were located on the Transform network. Staff we spoke with stated that paper forms were easy to access and fill out.
- The service reported no serious incidents during the period between June 2015 and July 2016. There was no still no serious reported found on our unannounced inspection.
- The incident reporting form was split up into several sections. There was a separate section used to provide details for what occurred and any immediate actions taken. We looked at several completed incident reporting forms and found that all sections had been completed in depth. All forms were neatly written with clear and legible writing.
- Regulation 20 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 requires the organisation to notify the relevant patient that an incident has occurred affecting them, provide reasonable support to the relevant patient in relation to the incident and offer an apology. This is widely known as a duty of candour.
- We saw that Transform had referred to a duty of candour in their incident policy. However, we saw no specific duty of candour policy. There were no additional prompts for a duty of candour in the incident reporting from. This meant that there was no documentation to say that patients received an apology or support from the hospital in response to an incident.
- Needle stick injuries were discussed in the Medical Advisory Committee (MAC). There was one reported injury in August 2016. This was due to poor compliance and no further action was taken on this. We looked at data from January 2017 to March 2017, which showed that there was a further four reported needle stick injuries. This meant that the hospital was not providing the necessary support and actions for staff to prevent needle stick injuries from happening again.
- There was one never event. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. A patient had sustained an injury at the

hospital in the reporting period July 2015 and June 2016, classified as a never event. However the injury received could have occurred spontaneously or could have occurred at the time of the surgery. This was not confirmed as symptoms appeared 10 days after the operation. The hospital had communicated this never event to the appropriate provider and was still awaiting an outcome.

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

- The NHS safety thermometer is a tool used to record four common, and largely preventable, harms to patients: pressure ulcers, falls, urinary tract infections in patients with a catheter and new venous thromboembolisms (VTE).The safety thermometer provides information for frontline teams to monitor performance and to make improvements to eliminate patient harms.
- The NHS Safety Thermometer was discussed at the hospital Medical Advisory Committee meetings and subsequently escalated to the Clinical Governance Forum. However, independent organisations are not required to collect this data in this format. Although, VTE assessments were done routinely at this hospital. Patients were healthy individuals who underwent elective surgery and therefore pressure sore grading on admission was not required. Patients were within the age range of 18-65, and elective surgery was only conducted if the patient was in good health, therefore falls assessment was not required. Also patients only had catheters on very rare occasions, which were always removed 24 hours post-surgery.
- The hospital conducted work into the management of sepsis. For example managers told us that there was an annual infection control training for clinical staff, conducted by the consultant microbiologist. We also saw monthly reporting forms for delayed healing and surgical site infections. The form allowed for clear documentation of the type of infection reported, the location of the infectious site and how the infection was being managed.

Cleanliness, infection control and hygiene

- There were no cases of hospital acquired methicillin-resistant Staphylococcus Aureus (MRSA) between July 2015 and June 2016.
- Out of 3272 breast procedures between July 2015 and June 2016, there were 29 identified cases of surgical site infection (SSI). This was below the 1% SSI benchmark identified by the hospital. We saw evidence that the number of SSIs was discussed in the clinical governance meeting, where a trend was identified and triggered a resultant audit. In the same period, there were no surgical site infections identified out of 174 gynaecology procedures.
- We looked at the data between January 2017 and March 2017 out of 869 procedures, there was no SSI reported during this period. There was also no cases of MRSA, methicillin-sensitive Staphylococcus Arues (MSSA) C Difficle and E Coli. This meant that the hospital maintained good infection prevention control and improved their SSI rates.
- Decontamination of surgical equipment was outsourced to a third party. We reviewed the service level agreement for this which was signed on30 April 2016 and valid for two years. The cleaning, decontamination and sterilisation processes were in accordance with the International Organisation for Standardization; ISO9001 (2008) and ISO13845 (2012) and Medical Devices Directive 93/42EEC- Annex V for surgical instruments, trays, utensils, containers, glassware, polypropylene and other reusable items. The hospital had access to the third party's secure web-based portal to be able to track equipment and view service reports.
- We saw hand washing advice for patients and visitors in the form of a leaflet. The leaflet gave advice on when, how and what should be used to wash hands. The area's most frequently missed when washing hands were portrayed in pictures.
- We looked at a clinical practice process improvement tool audit that looked at hand hygiene in the recovery area and in the theatres. The audit had 13 questions that included 'are health and social care workers fingernails short?', 'are taps turned off using a no touch technique following hand washing?' and 'is the correct hand hygiene's product used?'. The tool included guidance on what the assessor should look for, for example question nine was 'is the correct amount of hand hygiene's product used?' The guidance stated it should be a 'single shot from the dispenser'. The audit showed 100% compliance to hand hygiene techniques in clinical areas.

Surgery

- We looked at an infection control audit which looked at the two wards, the kitchen , the bathrooms, toilets, utility rooms,store room, water coolers and dispensers, hand hygiene, waste management, personal protective equipment, medical equipment and isolation precautions. There were two wards assessed: one was scored lower than the other. The areas of shortfall in the lower scoring ward included unclean environment, unclean floor, unclean computer systems and telephones. The kitchen audit found shelves, cupboards and drawers not clean inside and out and were not free from damage, dust litter or stains and was not in a good state of repair. Hands were not decontaminated and a clean plastic apron was not worn to serve patients meals and drinks.
- The audit did not show any action plans as a result of shortfalls in any of the areas audited. Isolation precautions achieved 100% in the audit and showed that isolation facilities were available when required. Personal protective clothing (PPE) was available before entering the room and clear instructions for staff and visitors were in place when a patient was in isolation.
- Hand washing sinks were available in patient rooms. We saw sanitising hand gel was available throughout the hospital. The hand gel was attached to walls for easy dispensing and small posters promoted use of these dispensers. We observed staff cleaning their hands with sanitising gel prior to using the observations machine.
- We found some non-compliance with bare below the elbow by medical and nursing staff. We observed a consultant performing a ward round wearing a long sleeve shirt, jacket and cufflinks. The consultant moved between patient rooms and no hand hygiene was observed. We also observed a nurse giving care whilst wearing a long sleeve cardigan, and another nurse wearing a ring with a stone when performing observation tests on a patient.

Environment and equipment

- The entrance to the ward was unsecured. We saw clear signage on the ward for the way out, fire exits and the lounge.
- The lounge consisted of a seating area for six patients, with wipe able surfaces. The lounge was not heated.
- We looked at four empty rooms that could be used for patients. All of the rooms were visibly clean.
- The Department of Health, Health Building Note 00-10, Part A Flooring states that; carpets should be avoided in clinical areas. Floor finishes should be of a material that is not physically affected or degraded by the detergents and disinfectants likely to be used. We observed several floor finishes in patient rooms including carpet and laminate flooring. There was no standard of flooring across all the rooms which meant that cleaning of the rooms was not of a set standard either. We also observed carpets in the corridors. The Health Building Note 00-10, Part A Flooring states that if carpets are to be considered for non-clinical areas it is essential that a documented local risk assessment is carried out with infection prevention control involvement. This was missing from the hospitals risk assessment matrix.
- Clinical waste bins were not present in all rooms. This meant that clinical waste would need to be carried out of certain rooms to dispose of, which was a potential infection control risk.
- We looked at mattresses, pillows and duvets used by patients which all had wipe able surfaces. There were no breaks in the plastic material and no stains. The linen was clean and free from any marks.
- The TV's in the rooms all displayed in date PAT stickers (Portable Appliance Testing).
- We observed an observations machine that was plugged in and charging in the corridor. There were two machines in this ward, both had PAT stickers that were in date.
- We looked at the resuscitation trolley which was located between the nurses station and the day care ward. The trolley had a snap seal design to indicate use or potential missing drugs from the trolley. The trolley was checked daily and records showed this. The hospital's policy stated that two trained nurses must check the trolley daily, but records showed that on six occasions only one nurse had checked the trolley. This was found between 25 and 28 November 2016 and 17 and 19 of September 2016.

Surgery

- The resident medical officer (RMO) was required to check the defibrillator daily, records showed no gaps in the daily checks. We saw alert stickers on medications that were due to expire soon.
- On top of the defribulator trolley we saw a yellow sharps bin stored on its side with the lid open. There were several sharps items inside. Correct storage of sharps bins should be vertical. Sharps bins should be legibly marked with a horizontal line to indicate when the sharps box is filled to between 70% and 80% of its maximum volume.
- We looked at the five bedded day ward, which was visibly clean. Three beds were out of action and were not in use due to battery issues. There were signs on each bed to show this. The bed spaces were divided with disposable curtains, which were all dated to show they were in time.
- The ward had two hand wash basins, PPE and a first aid kit was available. There were two clinical waste bins and one general waste bin.
- We observed the patient shower room which had steps to access. This meant that this shower may prove difficult to use for all patients. There was an observations machine stored inappropriately in the shower room.
- We were informed that the day ward was only used for female patients; and there was never a mix of male and female patients in a ward.
- The nurse in charge allocated patients to specific rooms or bays. Those patients who required a longer stay were allocated single rooms. If single rooms become available, patients in the bay would be transferred to these.
- There were no specific bariatric beds available although regular beds that were used had a safe working load of 240kgs, which was sufficient for the needs of the service.
- The nurses station used notice boards to display information such as where to find minutes from the latest clinical governance meetings or staff meetings.
- The use of Natural Rubber Latex (NRL) gloves have the potential to cause asthma and urticarial (itchy rash) including more serious allergic reactions such as anaphylaxis (extreme serious allergic reaction). The Health and Safety Executive recommends employers should carefully consider the risks when selecting gloves in the workplace, because of the importance of latex gloves as a source of exposure to NRL proteins. Employers must be able to demonstrate that they have carried out an assessment to select which type of gloves they should provide and have an effective glove use policy in place. We spoke to the nurse in charge who told us that there were no latex gloves in use, this was confirmed by an anaesthetic nurse in theatre; who said that all sterile gloves were latex free.

Medicines

- Medicines were stored in locked medicine cupboards, within a keypad locked treatment room. This room had a sensor for additional security. The key was kept with the nurse in charge on the day.
- Medicines that were locked away included; antiemetic's, analgesia, antibiotics, diazepam and tramadol.
- We saw that all controlled drugs (CDs) were kept in a separate locked cupboard away from other medicines, such as Oramorph and Morphine.
- The CDs cupboard remained locked at all times and the keys were kept with the nurse in charge of the ward, and in theatre by the on duty operating department practitioner (OPD).
- When the theatres closed in the evening the theatre keys were given to the nurse in charge on the ward. The keys were locked away on the ward until the next morning.
- When CDs expired the drugs were destroyed. This was witnessed by the hospital manager, who was also the accountable officer.
- Pharmacy services for patients' tablets to take away (TTAs) were outsourced to a third party. The ward received regular deliveries of TTAs which were ordered in advance for patients being admitted for surgical procedures. The TTAs contained medicines such as antibiotics and analgesia which staff anticipated patients would need upon discharge from hospital.

Surgery

- A medicines audit was completed in August 2016 by an external pharmacist. The audit identified that medicines management within the hospital was generally good and improvements had been made in response to the previous audit in 2015.
- A monthly CDS documentation audit was completed in theatres. Results showed 12 errors in July, 12 errors in August and 17 errors in September. We noted that action points had been identified, however the action points for July and August were largely the same, indicating that staff had not learnt from the dissemination of information. We also noted that the initials of some staff who had made the errors appeared for the same reason more than once over the three months. This further indicated that appropriate learning had not occurred.
- CDs were ordered separately to other drugs.
- Denaturing kits were available for the destruction of expired drugs.
- We found two out of date sterile water used for injections in the cupboard dated 05/2016, and also an out of date packet of polypropylene stiches dates 07/2016.

Records

- Individually numbered bar codes were used to identify individual patients facilitate easy storage. When a patient was discharged from the hospital, their records were stored on site for approximately one year. After this period, their records were stored at an archive facility for a minimum of ten years.
- We looked at patient record summary audits that looked at patients' records on a monthly basis. The audit looked at consent forms, the WHO surgical safety checklist and other pre and post operation procedures. The audit found high standards of documentation, incorrect colour ink on documentation and incomplete preoperative screening forms. We saw no action plans from this audit which meant that no learning had resulted from this audit.
- Patient records audits were completed monthly by senior nurses on the ward. Results from March to September 2016 showed a gradually worsening score from 87.5% in March to 50% in September (however results for July and August were not provided). Information provided on the audit sheet suggested incorrect completion would be raised with individuals, but a wider dissemination was not identified.
- When reviewing patient records we found completed venous thromboembolism (VTE) risk assessments, completed on admission. We saw a letter from the patient's GP, that stated that chaperones had been offered when performing a breast examination and patients were required to sign to accept or decline a chaperone. We saw a consent form for pre and post operation photos and a consent form for the operation completed by the surgeon signed by the patient on the morning of the procedure.
- The patient's name was printed on each page in the notes, but no other identifiable information was printed, for example the patient's hospital number. We also saw a dedicated area for recording oxygen on the observation chart. Furthermore, the notes were well completed with signatures in relevant places.
- Patients' records were prepared by the ward clerk. When patients were discharged, the records were then updated onto their electronic system.
- These records were stored in the ward cupboard for one month, then moved up to the archive room. They were kept there for one year before being stored off-site in Manchester.

Safeguarding

- There had been no safeguarding concerns raised from the hospital.
- We looked at the safeguarding policy which was in date and included alerting the CQC of any safeguarding concerns.
- We saw a flow chart displayed on the wall advising staff of the hospital safeguarding procedures.
- The flow chart was easy to follow in case of raising a safeguarding concern and included the telephone number for the local authority.
- The flow chart was displayed on numerous walls around the hospital, which meant that it was accessible for all staff members.

Surgery

- Staff were able to identify the main safeguarding lead within the hospital when questioned.
- All staff were trained to a level 2 in adults safeguarding and to a level 3 in children safeguarding.
- Safeguarding was a part of statutory mandatory training which was completed yearly online.
- We spoke to staff who had good knowledge of the safeguarding flowchart and knew who to report safeguarding concerns to.
- Staff had a good understanding of the term safeguarding and were able to give several examples of the types of abuse covered in safeguarding.
- Staff we spoke with were able to show us their certificate demonstrating a completed online safeguarding training course.

Mandatory training (if this is the main core service report all information on the ward(s) here.

- Records showed that all staff members had completed equality and diversity, safeguarding vulnerable adults, data protection and display screen equipment training.
- In January 2017 eight members of staff needed to renew their training for manual handling. In May 2017 this number had reduced to two members of staff requiring an update in their manual handling training. This meant that the process for tracking training needs were effective and sufficient.
- All the necessary staff members had completed intermediate life support training.
- All bar one member of staff had completed control of substances hazardous to health training (COSHH).
- All bar two members of staff had completed basic life support training and infection prevent control.
- Seven out of 20 members of staff had not completed their fire training and manual handling training.
- Blood transfusion training was completed by ten members of staff out of twenty, due to issues with logins.
- Oxygen training was completed by ten out of nineteen required members of staff.

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

- All patients being admitted to the hospital to undergo a procedure received a preoperative screening. This assessment was completed at the patient's local clinic and the information was passed on to the hospital afterwards. Details from each patient's preoperative screening were reviewed by the nurse medical advisor (a registered nurse) who ensured there were no conditions in the patient's past medical history which would suggest they should not have their procedure.
- Patients were assessed for their risk of developing venous thromboembolism (VTE) on admission to the hospital. Hospital audit data showed that 100% of patients had a VTE risk assessment completed on admission between July 2015 and June 2016. During our inspection, we observed completed VTE assessments in all patient records we reviewed.
- Between July 2015 and June 2016, there were two cases of patients sustaining VTEs post operatively. Staff told us both patients had a suitable VTE risk assessment completed and were found to be low risk, so VTE prophylaxis had not been indicated.
- The preoperative screening also checked pregnancy status and known allergies, including reactions to latex allergies. It was very important for the patient to note down the reactions and symptoms to their allergies.
- The World Health Organisation (WHO) Five Steps to Safer Surgery checklist was in use within theatres. We looked at the checklist which was neatly organised and divided into three sections; sign in, time out, and sign out. There was a dedicated space for the patients ID label and another dedicated space for implants and medical devices used within the operation. The ward sister had decided to recently audit the WHO surgical safety checklist with designated forms. We looked at a WHO checklist that had been completed the day before the inspection, this had been completed correctly.
- There was a policy in place to guide staff in the management of deteriorating patients. This policy was available on the ward and staff were aware of its location.

Surgery

- Patients who became unwell would be managed within the hospital as far as possible but those who needed additional support, such as high dependency care, would be transferred elsewhere.
- There was a specific service level agreement with a nearby hospital who would receive patients requiring higher levels of care than the ward could provide. A service level agreement was also in place with an independent ambulance service who would assist in transferring these patients.
- We looked at the operation notes which were legible and clear. The recovery observations charts had been completed every five minutes. We looked at the ward observation charts. We, saw no national early warning signs (NEWS) documented on the chart and no guidance on how to score NEWS in order to recognise deteriorating patients.

Nursing and support staffing

- There were six scrub nurses, four outpatients nurses, four recovery nurses, four health care assistants (HCA's), four escort nurses and two theatre porters.
- If the service used agency staff, the service would take a photocopy of their ID.
- New members of staff received and introduction book, and were shadowed closely by their mentor.
- New members of staff received an orientation, and were required to read and sign polices.
- We looked at the competencies for new members of staff which were all completed.
- An acuity tool was used to plan the staffing required on the inpatient ward, according to patients numbers and needs. There were 11 whole time equivalent (WTE) registered nurses on the inpatient ward, including 0.8 WTE vacancies. There were 2.2 WTE health care assistants in post, which was 0.2 WTE above establishment.
- Between July 2015 and June 2016, the use of bank registered nursing staff on the inpatient ward fluctuated between 11.6% and 30.9%. Within this period the inpatient ward
- Staffing within theatres was arranged according to the planned lists for the following week and we observed that staffing within theatres was compliant with recommendations from the Association For Perioperative Practice (AFPP).
- There were 9.5 WTE registered nurses and 15.5 WTE health care assistants and registered operating department practitioners (ODPs) in theatres. These figures included 2.25 WTE nursing vacancies and 3.5 WTE health care assistants and ODP vacancies.
- Between July 2015 and June 2016, the use of bank registered nursing staff in theatres fluctuated between 8% and 46%. Within this period the staff in theatres
- Between July 2015 and June 2016, the use of bank health care assistants and ODPs in theatres fluctuated between 1.2% and 10.2%, which met best practice recommendations.
- We spoke to the manager about the high level of bank staff used within this service. The manager told us that the service always worked with a set percentage of bank staff versus contracted staff to allow for flexible and cost effective resource planning. This was approximately 30% bank staff and 70% permanent staff. There were fewer bank shifts when theatres and hospital bed occupancy had reduced activity. The bank staff were known to the hospital and all bank staff had undergone training at this hospital. There was a significant number of bank staff that had permanent contracts at this hospital and chose to switch to bank work. This was because staff wanted greater flexibility within their role.
- On the inpatient ward and in theatres, there were no unfilled shifts between April and June 2016.
- There was an on call rota for a theatres team so patients could be operated on at any time of day and night in the event of an emergency.

Medical staffing

- Consultants and anaesthetists who operated at the hospital were required to maintain current practicing privileges in line with the corporate practicing privileges policy to be eligible to work on site. At the time of our inspection, there were 45 consultants with practicing privileges at the hospital.

Surgery

- Most consultants with practicing privileges had completed more than 10 episodes of care in the previous 12 months (81%).
- No consultants had their practicing privileges revoked between July 2015 and June 2016. At the time of our inspection, one consultant had been suspended from performing a specific procedure following an incident. This was being investigated by senior staff within the hospital, in conjunction with the Medical Advisory Committee (MAC).
- All surgeons were responsible for their own patients throughout their admission, including any unexpected readmissions or emergencies. When surgeons were not available (for example due to holiday or sickness) another surgeon was identified to cover for their patients.
- Overnight readmissions and emergencies were attended to by the on-site resident medical officer. The RMO would liaise with the surgeon in charge for each patient and follow any instructions given, until the surgeon was able to review the patient in person.
- Anaesthetists were responsible for all patients they anaesthetise on the day and for any emergencies or unplanned returns to theatre that might occur during the following night.
- Contact details for all surgeons and anaesthetists were held on the ward and in theatres, so they could be easily contacted if required. The responsibilities for all surgeons and anaesthetists were explicit within the corporate practising privileges.
- RMOs were provided to the hospital by an external organisation. There was one RMO deployed to cover the inpatient ward for seven days to complete ward tasks such as assessing patients, inserting cannulas and writing drug charts.
- RMOs were available 24 hours per day during their seven day deployment, although the emergency phone could be left with the night nurses between 10pm and 7am. The nurses answered calls and made judgements about whether the RMO should be disturbed.
- RMOs were sometimes expected to review patients overnight which therefore disturbed their rest period. If RMOs had a significantly disturbed night, staff told us the hospital could access a locum doctor to support the running over the hospital, while the duty RMO rested.

Emergency awareness and training

- There were fire evacuation test and evacuation plan performed yearly.
- Every Monday afternoon there was a fire drill test.
- During induction processes, orientation included the fire exit signs and the locations of fire extinguishers.

Are surgery services effective?

We regulate this service but we do not currently have a legal duty to rate it. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

Evidence-based care and treatment

- Staff were able to access national and local guidelines through the intranet, and information folders which were readily available to all staff.
- All staff had individual log ins to access the intranet, including bank and agency staff. The hospital tended to use the same bank and agency staff.
- Nursing staff confirmed clinical governance information and changes to policies and procedures and guidance had been cascaded down by the ward sister via email, communication books, memos and via the notice board.
- All updates received by the ward sister had been cascaded down via email from Transform head office. These updates included updates from national guidelines such as NICE (National Institute for Health and Clinical Excellence) as well as WHO (the World Health Organisation).
- Patients assessed as being at risk of developing venous thromboembolism (VTE) were provided with mechanical or pharmaceutical prophylaxis, in line with NICE guidance.

Surgery

- The hospital reviewed its cosmetic surgery services against the nationally recognised 'Professional Standards for Cosmetic Surgery' (Royal College of Surgeons, 2016).
- The hospital required patients to have a two week 'cooling off' period after deciding to go ahead with their procedure. This was in line with recommendations from the General Medical Council and professional standards set by the Royal College of Surgeons.
- The hospital submitted data to the Private Healthcare Information Network (PHIN), via an automated data upload computer software.
- The hospital recorded patient data on the Breast and Cosmetic Implant Registry (BCIR), when patients consented to this. This meant details of patients' implants were recorded on a national registry and aimed to improve safety if implants failed. Details of implants used were also kept by the hospital, in case patients did not consent to the national registry.
- The hospital had links to a nearby university for further development, there was particular interests in mentorship courses. The hospital displayed a list of ward hospital online training courses for nurses, which included: understanding wound healing, dynamics and concepts and IV care and maintenance training. These courses were put towards nurses CPD (Clinical Professional Development).
- Training in wound care and intravenous cannulations were organised for staff when the hospital was able.
- An audit calendar was in place and identified which local audits needed to be completed in which area on a month by month basis, for example patient records summary and hand hygiene audits.

Pain relief

- We spoke to patients who told us that their pain was well managed and controlled after surgery.
- Patient told us nurses responded quickly when extra pain relief was required and this was closely monitored.
- The resident medical officer gave out leaflets on pain relief upon discharge, however there was no dedicated pain team.
- We saw the use of a pain assessment tool used to assess the intensity of the patients pain. Nurses asked patients to rate their pain between zero and three, zero meaning no pain and three meaning extreme pain. There was a dedicated column used in the patients records to document this.
- Nurses told us that they always checked what the patient was given during their operation before administering any pain relief after theatre.
- We were told that staff take pain as a serious matter and the anaesthetist consultant was always contacted when the patient reported of pain, post operation.
- We saw a nurse call a doctor to discuss a patients pain relief. This discussion was held with the patient to enable patient choice in the matter.

Nutrition and hydration

- There was a robust process in place to ensure patients were appropriately starved prior to undergoing a general anaesthetic, which was audited.
- Staff kept good communications of theatre delays between the patient and the anaesthetist consultants. This meant that the amount of time patients were kept nil by mouth prior to their operation was kept to a minimal.
- Staff checked if patients were allowed water when delays had occurred. Patients were allowed to drink clear fluids up to two hours prior to their operation.
- Post theatre recovery nurses left a glass of water that was in reach by the side of their patient. A flask of water with a straw was also available for the patient and was also in reach.

Patient outcomes

- Several aspects of patient outcome data were monitored by the hospital. Data detailed within this section relates to the period July 2015 to June 2016.
- There were 50 unplanned returns to theatre. We noted that this had been identified in clinical governance meeting minutes, which allowed the hospital to identify trends. For example a concern was raised with a particular surgeon, who had higher return to theatre rates than expected. The hospital used data of unplanned returns to theatre to form part of the

appraisal data for surgeons. This allowed a systematic process to address concerns with individual surgeons. Furthermore, during our unannounced inspection in June 2017 we found a reduction in unplanned returns to theatre from July 2016 to April 2017. Out of 3113 patients there was 11 patients that returned to theatre in the immediate postoperative phase.

- Patients that required additional surgery were not charged for this.
- There was one patient transferred out of the hospital for further investigations and to receive additional care which could not be supported within the hospital. This was in line with performance in other services.
- There were 33 unplanned readmissions to the hospital between July 2015 to June 2016 and 20 unplanned readmissions to the hospital between July 2016 and April 2017.
- During both the announced inspection period and the unannounced inspection period, there were no patient deaths.

Competent staff

- Staff received an annual appraisal, where their performance over the previous year was discussed and goals for the following year were agreed. All staff we spoke with were positive about the appraisal process and told us they had received an appraisal in the last year.
- Records provided by the hospital showed appraisals had been completed with 100% of staff on the inpatient ward and in theatres.
- Consultants had to demonstrate periodic revalidation and annual appraisals to maintain their practising privileges. We noted evidence in the clinical governance meeting minutes showing that the medical advisory committee (MAC) considered revoking practising privileges where appraisals had not been completed within an appropriate timeframe (three months overdue).
- RMOs were provided by an external organisation that completed relevant employment checks, such as DBS and General Medical Council registration. CVs were sent to the hospital for approval before new RMOs were sent to work there. Mandatory training was organised and overseen by the agency, not the hospital.
- Training was organised by the ward sister, who took the overall responsibility of the completion of all training. The hospital used a traffic light system to highlight the training needs for staff. Red being out of date, amber being due for retraining and green for in date training. This was displayed in a chart at the nurses station, this was updated regularly.
- We looked at the latest training needs from May 2017 andsaw that training for blood transfusion displayed only three members of staff having in date training out of 17 members of staff that required the training.

Multidisciplinary working

- There were a number of Service Level Agreements (SLA) in place. The SLA's were for medical equipment servicing, maintenance agreement, pharmacy cover, ambulance services, resident medical officers (RMO), pathology processes, sterilization of medical equipment, fire alarm maintenance. There were also SLA's with GBE Fire and Security, HAC technical gas services, British Oxygen Company (BOC) and for diagnostic procedures and routine overnight stays after surgery at another provider.
- We saw evidence of medical advisory committee (MAC) meetings taking place quarterly. These meetings involved the hospital manager, consultant surgeon, clinical services director, senior nurse, theatre team leader and many more. The minutes displayed a list of people who could not attend this meeting.
- The hospital did not hold routine multidisciplinary team meetings. However, where clinically indicated the hospital did hold a meeting between the surgeon, anaesthetics and nursing team. For example to plan a patients safe admission and proactive care plan.

Seven-day services

- Clinics times ran from 9am to 5.30pm Monday to Friday and 8am to 6pm on Saturday and Sunday. This meant that patients could fit in their surgery to suit their personal life.

- The service also provided a late clinic on either a Monday or Tuesday finishing at 8pm, this meant that the service could provide appointments for patients working between 9am to 5pm.

Access to information

- Pathology services were outsourced to a third party. Blood tests taken during preoperative screening and during inpatient stays were collected by a courier, transported to the pathology laboratory and processed. Staff told us results could be received within a matter of hours, if they were needed urgently, otherwise results were available within 48 hours.
- Radiology services were provided by two external organisations and service level agreements were in place to reflect this. Staff told us patients could access imaging services at short notice, usually on the same day, and images were reported on within 24 hours.
- We saw a range of information leaflets on all different procedures which were differed according to consultants. These were kept in a folder in the nurses station.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were aware of their duties in relation to obtaining consent. The hospital had an up-to-date consent to treatment policy. There were systems in place to obtain consent from patients before carrying out a procedure or providing treatment which we saw evidence of in patients notes.
- Staff were able to give clear explanations of their roles and responsibilities under the Mental Capacity Act 2005 (MAC) regarding mental capacity assessment. The hospital consent policy identified that procedures would not be completed on patients lacking the mental capacity to provide informed consent.
- Consent was obtained specifically in relation to recording patient details on the Breast and Cosmetic Implant Registry (BCIR). Patients told us they were informed what information would be recorded and what it would be used for.
- Consent forms were given to patients at their pre-operative appointment by a clinic nurse, just so the patient can read the form before they actually have their surgery.
- Surgeons gained verbal consent from the patient as well as written consent forms before surgery.
- Patients were asked to consent to photographs being taken pre and post operatively of the surgical site.
- The consent form included a section to ask the patients GP (general practitioner) for general medical information on the patient. This was to obtain information on the general health and fitness for surgery.

Are surgery services caring?

We regulate this service but we do not currently have a legal duty to rate it. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

Compassionate care

- We were told by patients that nurses were very kind and friendly and frequently checked their wellbeing.
- Patients told us that the whole experience at Transform including the telephone coordinator had 'felt personal and spot on'.
- Patients told us their privacy and dignity was maintained during their admission, including during examinations and dressing changes.
- However, we observed some occasions where patient privacy and dignity was not fully maintained. For example, a member of the inspection team was in a patient room speaking to the patient when a member of nursing staff came in. The nurse began intimate personal care in front of the CQC staff member, without asking for permission or advising the patient what she was doing.
- We saw a number of thank you cards displayed with personal messages reading 'thank you for all your help and support' and 'I wanted to say thank you so much for all your help you've been so helpful and gone the extra mile'.

- Patient satisfaction scores for overall care from the medical and nursing team between January and March 2017 was scored as excellent by 92% of patients. This was a 3% increase from the results from July 2015 and June 2016.
- The hospital facilitated patients requests for spiritual support from priests, Rabbi's and other religious sectors. The hospital provided chaperones for all patients.

Understanding and involvement of patients and those close to them

- Patients reported feeling safe and confident, and were happy with their surgeon who was very open and honest with the risks and the procedures. Patients told us that they had ample opportunity to ask questions about their operations.
- Patients told us that they were kept well informed of when they were about to go into surgery for their procedure.
- Friends and families reported that they were kept up to date and informed of any updates while their loved ones were in theatre. They also reported that they were offered hot drinks and were kept informed of when the patient was in recovery .
- Patient satisfaction scores for general helpfulness from the medical and nursing team between January and March 2017 was the highest scored question, with 94.6% of patients scoring this service as excellent. This was a 1.6% increase from the results from July to June 2016.
- The hospital had access to a language line service that was able to provide interpretation services for all languages. The service also has access to a sign language interpretation service when required.
- Staff we spoke with told us that that patients were offered flexible payment plans, and that this was offered to all patients. We saw that payment plans conformed to all regulations regulated by the financial services authority (FSA). Patients were given a detailed quotation document that clearly listed all costs for their procedure. Final costs were discussed between the patient and the operating surgeon. The final costs included after care services.

Emotional support

- There were no formal leaflets given to patients regarding psychological support. However patients were offered psychological support post operatively via a direct 24 hour telephone line. Patients we spoke to knew who to call if they had any questions or concerns after surgery.
- Staff we spoke with told us that patients undergo a pre –operative screening process. During this process the hospital performed a risk assessment to identify any psychological problem s that could be a barrier to the patient undergoing surgery. The patients GP was contacted prior to surgery and asked to provide clinical information related to the patients psychological status that may adversely impact the patient undergoing the planned procedure.
- It was routine practice for every patient to be seen by the surgeon post operation before being discharged.
- Patients that did not require admission for surgery were contacted by the RMO on the day of surgery. The RMO also contacted these patients one day after discharge. Where psychological support needs were identified, the patient was encouraged to either return to the hospital for a face to face consultation or was referred to their GP.
- Patients were also contacted one week after surgery by a member of the clinical nursing team via telephone. Psychological needs if any were identified and escalated to the RMO where an action plane would be agreed.
- Patients we spoke to said that they were happy with the support that they had been given thought out their stay and confirmed that counselling services had been offered to them if they required it.

Are surgery services responsive?

We regulate this service but we do not currently have a legal duty to rate it. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

Service planning and delivery to meet the needs of local people

- Riverside Transform provided a wide range of planned cosmetic surgery such as facial surgery including

Rhinoplasty and Septorhinoplasty. Breast surgery including breast augmentation, removal of implants, Mastopexy and Gynecomastia. And Abdominal surgery such as lap bands and Abdominoplasty.

- Patients attended their preoperative consultation and assessments at a range of clinics across the country. Local people could access these services on site at the hospital.
- Theatres were operational every day of the year, other than Christmas Day and Boxing Day. However, on call emergency theatre cover was provided on these days. Usual opening hours of theatres was 8am to 6pm.
- The service used the same RMO for consecutive months at a time.
- We spoke with staff who told us that patients were asked if their GP (general practitioner) could be contacted for general medical information on the patient. This was to obtain information on the general health and fitness for surgery.
- The shower room in one of the wards was not wheelchair friendly, even though the door to the shower room was. This shower was also housing equipment which meant that equipment was stored in rooms intended for other purposes. However, the hospital had a wheelchair accessible bathroom available for patients.

Access and flow

- Patients could access the hospital by contacting the provider to organise a consultation at their local clinic. If the patient wanted to go ahead with their procedure, they were directed to the hospital to continue the booking process.
- Patients were given a choice of surgeons and advised regarding the surgeons' specialty. For example patients undergoing a breast augmentation procedure could choose between different consultants who do the operation in slightly different ways, depending on the end result the patient wanted.
- Waiting times for procedures were not formally monitored by the hospital. They advised us that patients were scheduled in around their own commitments and patients did not have to wait for admissions. We reviewed booking information which showed patients were usually booked within one month after their consultation. Patients told us they did not have to wait long for their procedure and that their procedure date had been scheduled around their own commitments, such as childcare and work.
- Between July 2015 and June 2016, one patient had their procedure cancelled for non-clinical reasons. This patient had an alternative date booked within 28 days of their cancelled procedure.
- Patient arrival times at the hospital were usually staggered throughout the day. Senior staff told us this allowed a steady flow of patients into the ward and through theatres. The staff member responsible for booking patients in for procedures told us they tried to make sure patients were asked to arrive at the same time came from different parts of the country. They said this was to limit disruption to the service if there was a particular traffic problem.
- We spoke to a few patients that were running late due to traffic, patients reported that staff were kind and lovely about the situation and stressed that it wasn't an issue.
- After being discharged from hospital, patients received a follow up telephone call within 24 hours to check their progress. They were also provided with a follow up appointment at their local clinic within seven days.
- The hospital did not monitor did not attend (DNA) rates. This was because patient self-refer and self-fund their procedures and DNA's were not as issue at this hospital.

Meeting people's individual needs

- Services were available for adults aged 18 and above. No children or young people underwent procedures at the hospital.
- There were 14 individual rooms available on the inpatient ward, and an additional five beds in the day care unit. Staff told us the day care unit was only used to accommodate female patients, as most patients undergoing procedures were female, so there were no issues with mixed sex accommodation breaches.
- Senior staff told us the hospital could accommodate patient requests to have an entirely female care team, including the surgeon and theatre team, as well as nurses on the ward. They told us they had accommodated this type of request previously but that it was not common.

Surgery

- The hospital offered laparoscopic gastric band surgery for patients with a body mass index (BMI) of up to 45. This was a higher threshold than other centres offered, which meant a greater proportion of bariatric patients were able to access the service.
- On the ward, there was a bathroom with a specially designed sink that allowed patients who had undergone facial procedures to wash their hair. Staff told us patients were not able to get their faces wet after this type of procedure and this sink allowed them to have a hair wash when it would not have been possible otherwise.
- The service had introduced a new vegan menu, there was also an option to highlight specific allergens when ordering food.
- Visitors could pre order food from the kitchen when visiting patients at the hospital, this meant that the patient could eat meals with their family or friends.
- Patient rooms were fitted with a television and Wi-Fi, which meant that patients could keep up to date with the outside world and social media.
- Staff told us that they were not aware of translation services, however most patients spoke English and this had not caused any communication issues. Senior members of staff were aware of the translation services available, and took the responsibility of organising these services when they were required.
- Patients were assigned with particular surgeons in accordance to the patients emotional needs, for example some surgeons undertook procedures at a much slower rate which made the patients feel more at ease.
- Patients that had known allergies were first on the list of surgery. Outside patient rooms nurses left notes to remind them of any know allergies the patient had.
- All patients were provided with a number to call following discharge and were informed that support is available 24 hours a day from the hospital nursing team and the RMO.
- Riverside hospital had a private end-suite room specifically designed for patients with physical disabilities. Patients using wheelchairs were able to access the hospital using a ramp, the ward was on the ground floor. There was two lifts in the hospital for access to the upper floor. There was also a patients hoist available to assist patients with limited mobility and all staff were trained in the use of this hoist.

Learning from complaints and concerns

- Between July 2015 and June 2016, there were 31 formal complaints received by the hospital. Hospital policy states that all complaints receive an acknowledgement within two working days, unless a full response will be sent within five days. In most cases, a full complaint response was sent within 20 working days. Where this was not possible (for example if a member of staff on leave needed to be interviewed regarding the complaint), patients received an update letter every 20 working days. Complaints data we reviewed showed the hospital complaints policy was adhered to.
- The hospital was registered with the Independent Sector Complaints Adjudication Service (ISCAS). Patients who complained to the hospital were provided with contact details for ISCAS so that they were able to escalate their complaint if they were unsatisfied with the response from the hospital. There was one complaint escalated to ISCAS between July 2015 and June 2016.
- Any issues identified as learning points from complaints were labelled as 'shortfalls' and disseminated to staff in a memo. One example of a learning point that was disseminated in this was the need for staff to have greater empathy with patients returning from theatre. Staff we spoke with were unable to identify any issues highlighted via the shortfall memos, however told us complaint feedback was also provided during staff meetings.
- We saw evidence root cause analysis from shortfalls/ complaints and action plans to prevent further mishaps.
- The hospital was had subscribed to ISCAS (independent healthcare sector complaints adjudication service) to help resolve complaints. Patient had the right to use this service if they were unsatisfied with the response from Transform and having exhausted all other internal complaints processes.

Surgery

Are surgery services well-led?

We regulate this service but we do not currently have a legal duty to rate it. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

Leadership / culture of service related to this core service

- Medical leadership was provided by the medical advisory committee (MAC), which provided expert advice to the senior management team regarding specific medical issues.
- Nursing leadership was provided by the ward sister. A nurse in charge led the day shift and a different nurse in charge lead the night shift. The clinical service manager and the ward sister took turns to be on call during the weekend.
- Between July 2015 and June 2016, there was up to 6% sickness rates for nursing staff on the inpatient ward. The sickness rates for health care assistants was up to 6.6% These figures were in line with other similar organisations.
- Between July 2015 and June 2016, sickness rates for nursing staff in theatres was up to 7.8%. These figures were in line with other similar organisations. The sickness rates for ODPs and health care assistants in theatres was up to 12.5%, which was slightly worse than in other similar organisations.
- The manager reported confidence in all her staff and staff reported a good working atmosphere.
- There was a no blame culture within the hospital, incidents were investigated by root cause analysis but this was to gain a greater understanding and provide learning opportunities.
- Staff reported feeling proud to work at this hospital and reported that it was a great organisation to work for, which has been demonstrated in the feedback received from patients.

Vision and strategy for this core service

- The hospital's vision was to provide the highest quality patient care, products and deliver excellent patient experiences and outcomes safely. Transforms mission was to be the UK's largest and most innovative aesthetic provider, leading the industry from the front in areas of safety and patient experience.
- We spoke to staff members who were able to tell us about the values of the hospital which were based on the six C's: care, compassion, courage, communication, commitment and competence.
- Senior staff told us they hoped to develop the laparoscopic gastric band surgery service in the future. They told us there was an increasing demand for this type of service and that they planned to increase the number of theatre lists from two to four days per month up to two theatre lists per week.
- Senior staff also told us they hoped to develop the hair transplant service. At the time of our inspection, an average of two hair transplant procedures were completed each month. Senior staff told us this low number meant it was not appropriate to recruit a permanent hair transplant team, which they hoped to do in the future when the service had expanded sufficiently.

Governance, risk management and quality measurement

- Clinical governance meetings were held in conjunction with the provider's other hospital monthly. Meeting minutes showed governance issues across both hospitals were discussed.
- The MAC meetings had representatives from a range of surgical specialities, as well as anaesthetics. This committee reviewed any clinical issues or complaints, as well as monitoring surgeon performance. For example the number of surgical site infections were discussed, Transform Riverside had a 0.8% infection rate. We saw there were suitable responses to concerns about surgeon's practices, for example an issue with documentation led to an audit of surgical notes to ensure standards were being met.
- The MAC fed into the clinical governance meeting where key operational issues were discussed.
- The risk register was reviewed every three months. We reviewed the risk register which was kept in an electronic spread sheet and also a paper format. The risk register used a standard scoring system to measure

risks, e.g. the severity of risk versus likelihood. Mitigating actions was included in the matrix. This risk register included risks such as leaving oxygen on whilst prepping the room for a patient. The service made 'oxygen in use' signs outside doors to prevent this risk. The risk register also documented a lack of hand wash basins as a risk. However the use of carpets within the service was not documented as a risk.

- All surgeons, aestheticians and independent medical contractors were required to have a minimum of £2 million UK based insurance or proof of defence membership, prior to commencing work with Transform. Transforms company secretary required approval as per part of the policy for accepting new surgeons, before work can commence. The human resources (HR) team managed and monitored all surgeons and medical practitioners insurances. Prior to renewal all surgeons were requested to submit their renewal proof which was approved by the company's secretary. If renewals were not received by Transform, Riverside hospital was informed and surgeons could not operate and practicing privileges were removed.

Public and staff engagement (local and service level if this is the main core service)

- The hospital used various means of engaging with patients and their families. This included a patient discharge questionnaire; given at the end of their admission and also an opportunity to provide feedback via the 'Tell Transform' page on the providers website.
- Patients and the public were given a wide range of information from the provider's website for example information regarding payment options, a brief history of the provider and patients testimonies.
- We looked at the results of patient satisfaction surveys from July 2015 to June 2016 and compared the results from January to March 2017. We found that the overall satisfactory ratings had increased by 3.5% from 85% satisfied to 88.5% satisfied in 2017.
- Staff engagement was through a variety of mechanisms such as incident reporting, clinical meetings, corporate staff surveys, 'Tell Transform' feedback and by using the whistleblowing and bullying and harassment policy. However, there was no regular annual staff survey undertaken, the last survey was conducted in 2015.
- The hospital had a fully integrated sales and marketing team who were compliant with the requirements as stated in the guidelines of the Committee on Advertising Practices.

Innovation, improvement and sustainability (local and service level if this is the main core service)

- We saw staff wanting to learn develop and improve their skills, this was supported by the service. Staff had asked for specific courses and they were able to do this through the service having links to a nearby university in order to facilitate this learning.
- Staff had the opportunity at monthly operations meetings to put any ideas forward to improve the service. Staff reported that ideas were shared amongst each other, and that management listened to them.
- Transform continually recorded and monitored surgeon activity and outcomes which were reported to the clinical governance committee. Surgeon outcomes data were discussed in surgeons appraisals.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that all national and local policies adhering to medicines is understood and followed by all staff members.
- The provider should ensure that infection prevention control is of a high standard across the hospital.
- The provider should ensure that a patients dignity is respected at all times.