NLK Limited

Natural Look Clinic

Inspection report

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

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

The CQC carried out a responsive follow up inspection at Natural Look Clinic on the 15 October 2020. This inspection was undertaken following a notice served to the provider under section 31 of the Health and Social Care Act 2008. The section 31 notice was served in August 2020 and required the provider to immediately suspend the carrying out of any surgical procedures which require local anaesthetic or sedation on patients.

We undertook the inspection in October 2020 to see if improvements to the service had been made.

Natural Look Clinic is operated by NLK Limited.

The service provides pre-operative assessment and post-operative follow up, including wound care for surgical procedures in cosmetic surgery. On site operative surgical procedures include liposuction and fat transfer, breast augmentation with or without uplift, non-major breast reductions, hair transplant, upper lid blepharoplasty, pinnaplasty, labiaplasty, mini-abdominoplasty/small abdominoplasty and mini-facelift.

Documentation submitted to CQC by the provider stated that all procedures were carried out under local anaesthesia with conscious sedation.

The service is registered for the regulated activities of diagnostic and screening procedures, services in slimming clinics, surgical procedures and treatment of disease, disorder or injury.

Our rating of this service improved. We rated it as requires improvement overall because;

- The service provided mandatory training in key skills to all staff. Mandatory training had been updated and new processes introduced. Clinical staff understood how to protect patients from abuse and work with other agencies to do so. Staff used equipment and control measures to protect patients, themselves and others from infection
- The service had introduced new equipment and processes to monitor and record patients under conscious sedation and reduce their risk of deterioration. Additional training on identifying and acting on patients that may become unwell had been provided
- The service was updating systems and processes to safely prescribe, administer, record and store medicines
- The service had made changes to their senior team to strengthen leadership. New managers had the skills and abilities to run the service. Improvements had been made to governance processes throughout the organisation.

However;

- We were unable to see if new policies and procedures had been implemented with patients and their records as no treatments had been undertaken since our last inspection
- We were not assured that new policies and procedures had become embedded with staff. Training on new equipment had yet to be implemented and incorporated into policies
- Not all non-clinical staff had received safeguarding training appropriate to their role
- Gaps in documentation relating to medical staff practicing privileges were identified
- Records of risks were not maintained, nor any actions taken to mitigate these risks

Following this inspection, we told the provider that it *must* take some actions to comply with the regulations.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Requires Improvement 	Our rating of this service improved. We rated it as requires improvement because: • The service provided mandatory training in key skills to all staff. Mandatory training had been updated and new processes introduced. Clinical staff understood how to protect patients from abuse and work with other agencies to do so. Staff used equipment and control measures to protect patients, themselves and others from infection • The service had introduced new equipment and processes to monitor and record patients under conscious sedation and reduce their risk of deterioration. Additional training on identifying and acting on patients that may become unwell had been provided • The service was updating systems and processes to safely prescribe, administer, record and store medicines • The service had made changes to their senior team to strengthen leadership. New managers had the skills and abilities to run the service. Improvements had been made to governance processes throughout the organisation However • We were unable to see if new policies and procedures had been implemented with patients and their records as no treatments had been undertaken since our last inspection • We were not assured that new policies and procedures had become embedded with staff. Training on new equipment had yet to be implemented and incorporated into policies • Not all non-clinical staff had received safeguarding training appropriate to their role. Gaps in documentation relating to medical staff practicing privileges were identified • Records of risks were not maintained, nor any actions taken to mitigate these risks

Summary of findings

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Summary of this inspection

Background to Natural Look Clinic

The CQC carried out a responsive follow up inspection at Natural Look Clinic on the 15 October 2020. This inspection was undertaken following a notice served to the provider under section 31 of the Health and Social Care Act 2008. The section 31 notice was served in August 2020 and required the provider to immediately suspend the carrying out of any surgical procedures which require local anaesthetic or sedation on patients.

The section 31 notice was served following an inspection carried out in August 2020 in response to concerns received. In August we found patients may have been exposed to a risk of harm due to the use of conscious sedation, the management of patients who become unwell during treatment and how this was escalated, the governance processes at the service and the management of medicines.

Following the inspection in August we rated safe and well led as inadequate.

We inspected this service using our focused inspection methodology. We carried out a short notice inspection on 15 October 2020.

How we carried out this inspection

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

Areas for improvement

Action the provider MUST take to meet the regulations

- The provider must ensure training on new equipment and procedures including the administration of blood products is undertaken in a timely manner (Regulation 12)
- The provider must ensure that policies and protocols are updated to reflect new equipment and procedures (Regulation 12)
- The provider must ensure that all clinical and non-clinical staff receive safeguarding training relevant to their role (Regulation 13)
- The provider must ensure policies are implemented and embedded with staff (Regulation 17)
- The provider must ensure that practicing privilege documentation is updated in line with best practice recommendations (Regulation 17)
- The provider must ensure that they record risks and any associated actions to mitigate these risks (Regulation 17)

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Requires Improvement	Not inspected	Not inspected	Not inspected	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Not inspected	Not inspected	Not inspected	Requires Improvement	Requires Improvement

Requires Improvement

Surgery

Safe	Requires Improvement
Well-led	Requires Improvement

Are Surgery safe?

Requires Improvement

Our rating of safe improved. We rated it as requires improvement because:

Mandatory training

The service provided mandatory training in key skills to all staff. Mandatory training oversight and compliance had improved.

- At our inspection in August 2020 we found mandatory training compliance for nursing and operating department staff was 40%. Since our last inspection the service had implemented an electronic staff training data base to improve oversight and set up a contract with an external provider to deliver their training.
- Managers told us overall compliance for training had increased to over 75% since our last inspection. Mandatory training records we reviewed following the inspection confirmed this.

Safeguarding

Clinical staff understood how to protect patients from abuse and work with other agencies to do so. However not all non-clinical staff had not received training.

- At our inspection in August 2020 we found policies detailed the Registered Manager (RM) who was the nominated safeguarding lead would be trained to level 3 in adults and children's safeguarding, however no evidence of training was found. At this inspection we saw the RM had updated their training to include level 3 adults and children's safeguarding training.
- At our last inspection we found the service had policies and procedures for protecting those that use the service from abuse. Staff received training in safeguarding and were able to access all relevant safeguarding information. At this inspection we found clinical staff had updated their safeguarding training. However, non-clinical staff had not received safeguarding training.

Cleanliness, infection control and hygiene

The service, controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

- At our inspection in August 2020 we found that service had systems and processes to minimise the risk of spreading infection, including Covid-19. At this inspection we saw these systems remained in place.
- The service had maintained levels of cleanliness during the period it not been undertaking surgical procedures and had ensured regular deep cleans of all areas had taken place.

Requires Improvement

Surgery

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe.

- At our last inspection we saw ventilation covers in the operating theatre were dusty and the operating table had small tears in the cover. At this inspection we saw that the ventilation cover was clean, and we were told and saw cleaning rotas had been updated to include regular ongoing cleaning of the ventilation unit. The service had replaced the cover on the operating table.
- At our last inspection we found staff had not been trained in emergency evacuation processes or equipment. Staff told us that since the last inspection they had received information on how to use equipment and undertake an evacuation in an emergency. Managers said they planned to carry out scenario-based training with staff every six months as a minimum.
- The service had an emergency fire procedures and managers told us that three staff had received fire warden training.
- The service used disposable gowns for patients. An external provider laundered theatre scrubs worn by staff through a service level agreement.
- All equipment we checked had been serviced and tested for electrical safety. Managers had a folder with details of all equipment and records of when it had last been checked and serviced.
- Staff were able to call for help if urgent assistance was required in the operating theatre by pressing a button located on the wall. There was a red button for emergency assistance, a grey button to request administration staff to attend and a green button to request a member of staff from the first floor to attend.

Assessing and responding to patient risk

The service had introduced new equipment and processes to monitor and record patients under conscious sedation and reduce their risk of deterioration. Additional training on identifying and acting on patients that may become unwell had been provided to staff.

- At our inspection in August 2020 we found the service did not have a policy on the management and escalation of a deteriorating person. Through speaking to staff, we were not assured that the risks associated with a deteriorating patient would be recognised and acted upon appropriately. The 'Patient Monitoring, Deterioration, and Escalation' policy was produced following the inspection. However, this contained information that was not relevant to the service and there was no evidence that information in the policy was being utilised.
- At this inspection we found that the 'Patient Monitoring, Deterioration, and Escalation' policy had been updated to reflect the service and had been produced in line with best practice guidance. Staff we spoke to were aware of the updated policy.
- At our last inspection we found that 'Patient Monitoring, Deterioration, and Escalation' policy identified four different levels for the transfer of patients who become unwell, as no surgical procedures had been undertaken since our last inspection, we were unable to see if levels were now being recorded.
- At our last inspection we found that the service did not use the recognised national early warning scores (NEWS2) monitoring system to help identify a patient's pre and post-operative condition. At this inspection we found NEWS2 had been implemented. NEWS2 documentation was available for staff to complete and guidance on the escalation process and responsibilities depending on NEWs score was included in relevant policies. We were unable to see if the system had been implemented with new patients as no surgical procedures had been undertaken since our last inspection.

Requires Improvement

Surgery

- At our last inspection we found systems and processes were not consistent to ensure staff recognised the correct levels of sedation provided to patients undergoing surgical procedures. At this inspection, we saw the policy on conscious sedation had been updated with reference made to national guidance. The policy contained clear definitions around the level of sedation and the expected physiological and verbal response of a patient.
- Since our last inspection, the service had given staff additional training around the conscious sedation policy and the differences in levels of sedation.
- To improve staff awareness and monitoring of sedation, anaesthetic records had been updated following our inspection in August 2020. Mandatory recording of a recognised sedation score (Modified Ramsay Sedation Score), end tidal volumes (capnography, exhaled carbon dioxide recording) and respiratory rate were now required. The Modified Ramsay Sedation Score was available for reference by staff, at the point of patient care.
- At our last inspection we found end tidal volume (capnography) was not monitored during sedation. At this inspection we found equipment to measure end tidal volume was available and ready to use. The provider told us all anaesthetic staff agreed to monitor and record levels throughout all procedures involving sedation, meeting minutes we reviewed following the inspection confirmed this.
- Since our last inspection, the service had introduced a safety huddle checklist prior to each operating list to cover key areas of patient safety including staffing levels, equipment and any potential issues with the persons undergoing treatment. The huddles also provided an opportunity for nursing and operative staff to ask any questions to the anaesthetist or surgeon. The service had not had any new patients since our last inspection therefore we were unable to see if new the new processes for monitoring or safety huddles were being implemented with patients.
- At our last inspection we found there were no arrangements in the event of major or significant blood loss during surgery. The service did not have a service level agreement (SLA) to obtain blood products for transfusion with any provider. At this inspection we found that the service was in the final stages of producing an SLA with a local NHS trust for the supply of blood products.
- Managers told us that once an agreement had been reached with the local trust, staff would be trained in the administration of blood products and a policy would be produced. The service had plans to train staff in the administration of blood and blood products once the SLA was in place. There was an interim policy for significant blood loss whilst the SLA was finalised.
- Since our last inspection the service had acquired new equipment to help manage a patient during surgery. This included; a ligature clip to help prevent blood loss, equipment to monitor the level of haemoglobin in blood at the point of patient care and an additional suction machine in the operating theatre.
- A target controlled infusion pump (which allows objective monitoring of blood sedative levels and prevents a patient falling into deep sedation) had also been introduced to the service since our last inspection.
- The new equipment was not included in the updated 'Patient Monitoring, Deterioration, and Escalation' policy. Managers told us the service had plans to train staff on the new equipment and once completed these would include these in relevant policies.
- Managers said in an emergency patients would sent to a local NHS trust via ambulance to the Accident and Emergency Department. The transfer processes for patients that were unwell was available for staff to follow, this included when to call emergency services

Nursing and support staffing

The service had enough staff with the right qualifications, skills, training and experience.

- At our last inspection in August 2020 we found that the service was managed by a registered manager (RM) who was also the nominated individual and principal surgeon. At this inspection we found that the service had appointed a new clinic manager who was in the process of becoming the RM. The clinic manager had the knowledge, skills and experience to fulfil their role.

- At our last inspection we found that the service employed registered nurses, health care assistants, reception staff and operating department practitioners. At this inspection we found there had been no changes to nursing or support staff. During the inspection there were limited staff on site as the service was not carrying on any surgical procedures.

Records

Staff had received additional training in keeping records and documents had been updated to improve standards.

- At our last inspection we found records were non-compliant with service policies ('Policy for completion of health records' (2020/21)), illegible and difficult to understand. Records did not always have clear dates, times, and designations of the persons completing the documents. At this inspection we were unable to review any further notes as there had been no new patient records created. The service told us they now used digital dictation and counter-signatures for individuals with poor hand-writing.
- Staff we spoke to following the inspection told us that they had received additional training on record keeping and that the service was introducing a debrief at the end of the day to ensure documentation was complete.
- Since our last inspection the service had undertaken a further audit of records and identified intervention was needed to improve compliance with record keeping policies. We reviewed findings of audits and found results had been discussed with relevant staff and actions to improve records detailed.
- At our last inspection we found patient records reviewed did not contain a fully completed and comprehensive pre-anaesthetic consultation and there was no evidence of anaesthetic pre-assessment prior to the day of surgery. At this inspection we found consultation documentation had been updated and a policy created to ensure a pre-anaesthetic assessment was undertaken and clearly documented prior to the day of surgery. No new patient consultants had been undertaken since our last inspection, so we were unable to review if new pre-anaesthetic documentation had been completed in line with policies.
- The service had worked with their anaesthetists to create guidelines on the recommended preparations of local anaesthetics to be used for operative procedures.
- No new patient consultations had been undertaken since our last inspection, so we were unable to review if new pre anaesthetic documentation had been completed in line with policies.
- The review of patient records at our last inspection showed not all consent forms were signed by the patient in line with the organisation's consent policy. We were also unable to confirm the service consistently applied the professional standards of a two-week 'cooling off' period prior to surgery. At this inspection we saw patient information packs had been updated to include consent forms with a mandatory two week reflection (cooling off) period which was to be signed by the patient and surgeon.
- Updated patient information packs included an amended informed consent section. This was now called a detailed written explanation of the risks with each section to be signed by the patient. Changes to the format will make it easier for a patient to understand the risks associated with surgery. No new patient consultations had been undertaken since our last inspection, so we were unable to review if new consent documentation had been completed in line with policies.
- At our last inspection patient records did not contain completed NEWS2 assessments, clear written monitoring plans, observation records or recognised handover documentation. Further, it was not clear from the records that the levels of sedation used were consistent with the service commitment to using only conscious sedation. At this inspection we found that the service had updated records to include NEWS2 assessments, anaesthetic records had been updated to offer greater monitoring of sedation and the recognised hand over technique, situation, background, assessment, recommendation (SBAR) had been incorporated into relevant policies.
- The service had updated the information it will provide to patients prior to surgery to include more detailed information on conscious sedation.

Requires Improvement

Surgery

Medicines

The service was in the process of updating systems and processes to safely prescribe, administer, record and store medicines.

- At our inspection in August 2020 we found the RM lacked understanding around different levels of sedation as defined by the Royal College of Anaesthetists. At this inspection, the RM told us they had reviewed all policies and updated their knowledge around sedation. Policies we reviewed referenced recognised practice for sedation.
- At our last inspection we found that clinical staff had limited knowledge around conscious sedation. At this inspection we found additional training in this area had been provided to nursing and operating staff. Staff we spoke to following the inspection confirmed they had received additional training.
- At our last inspection we found that staff were unable to provide policies on conscious sedation or managing a deteriorating patient. At this inspection we found the service had made policies available and had recently updated them. Staff we spoke to following the inspection confirmed they had received updated policies.
- At the last inspection we were not assured the service accurately measured levels of sedation in patients. At this inspection we found that anaesthetic records had been updated to incorporate new monitoring measures including exhaled carbon dioxide, respiratory rate and a recognised sedation score.
- We were unable to review if staff completed new records accurately during procedures as there had been no patients under sedation since our last review.
- At our last inspection, the RM was unable to provide a licence issued by the Home Office for the possession and management of controlled drugs. At this inspection managers told us that only the principal surgeon with individual prescriber rights was operating and they were in the process of obtaining a licence.
- At the last inspection it was unclear who was the Accountable Officer for Controlled Drugs. At this inspection managers told us the new clinic manager was applying to undertake this role.

Incidents

The service had made changes to how it managed and reported patient safety incidents.

- There were no never events reported by the service during the twelve months before inspection. Never events are serious patient-safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death, but neither need have happened for an incident to be a never event.
- Since our last inspection the service had reported one serious incident. Serious incidents are events in health care where there is potential for learning or the consequences are so significant that they warrant using additional resources to mount a comprehensive response.
- At our last inspection we found the RM had limited knowledge of their requirements to report incidents to the CQC under Care Quality Commission (Registration) Regulations 2009. Following the inspection, the RM told us they had reviewed the requirements on reporting and had subsequently reported an incident.
- The service had introduced a new significant incident report form that had been created in line with NHS England standards.
- Since our last inspection the service had commissioned a root cause analysis to review the serious incident that led to our previous inspection. A timeline for the incident investigation had been produced and was being met. Changes to practice and additional safety measures had been introduced to prevent a similar incident from occurring. Managers told us further lessons would be learnt and shared with staff once the investigation was complete.

Requires Improvement

Surgery

Are Surgery well-led?

Requires Improvement

Our rating of well-led improved. We rated it as requires improvement because:

Leadership

The service had made changes to the senior team to strengthen leadership. New managers had the skills and abilities to run the service.

- At the last inspection we found the RM was unable to show a full understanding of their responsibilities in carrying out or managing regulated activities and meeting the standards required. At this inspection we found that the RM had spent time updating their knowledge and skills to undertake their role.
- The service had recently employed a new clinic manager. The manager was in the process of becoming the service's RM. The clinic manager had knowledge, experience and skills to help undertake their role.
- Since our last inspection the service had enlisted the services of an experienced office manager. The office manager was a registered medical professional with experience in business management.
- Both the office and clinic managers had worked with existing managers to strengthen the leadership of the service.

Culture

Staff were focused on the needs of patients receiving care.

- At the last inspection staff told us that there was an open culture and they were comfortable with raising ideas and concerns with the registered manager. They also told us that they felt valued and they were supported to carry out additional, appropriate training. We found no changes to the culture at this inspection.
- The service provide all patients with a statement of terms and conditions and the amount and method of payment of fees. There had been no changes to this process since the last inspection.

Governance

The service had made improvements to the governance processes throughout the organisation.

- At the last inspection we found staff were not clear about where to find and how to follow policies and procedures and did not always understand their responsibilities in respect of these. At this inspection managers told us that new and updated policies had been disseminated to staff. Staff we spoke to following the inspection confirmed they had received the policies.
- No patients had been treated at the clinic since our last inspection so we were unable to see if new policies and processes had been embedded with staff and implemented within their practice.
- At the last inspection we found documentation held to support the practicing privileges of medical staff was not complete. Since the last inspection the service had reduced the number of medical staff granted practicing privileges.
- We reviewed the files of staff that continued to have practicing privileges and found improvements in documentation had been made. A newly introduced cover sheet provided an overview of records available and some information had been updated. However, gaps were still found in records including copies of up to date appraisals and written references.

Requires Improvement

Surgery

- The service had plans to introduce a monthly clinical governance meeting led by the new clinic manager. Clinical governance meetings will be held monthly and cover any incidents, lessons learnt, audits and staff appraisals.
- The service had produced an audit timetable to commence from October 2020. Audits to be undertaken included reviews of patient records and clinician documentation.

Managing risks, issues and performance

The service had plans to cope with unexpected events. Systems to manage, report and escalate patient risk had been updated.

- The service had a business continuity plan to be followed in the event of a severe threat or interruption to the service. The focus of the plan was to cancel all forthcoming activity and communicate as widely as possible with staff and patients until the service could be restored. No changes to this plan had been made since the last inspection.
- At the last inspection we found the electricity supply to the theatre was supported by a battery-pack which provided an hour of electricity in the case of a power failure. This would give the surgical team time to make the patient safe and arrange an emergency transfer should there be an electrical failure or interruption. No changes to this system had been made since the last inspection.
- The service was registered with the Medicines & Healthcare products Regulatory Agency (MHRA) Central Alerting System (CAS) so that it received medical-device and medicine alerts that may be relevant to its practice.
- The service had policies associated with risk management. However, we did not see that records of risks were maintained or any actions taken to mitigate these risks.
- Managers told us the service would reintroduce submitting data about their services to the Health and Social Care Information Centre Breast Implant Registry and Private Health Information Network, in line with good practice.

Managing information

The service collected data.

- Since our last inspection managers had added all documentation used by the service to a digitised, cloud-based system to ensure staff had easy access. The system provided a clear audit trail when changes to documents were made. It also allowed version control of documentation used by the service to ensure staff used only the most up to date documentation or policy.

Engagement

Leaders and staff actively and openly engaged with patients and staff to manage services.

- At the last inspection we found the service asked all patients to complete a post-surgery survey. All patients who responded said they would recommend the service and they were involved in decisions about care and treatment. Patients rated the level of trust they felt in the clinical staff as 'very good'. No changes in patient feedback were noted at this inspection.
- The registered manager held regular staff meetings and was available for informal conversations.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment • Not all staff had received safeguarding training relevant to their role.

Regulated activity	Regulation
Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • Training on new equipment and procedures had not taken place at the time of inspection and needed to be implemented. • Policies and protocols needed to be updated to reflect new equipment and procedures.

Regulated activity	Regulation
Surgical procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance • Policies and procedures had been updated and needed to be implemented and embedded with staff. • Gaps were identified in documentation relating to practicing privileges. • There service had no record of risks or mitigating actions.