Bearwood Cosmetic Clinic

Quality Report

Bearwood Cosmetic Clinic
Bearwood Dental Clinic, 4 St Marys Road
Smethwick
West Midlands
B67 5DG
Tel:
Website:

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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

Bearwood Cosmetic Clinic is operated by Bearwood Cosmetic Clinic Ltd.

The service provided cosmetic surgery for adults over 18 years either as out patients or on a day case basis. The service has no overnight beds.

We inspected this service using our focussed inspection methodology. We carried out an unannounced inspection on 29 November 2018 due to concerns we identified through routine intelligence monitoring processes.

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

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

The main service provided by this service was surgery.

Services we rate

We did not rate this service in line with our focussed inspection methodology. This inspection focussed on the safe domain and specifically the assessment and response to risk, medicines management and staffing. Where we identified and gained information in other areas and domains we have also included this throughout the report.

Due to the very serious nature of our concerns, we made an urgent cancellation of the providers registration. This means they can no longer undertake the regulated activities they were previously registered to provide.

Throughout this report the person undertaking the surgery will be referred to as the 'provider'. This is because the doctor undertaking the surgery was the registered provider, registered manager and doctor for this service.

We found areas of significant concern during this inspection including:

- The provider was undertaking surgery that he was not competent or trained sufficiently for.
- The provider was administering large doses of sedation without sufficient safety arrangements. This placed patients at risk of severe harm or death.
- The provider was operating in unhygienic conditions which posed a serious risk of infections to patients.
- Cleaning arrangements were insufficient.
- The equipment used for surgery was visibly dirty and soiled with malodourous bodily fluids and rust.
- The machine used to sterilise surgical instruments was visibly dirty inside with obvious signs of rust.
- The theatre environment was unsafe and not fit for purpose. This included holes in the theatre walls with live wires exposed and plaster falling out.
- There were insufficient safety arrangements in the event of an emergency. For example, there was a lack of available resuscitation equipment and airway support in the event of medical emergencies.
- Medications were managed unsafely. The provider providerwas prescribing medicines in larger doses than recommended and for uses for which it was unintended.
- Patients were sedated without appropriate safety measures in place. This posed a risk of serious harm or death.

Summary of findings

- Records were poorly completed and the inspection team observed the provider retrospectively adding entries into records at the time of the inspection.
- There was insufficient monitoring of patients during and post-surgery.
- The provider did not ensure there were suitably qualified staff to undertake surgery.
- Staff did not undergo any expected checks such as qualifications and criminal records checks.
- There was an absence of any safety and escalation measures should a patient deteriorate and become unwell.
- There was inconsistent follow up arrangements for patients and a lack of clarity around how patients could seek help for complications or concerns post procedure.
- There were poor arrangements in place for governance and risk management.

As a result of these concerns the providers registration was urgently cancelled.

Heidi Smoult

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery		This was a single speciality service providing cosmetic surgery. We did not rate this provider as it was inspected under our focussed methodology.

Summary of findings

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Bearwood Cosmetic Clinic

Services we looked at
Surgery

Summary of this inspection

Background to Bearwood Cosmetic Clinic

Bearwood Cosmetic Clinic was operated by Bearwood Cosmetic Clinic Ltd. It was a private cosmetic surgery clinic in Birmingham in the West Midlands. The centre primarily served the communities of the West Midlands.

The service was registered to provide the following regulated activities:

Treatment for disease, disorder or injury

Surgical procedures

The service provided consultation, examination and treatments in cosmetic and aesthetic medicine, including liposuction and vaginoplasty.

Our inspection team

The team that inspected the service comprised a CQC inspection manager, lead inspector and a pharmacy specialist inspector. The inspection team was overseen by Victoria Watkins, Head of Hospital Inspection.

Information about Bearwood Cosmetic Clinic

Bearwood cosmetic clinic was the only location for the provider Bearwood Cosmetic Clinic Ltd. The service provided cosmetic surgery included vaginoplasty and liposuction and used sedation in their procedures and also local anaesthetic.

The service had one consulting room and one theatre where surgery was performed. It was registered to provide the following regulated activities:

Surgical procedures

Treatment for disease, disorder or injury.

There was one provider who operated and no permanent clinic staff. The other staff worked on an adhoc, sessional basis. These staff were not always qualified to perform the roles in which they were employed, for example dental nurses assisted in major surgery procedures.

During the inspection, we visited the consulting room, the room where equipment was cleaned and maintained, the reception area of the building and the theatre. We spoke with one staff member who was the registered manager and only provider performing surgery at the location. We did not speak with any patients or relatives. During our inspection, we reviewed five sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. This was the services first inspection since registration with CQC in 2016. This inspection found that the service failed to meet the main standards of quality and safety it was inspected against. This posed a serious and significant risk to patient safety and as such CQC took urgent action to cancel the registration of the provider.

- The provider did not have any system for monitoring and reporting safety incidents.
- The provider did not have any systems to monitor infection rates.
- The provider did not measure any safety measures or patient outcomes.

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?

We did not rate this service as we were undertaking the inspection under our focussed inspection methodology as a result of patient safety concerns. However, we found many areas of significant concern:

The registered manager who was the provider and the only provider operating at the location was undertaking surgery that he was not competent or trained sufficiently for.

The provider administered large doses of sedation without sufficient safety arrangements. This placed patients at risk of severe harm or death.

The provider operated in unhygienic conditions which posed a serious risk of infections to patients.

The equipment used for surgery was visibly dirty and soiled with malodourous bodily fluids and rust.

The machine used to sterilise surgical instruments was visibly dirty inside with obvious signs of rust.

The theatre environment was unsafe and not fit for purpose. This included holes in the theatre walls with live wires exposed and plaster falling out.

There were insufficient safety arrangements in the event of an emergency. For example, there was a lack of available resuscitation equipment and airway support in the event of medical emergencies.

Medications were managed unsafely. The provider was prescribing medicines in larger doses than recommended and for uses for which it was unintended.

Patients were sedated without appropriate safety measures in place. This posed a risk of serious harm or death.

Records were poorly completed and the inspection team observed the provider retrospectively adding entries into records at the time of the inspection.

There was insufficient monitoring of patients during and post-surgery.

The provider did not ensure there were suitably qualified staff to undertake surgery.

Staff did not undergo any expected checks such as qualifications and criminal records checks.

Summary of this inspection

There was an absence of any safety and escalation measures for patients who deteriorated and became unwell.

There was inconsistent follow up arrangements for patients and a lack of clarity around how patients could seek help for complications or concerns post procedure.

Cleaning arrangements were insufficient.

Are services effective?

We did not rate this service as we were undertaking the inspection under our focussed inspection methodology as a result of patient safety concerns. However, we found many areas of significant concern:

Consent processes were unclear and appeared to be absent in some cases.

The provider was unaware of significant national guidelines and standards in the cosmetic surgery field.

The provider did not measure any patient outcome measures.

There was no consideration of patients mental health or their mental capacity to consent.

The provider did not ensure that staff were competent for their roles and this put patients at risk.

Are services caring?

We did not inspect this key line of enquiry.

Are services responsive?

We did not inspect this key line of enquiry.

Are services well-led?

Are services well-led?

We did not rate this service as we were undertaking the inspection under our focussed inspection methodology as a result of patient safety concerns. However, we found many areas of significant concern:

There were no governance and risk management processes in place.

The provider and registered manager had a lack of insight into their own practice and failed to understand and action feedback provided.

Leaders were not competent to undertake their roles.

There were significant risks which had not been recognised or actioned.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	N/A	N/A	N/A	N/A	N/A	N/A
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Notes

We did not rate this service based on this inspection. This was because the inspection was undertaken as a result of patient safety concerns using our focussed methodology.

Surgery

Safe	
Effective	
Well-led	

Are surgery services safe?

Mandatory training

There was insufficient evidence to provide assurance staff had received mandatory training. There were inadequate systems in place for managers to monitor staff compliance with mandatory training.

It was unclear what level of training staff had completed as there were no monitoring arrangements in place.

There was no mandatory training programme in place and there was no information available which identified what mandatory training staff were required to have. The provider advised the inspection team that they had a 'friend' who was a provider and assisted them with larger cases. The provider did not check any training of this individual. They also did not check that they had the competence to undertake the surgery being provided. This meant that patients could potentially be receiving surgery from unqualified staff without the relevant competencies.

The provider was unclear on what training staff required or even which roles staff needed to be trained in to assist during surgery. For example; of this was that the provider was frequently assisted by a dental nurse during surgery where patients were sedated and waking voice contact was lost. The dental nurse did not have any qualifications or training in assisting and caring for patients with medical and surgical needs. The provider failed to recognise why this was a concern.

Essential mandatory training in life support, health and safety, information governance, fire safety, infection prevention and control and safeguarding adults and children were not provided or recorded as having been undertaken by staff including the registered manager.

Safeguarding

The provider and registered manager did not understand how to protect patients from abuse and risk of harm. Staff had not received training on how to recognise and report issues of a safeguarding nature.

The service did not have a safeguarding lead and the registered was unaware of the need to consider any measures in relation to safeguarding.

The provider did not undertake the relevant checks on staff working in the service to ensure they were safe to work with vulnerable adults and children.

Cleanliness, infection control and hygiene

Infection control practices did not follow best practice guidance. For example there was a lack of scrubbing facilities and basic hygiene measures which meant patients were at serious risk of infection.

The environment in the theatre area was visibly dirty and unhygienic.

There was dust on areas of the theatre such as cupboards and trolleys.

Equipment was visibly dirty and malodorous. There was visible soiling to the trolley used for patients to lay on for the procedures and the surrounding area. This included water mark type stains to Velcro under the bed and also brown reddish stains to the bed itself which were ingrained into the fabric and structure of the bed and emitted a foul smell. This posed a serious risk of cross infection to patients as all the surfaces of the bed were not clean and could lead to pathogens being passed between patients due to the invasive nature of the surgery performed.

The provider and registered manager was unable to tell us whether the practice they used for sterilising surgical equipment was in line with national guidance.

There were spots of rust on multiple pieces of equipment including equipment used directly during the surgical procedures including trolleys, stand and bed rails. This

posed a serious risk of infection as surfaces with rust present cannot be appropriately decontaminated and may then harbour pathogens which could be dangerous to patients.

The registered manager advised they undertook all the cleaning tasks and showed us the cleaning cupboard. Although there were some proprietary cleaning fluids, they advised that they wiped things down with wipes and in this cupboard was an open pack of baby wipes.

The theatre had two sets of surgical equipment and they were decontaminated on site by the registered manager. They stated that they left them to soak in a proprietary cleaning agent for 30 minutes then placed them in the table top autoclave for 18 minutes and then sealed them. They could not advise if he had received training in sterilising surgical equipment or followed national guidelines for this. This practice did not follow national guideline and expected standards of sterilisation.

The autoclave machine had rust present on the outside and inside. It was visibly soiled and had limescale and debris inside. This meant that these areas and instruments could not be cleaned to the required standard.

The autoclaves that were being used did not meet the requirements for cosmetic surgery which liposuction is categorised under. This falls under surgical procedures, as liposuction instrumentation are being inserted into a "sterile cavity" and therefore the legislation it falls under is Health Technical Memorandum 01-01: Management and decontamination of surgical instruments (medical devices) used in acute care. This memorandum prohibits the use of table top autoclaves for sterilising equipment.

The theatre area was not always secure and did not have sufficient scrubbing in facilities for major surgery. There was no availability of scrubbing fluids or no touch taps. The provider was unable to tell us where they would scrub in and maintain sterility.

There was no availability for scrubbing fluids and registered manager was unable to tell us where they would scrub in and maintain sterility. This was not in compliance with National Institute of Care Excellence (NICE) Quality Standard (QS) 61 Statement 3 and they were unaware of this standard. This posed the risk again that patients could contract infections.

There were no single use brushes or picks for cleansing the doctor's nails. This was not in line with NICE Clinical Guideline (CG) 74. This poses the risk again that patients could contract infections.

There was no decontamination policy in place.

There were also no records of decontamination and the provider could not demonstrate that they had received training or undertaken competencies in decontamination. This was not compliant with national guidelines on decontamination of surgical instruments which states staff are to be trained in cleaning and decontamination processes and hold appropriate competences for their role; and a record-keeping regime was to be in place to ensure that decontamination processes are fit for purpose and use the required quality systems.

The doctor did not screen any patients for infections prior to surgery.

There was rust present on several items including storage trolley, bed rails and drip stands.

There was an open hole into the wall where a plug socket had been removed with bare wires present and plasterboard. This was an open square hole in the upper part of the wall on one side of the theatre room. This appeared to be a plug socket which had been removed leaving a breach to the surface. Additionally, there were wires present and what appeared to be mortar or plaster. This again posed a serious risk of infection as the area could not be cleaned adequately.

Clinical waste was not disposed of safely. The fat removed during liposuction procedures was placed in sharps bins for disposal. The registered manager and provider advised they would take up to five litres of fat at any one time dependent on the patient but some of this would be fluid.

Patient records reviewed showed that the provider routinely prescribed antibiotics and was unable to explain why. This practice was not in line with national best practice. There was no monitoring of surgical site infections.

The registered manager was not aware of any national guidelines and could give no examples of how they used national best practice in relation to cleanliness and infection control.

Surgery

When we discussed the risks to patient's the registered manager and provider did not accept that there were concerns and showed a complete lack of insight into the significant infection control risks that were present.

All these issues pose a serious and significant risk of patients contracting potentially life-threatening infections.

The procedure of liposuction is invasive and requires the highest levels sterility and infection control. Due to the decontamination issues the inspection team could not be assured that patients bodily fluids were sufficiently removed from the equipment therefore there was a risk of cross contamination of blood and fluid borne pathogens.

Environment and equipment

The service did not have any processes to check that equipment was available and safe to use at the time of our inspection.

Staff did not carry out daily safety checks of specialist equipment.

Equipment maintenance and servicing systems were not robust or monitored.

Clinical waste was not disposed of safely. The fat removed during procedures was placed in sharps bins for disposal. The registered manager and provider advised they would take up to five litres of fat at any one time dependent on the patient but some of this would be fluid.

Emergency equipment was not readily available. There was no resuscitation trolley with defibrillator and emergency drugs on the same floor. This could not be located immediately when we asked to view it.

There was a drug box and defibrillator on the second floor which was shared with a dentist and GP who occupied the floors above. It was stored on the second floor and service staff were not sure where it was.

There were no anaphylaxis medications available which meant that if a patient had an allergic reaction, potentially life saving treatment was not available.

Equipment was not maintained to a safe standard.

Assessing and responding to patient risk

The registered manager showed a lack of understanding regarding specific risks to patients such as deterioration, venous thromboembolisms and sepsis.

Patients were not monitored appropriately for at risk of deterioration during or following surgery. There was no policy or procedure for the management of deteriorating patients.

There were no risk assessments to assess and mitigate risks to patients safety.

The processes for escalation and transfer to a higher level of care were unclear and largely absent.

Patients were sedated in an unsafe manner which was not in line with the Academy of the Medical Royal Colleges Safe Sedation Practice 2013. Medicines were being used at a higher dose than recommended, reversed by a drug not recommended for use in this situation by a doctor who could not demonstrate that he had training in anaesthesia.

There was no evidence that provider had received training in the use of anaesthesia. Anaesthetic agents had been administered above the recommended dosage which meant that there was a serious risk to patients.

The provider had been using a reversal agent, to reverse anaesthesia routinely. Guidance states reversal agents should be reserved for emergency use only. The provider told us and records confirmed that he used this drug on every patient.

The provider told us that this was to 'wake them up' as if he did not give this they would sleep in theatre for 10 hours. They further confirmed that he routinely used reversal agents to wake patients up.

This is unsafe practice and against national standards and guidelines. It could result in respiratory depression either in the theatre or when the patient is discharged home and this could result in death.

The doctor kept a surgical log and this showed that several patients were drowsy and unable to walk after surgery with no records as to how this was addressed. The reversal agent used is short acting and therefore there was a risk that patients would start to feel drowsy once the drug started to wear off and they would not have been monitored by staff.

Surgery

The theatre contained several airways and laryngeal masks and the doctor advised these were for emergencies and if the patient got drowsy. This was not when this equipment should be used and demonstrated a lack of knowledge and skills which put patients at risk.

These practices were not in line with national guidelines and standards and placed patients at significant risk of harm and death.

The doctor did not understand why we were concerned about any of these issues.

The doctor advised he would take up to five litres of fat at any one time dependent on the patient but some of this would be fluid. This is classed as major surgery and was not appropriate for the environment and set up at the clinic.

Nursing and support and medical staffing

There was insufficient staff with the required skills and competency to manage the sedation of patients and the undertaking of surgical procedures.

The provider was not assisted during surgery by people with the necessary skills. When undertaking surgery, the provider was assisted by a dental technician. They did not have the support of registered nurses or operating department practitioners.

The records for the dental technician confirmed they were a dental technician and had no training in acute general surgery or cosmetic surgery.

There was insufficient staff with the required skills and competency to manage the sedation of patients and the undertaking of surgical procedures.

The registered manager and provider was not on the specialist providers register and was not qualified to undertake surgical procedures including liposuction.

The provider was not a member of the Royal College of Surgeons and was not certified as a cosmetic provider by the Royal College of Surgeons. There was no evidence of any formal surgical speciality training in cosmetic procedures. He advised the inspection team that he had received two days training in the use of the liposuction machine from the manufacturer.

The provider told us they had a 'friend' helped with 'big' cases and who worked in gynaecology. We saw no evidence of this and no evidence of any checks undertaken by the provider to ascertain their level of qualification and competence.

Records

Records were not completed fully and lacked detail required for surgical procedures. We also observed records being altered after the fact. However, records were clear and stored securely.

The inspection team observed the provider adding sections in to patient records to state another doctor was present. We advised this was not acceptable and seized the records to prevent further tampering. The provider told us that he was adding words.

Medicines

The service did not have effective systems and processes to safely prescribe, administer, record and store medicines. Medicines management was unsafe and posed a risk of severe harm or death.

Patients were sedated in an unsafe manner which was not in line with the Academy of the Medical Royal Colleges Safe Sedation Practice 2013. Medicines were being used at a higher dose than recommended, reversed by a drug not recommended for use in this situation by a doctor who could not demonstrate that he had training in anaesthesia.

The provider was administering anaesthetic agents above the recommended dosage which meant that there was a serious risk to the lives of patients.

They were also using an agent, to reverse anaesthesia which should not be used in this circumstance and guidance states should be reserved for emergency use only. The provider told us and records confirmed that he used this drug on every patient.

The inspection team reviewed the five patient records which were the only records available. Every patient had received both an oral and injectable high strength sedation, designed only for use in general anaesthesia. The prescription charts did not show the time medicines were given, or the correct doses or the route of administration. The doctor advised he would only give medication intravenously if the patient became difficult during surgery. This is not a valid reason for the use of drugs via this route.

Surgery

The doctor routinely prescribed antibiotics and could not give a rationale as to why. This was not in line with NICE CG74 which states that providers should not prescribe antibiotic prophylaxis routinely for clean non-prosthetic uncomplicated surgery. The doctor was unaware of this guideline.

The prescription charts did not record the time these drugs were given or the correct doses or the route.

Incidents

The service did not manage patient safety incidents. Staff did not recognise and report incidents and near misses.

There was no system in place to record and monitor patient safety incidents

The service did not monitor patients safety outcomes and results to improve safety. Staff did not collect safety information.

Are surgery services effective?

Evidence-based care and treatment

The service did not provide care and treatment based on national guidance and evidence-based practice.

The service was unaware of key national standards and guidelines in relation to cosmetic surgery and basic standards or safety.

Managers did not check to make sure staff followed guidance.

Patient outcomes

Staff did not monitor the effectiveness of care and treatment.

Competent staff

The service did not make sure staff were competent for their roles.

Managers did not appraise staff's work performance.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not support patients to make informed decisions about their care and treatment. They did not follow national guidance to gain patients' consent. For example, consent was taken on the same day as surgery.

The provider did use consent forms and take consent from patients but there was no evidence that they considered the patients mental state. They also did not follow national guidelines in relation to giving patients time to reflect on their decisions as consent was taken on the same day as surgery**.**

They did not assess patients mental capacity and did not know how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Are surgery services well-led?

Leadership

Leaders did not have the integrity, skills and abilities to run the service.

- The registered manager and provider who was the main member of staff for the service did not have the skills or abilities to run the service as detailed in other sections of this report.
- They did not have any insight into the very serious and significant risks present within the service.
- They lacked integrity as they were observed altering records after the fact in the presence of the inspection team.

Governance

Leaders did not operate effective governance processes, throughout the service and with partner organisations.

- There was a complete absence of governance systems and there was no effective governance structure in place.

Managing risks, issues and performance

Surgery

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

- The provider failed to recognise the risks and issues picked up during our inspection and when they were highlighted they failed to accept them and improve on them.
- There were no systems for the management, mitigation and escalation of risk.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

Due to the very serious and significant risks identified throughout this report we undertook urgent enforcement action to cancel this provider's registration. This was successful and the provider is now no longer registered to provide any regulated activities at this location. This cancellation was undertaken within two working days of the date of inspection.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	S30 Urgent Cancellation of registration **We urgently cancelled the registration for this provider.**