Bristol Plastic Surgery LLP

Bristol Plastic Surgery

Quality Report

Bristol Plastic Surgery
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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Summary of findings

Letter from the Chief Inspector of Hospitals

Bristol Plastic Surgery is a small independent acute hospital offering minor plastic surgery services to both private and NHS Patients. There are no inpatient beds at the hospital.

We inspected the hospital on 18 August 2015 as part of our schedule of comprehensive inspections of independent hospitals.

We have not published a rating for this service. CQC does not currently have a legal duty to award ratings for those hospitals that provide solely or mainly cosmetic surgery services.

Are services safe at this hospital?

There was open and transparent reporting of incidents of harm or risk of harm, which were reviewed at regular meetings. When things went wrong patients were informed in a timely manner. However, learning from incidents was not widely shared with staff and there were no records of this happening.

Patient records were inconsistent and often incomplete. Some assessments were not completed and we found loose documents in sets of notes that could easily be lost. However, the clinic had enough staff to meet patients' needs, and staff were up to date with safeguarding training and were aware of the reporting process if abuse was suspected.

Are services effective at this clinic?

Care provided within the clinic was evidence based. Staff were able to attend external study days and training such as wound care, and able to use this knowledge in practical terms. All policies, incidents and complaints were discussed at the medical advisory committees and a record of all action points was made.

We found patient's outcomes were not being monitored and there was no benchmarking against other similar services. The clinic did not participate in any national audits.

We found the staff were experienced and competent in delivering the service, appraisals were up to date and learning was completed as required.

Are services caring at this clinic?

We found the service provided to patients to be caring. This was reflected in the feedback by patients. Staff were found to be supportive, kind and considerate.

Are services responsive at this clinic?

The service did not have a waiting list and patients could choose when to have their operations. The clinic was able to meet the needs of patients with mobility issues by the use of a stair lift and access to consulting rooms at ground level. Open evenings were held to give potential patients information and advice about the services the clinic provided.

All complaints were taken seriously and acted upon if required. A complaints report was provided at the medical advisory meetings and was discussed as an agenda item.

There was some service planning in place but we did not see documented evidence of this.

Are services well led at this clinic?

The clinic had leaders who were held in high regard by staff, the culture was open and honest and staff felt able to discuss any concerns. However, the clinic lacked documented evidence of their vision, values and strategy.

Risk assessments had been completed, but there was not a risk register in place. There did not appear to be ownership of the risks and these had not been updated after two instances of needle-stick injury, for example.

Summary of findings

However, there were areas of poor practice where the provider needs to make improvements.

Importantly, the provider must:

- Undertake regular audits of the service provided, monitor patients outcomes and ensure that there is documented evidence of action learning processes in place to support the outcomes.
- Ensure that identified risks to people who use the services and others are continually monitored and appropriate action is taken when a risk has increased.
- Improve documentation and record keeping to ensure an accurate and complete patient record is maintained.
- Have an effective recruitment and selection procedures, which should assess the accuracy of the applications and be designed to demonstrate the candidates suitability for the role, while meeting the requirements of the Equality Act 2010.

In addition the provider should:

- Ensure that there are clear guidelines for antimicrobial prescribing to ensure good antimicrobial stewardship.
- Have a written strategy for the clinic that incorporates its values and vision.

Professor Sir Mike Richards Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Surgery		Patient outcomes were not being measured and there were very few audits being completed. The service was not measuring itself against other similar services enabling benchmarking to take place. We found the record keeping was inconsistent and there were incomplete documents and risk assessments within patients' files, the documents were not always securely fastened in the notes. There were no documented interview notes of staff newly appointed. However, we did see evidence of all other recruitment checks as having taken place. Bristol Plastic Surgery did not have any documented visions or values. The directors and general manager had a strategy they were able to communicate. However, no documentation could be presented to show how this was going to be developed, or when it was going to be developed by. We did find the service as being open and transparent; the staff felt valued and were proud to be working for the service. The staff were experienced and competent in the roles they performed. The service received positive feedback, which was reflected in the comments from a patient we spoke with. The service was planned to allow flexibility and choice for patients accessing care and treatment. All complaints were taken seriously and acted upon if required.

Bristol Plastic Surgery

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Background to Bristol Plastic Surgery

Bristol Plastic Surgery is a small independent acute clinic offering minor plastic surgery services to both private and NHS Patients. There are no inpatient beds at the clinic. It has one operating theatre. Children and young people attend for outpatient consultations. No surgical treatments are carried out on children or young people at Bristol Plastic Surgery.

In the year to March 2015, there were 1,765 visits to theatre.

The clinic has a registered manager who had been registered with the Commission for one year and five months at the time of our inspection.

We inspected the clinic as part of our schedule of independent hospitals.

Our inspection team

Our inspection team was led by:

Inspection Lead: Nicki Tonkin, Inspector, Care Quality Commission

The team included another CQC inspector, a consultant surgeon and a registered nurse.

How we carried out this inspection

We analysed information that we hold on the service prior to our inspection. Carried out an announced onsite inspection on 18 August 2015 where we observed practice, spoke with staff, patents and the provider.

Facts and data about Bristol Plastic Surgery

Bristol Plastic Surgery is a small hospital that provides plastic surgery services to private and NHS patients. It has one operating theatre where day case procedures are undertaken. No overnight hospital accommodation is provided by the hospital. The hospital is registered to provide the regulated activities:

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

The registered manager is Mr Antonio Orlando who has been registered with the Commission since March 2014.

Detailed findings

The hospital has a general manager who is also the nominated individual. The hospital also a controlled drugs accountable officer: Mr Nigel Stuart George Mercer who was registered in October 2011.

The hospital employs one nurse, a part-time operating department practitioner and five administrative staff, one of whom is part time. There are 10 consultants engaged to work at the hospital under practising privileges.

All operations at the hospital are carried out under local anaesthetic and therefore no anaesthetists work at the hospital.

Surgery

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Bristol Plastic Surgery is a partnership of consultant aesthetic plastic surgeons that provide a selection of cosmetic surgery procedures and non-surgical cosmetic interventions. The practice was set up in 2008. The surgery provides treatment for private self-funding and private insurance patients plus NHS patients in the removal of skin lesions and biopsies for the local acute NHS trusts. Bristol Plastic Surgery is registered as an acute day clinic with no beds. The building consists of five consulting rooms and one operating theatre. During the year to March 2015 there were 1,765 surgical procedures undertaken in the operating theatre.

The clinics senior management team comprises of two directors and a general manager who is responsible for seven staff.

Summary of findings

Patient outcomes were not being measured and there were very few audits being completed. The service was not measuring itself against other similar services enabling benchmarking to take place.

We found the record keeping was inconsistent and there were incomplete documents and risk assessments within patients' files, the documents were not always securely fastened in the notes.

There were no documented interview notes of staff newly appointed. However, we did see evidence of all other recruitment checks as having taken place.

Bristol Plastic Surgery did not have any documented visions or values. The directors and general manager had a strategy they were able to communicate. However, no documentation could be presented to show how this was going to be developed, or when it was going to be developed by.

We did find the service as being open and transparent; the staff felt valued and were proud to be working for the service. The staff were experienced and competent in the roles they performed.

The service received positive feedback, which was reflected in the comments from a patient we spoke with. The service was planned to allow flexibility and choice for patients accessing care and treatment. All complaints were taken seriously and acted upon if required.

Surgery

Are surgery services safe?

Although incidents were discussed at governance and clinical meetings, learning from incidents was not widely disseminated to staff and there were no records of this happening.

Record keeping of both NHS and private patients was inconsistent and often incomplete. Some assessments were not completed and we found loose documentation within the sets of notes.

There was open and transparent reporting of incidents, which were reviewed at regular meetings. Patients were informed when things went wrong in a timely manner.

There was sufficient staffing to meet patients' needs and mandatory training was up to date. Staff were up to date with safeguarding training and were aware of the reporting process.

Incidents

- Staff we spoke with were open, transparent and honest in reporting incidents. The staff were aware of and had access to an online incident reporting system that automatically informed the general manager when reports were submitted. Incidents were investigated by the lead nurse and actions taken if necessary. The manager said there was a positive culture of incident reporting and felt confident that all incidents were being reported. Staff we spoke with said they would go to the manager in the first instance if an incident occurred and would then fill in an incident form.
- Incidents were discussed at the Medical Advisory Committee (MAC) meetings. However, we were told that learning and information sharing from incidents was done by word of mouth as the team was small. The MAC was held on a bi-monthly basis, the team consisted of a consultant, lead nurse and the general manager.
- There had been two incidents involving needle stick injuries. These were investigated and mitigating actions introduced. For example, the purchase of an occupational therapy blood testing kit to ensure that this service was available to staff affected at any time. Staff said they did not receive feedback from incidents limiting the amount of learning disseminated from incidents occurring.
- The duty of candour explains what providers must do to make sure they are open and honest with patients and their families when something goes wrong with their care and treatment. This was implemented in the clinic when an incident occurred which involved a patient. However, one example (where a letter had been sent to the wrong patient) only the patient who received the letter received an apology. The patient whose confidentiality was compromised as a result of this incident was not informed. The lead nurse was able to talk about duty of candour and discussed the process undertaken to ensure this took place. We saw the organisation had appropriately notified the affected patient and written a letter of apology. Actions were taken to rectify the mistake.
- There was one never event in the 12 months prior to the inspection where a biopsy sample went missing resulting in the patient having to undergo repeat surgery. The investigation report identified actions to prevent this from happening again. However, there was no indication of who had overall responsibility for the actions or the time frame in which to complete them. No root cause analysis was conducted. This was not in line with the clinic governance policy. Despite this actions had been taken as a result of this event which had affected the way specimens were handled and obtained.
- A log of surgical site infections was kept along with the actions taken. However, no actions were taken as a result of the audit to improve the service. Safety performance was not benchmarked against other organisations so it was not clear how the service compared to others of a similar size.
- There were no incidences of mortality reported in the 12 months prior to our inspection.

Safety thermometer or equivalent

- Patients were assessed for risk of developing venous thromboembolism (VTE) but the clinic had not reached the 95% target rate for VTE screening for NHS patients. There were no incidences recorded of patients having a venous thromboembolism at the clinic. This was discussed with the surgeons and processes were in place to apply for an exemption, however at the time of the inspection this was not in place.
- None of the records contained a completed venous thromboembolism (VTE) assessments. We were,

however, informed that the provider was researching the need to complete VTE assessments due to the nature of the surgery performed at Bristol Plastic Surgery.

Cleanliness, infection control and hygiene

- Yearly infection control audits were completed. The audit tool used was from the infection control nurse association. An infection control audit had been completed within the 12 months prior to our inspection and actions taken as a result. The next annual audit was due in September 2015.
- Advice and recommendations were taken from an infection control nurse from another organisation on the regularity of the audits. There was an infection control policy in place.
- We also saw evidence of quarterly hand hygiene audits having been completed. This involved both nurses and consultants. If the hand hygiene audit results fell below 95%, a discussion was generated among staff. However, no action plans were in place.
- Methicillin-resistant Staphylococcus aureus(MRSA) screening for NHS patients was undertaken by pre-assessment clinics in other local trusts and not completed by Bristol Plastic Surgery. We did not see any evidence to demonstrate that private patients were screened for MRSA. Theatre staff routinely checked the patient's notes for any evidence of this being done. A patient with MRSA would routinely be placed last on the theatre list. A deep clean of the theatre took place after operating on a patient with MRSA
- The building was visibly clean, tidy and well maintained. There was a contract with a cleaning company to clean the inside of the building three times per week. We saw a schedule of cleaning and the appropriate cleaning materials required for individual pieces of equipment. The contract included daily cleaning of the toilets but we did not see any completed cleaning records to support this.
- The theatre was cleaned at the end of each session by the theatre staff. We saw a daily cleaning checklist and this had been fully completed. A deep clean of the environment took place every six months. Theatre wear was supplied by an external company, there were changing room facilities including a shower for the theatre staff. However, this was at the top of the building with the theatre being in the basement, this could increase the risk of infection to patients.
- We saw full containers of antibacterial hand gel in all the consultation room, within the operating theatre and reception.

Environment and equipment

- All the equipment we saw had been maintained by a contracted company and maintenance dates were visible on the equipment. The contracted company were able to respond to the needs of the clinic should a piece of equipment require repair. The equipment had also undergone portable appliance testing.
- Disposable items of equipment were used and disposed of appropriately either in clinical waste bins or sharp instrument containers. None of the waste bins or containers was full. Clinical waste was collected from the site three times per week. Waste bags were stored the sluice area until collection.
- We saw oxygen cylinders being stored correctly with oxygen masks being attached to the cylinders. Oxygen was supplied to the clinic through a contract with another company. Cylinders were stored securely.
- In the theatre there was resuscitation equipment including an automated external defibrillator (AED). These devices were able to diagnose life threatening cardiac conditions in a patient, and were able to treat them through defibrillation. Monthly checks of this machine had been completed and an annual maintenance check completed.
- Equipment was a regular agenda item on the medical advisory committee meetings. We were told (and saw evidence in the minutes) of old or new equipment being discussed and that decisions had been documented to proceed with purchasing if required

Medicines

- The clinic had a contract with a local NHS trust in the supply of medication. However, there was little use of medication in the clinic with the exception of local anaesthesia. The theatre manager was responsible for the ordering of the medication. There was no storage or use of controlled drugs. All medication was kept in a locked cupboard.
- We saw evidence of a weekly check of medication and stock levels were maintained. Room temperatures where the medications were stored were checked daily and were maintained within the recommended temperature.

- Medications were kept appropriately in the medication fridge and temperatures were monitored and recorded daily. This was to check that the medicines were stored at the correct temperature.
- Prescriptions were written and given to patients if they required antibiotics. There was no antimicrobial policy in place.
- The emergency drugs were in a tamper evident container. We saw evidence that this was checked on a weekly basis. Anaphylactic shock kits were readily available and were in date.

Records

- During the inspection, we reviewed five sets of patient records, which we found not fit for purpose as having complete and contemporaneous records of each service user was at risk. None of the records we looked at contained a completed venous thromboembolism (VTE) assessments. However, informed that the provider was researching the necessity to complete VTE assessments due to the nature of the surgery performed at Bristol Plastic Surgery. We also found that four patient records lacked discharge summary documentation or evidence of any nursing documentation to support patient discharge. We found that one set of records had an incomplete surgical checklist.
- For NHS patients, all the documentation used was the NHS trust documentation. It was difficult to identify where the surgery had taken place from the records maintained. However, the consultant informed us that the notes were coded in the individual trust, which identified where the surgery had taken place.
- We found that private patient notes were legible and accurate. However, one set of records had sheets in them that had no personal identifiable information on them. This means that if they were misplaced it would be difficult to repatriate with the applicable notes.

Safeguarding

- Over 80 percent of staff had received mandatory safeguarding adults training; the hospital had not set themselves a target for the number of expected staff to be up to date with mandatory training. However, all staff we spoke with were confident in their responsibilities to report safeguarding concerns and could identify the processes followed to alert a safeguarding concern.
- When children were being seen as an outpatient, there was a registered children's nurse on duty. Two staff had received refresher training for safeguarding children.
- There was a safeguarding policy with an accompanying flow chart of who to contact and a comprehensive list of contact numbers for relevant organisations across 11 different networks. There were four safeguarding leads in the hospital, the staff were able to identify who these leads were and explain their responsibilities in adhering to policy and reporting suspected abuse. There had been no safeguarding concerns reported to the local authority in the last 12 months.

Mandatory training

- We saw evidence of over 82% of permanent staff; both clinical and non-clinical, were up to date with mandatory training. All the mandatory training was undertaken on an annual basis, this training was off site and completed in one day. Staff said that the quality of the mandatory training was good and properly equipped them to perform their job safely.
- All staff including administration staff were trained in basic life support techniques.
- We looked at two staff records and found that they were both up to date with their mandatory training and had certificates available to demonstrate this. This information was stored on a spreadsheet for the manager to have oversight of training.
- Medical staffing mandatory training was not up to date. Some medical staff were up to 3 years out of date for infection control training, which could lead to an increased risk for patients.

Assessing and responding to patient risk

- There were set inclusion and exclusion criteria to ensure that the clinic was able to meet patients treated.
- All staff were aware of the processes involved when a patient collapses. All rooms had a telephone in them with a single digit number to ring during an emergency. When this number was called every phone in the hospital would ring and display the location of the emergency on the phone.
- The hospital had the world health organisation surgical safety checklist in use. We saw a sample of these having been completed. The theatre manager could describe how the checklist was used. However, an audit of the checklist was not completed.

Surgery

Nursing staffing

- The hospital employed adequate numbers of nursing staff. In the theatre department, there was one part time registered theatre nurse and one part time operating department practitioner. The lead nurse was part time. The hospital also maintained a small number of bank nurses to complement the existing staff should it be required. The clinic had not required the use agency staff.
- The staffing need was assessed on a daily basis and there was always a registered nurse on duty whenever the consulting rooms were in use. The clinical staff did not work shifts and therefore handovers of patients were unnecessary.
- Patient observations were recorded on those undergoing surgery. If a patient became unwell, the patient would be cared for in the theatre until further assistance arrived, for example, an ambulance.

Surgical staffing

- There was nine medical staff providing consultations with patients' and performing surgery at Bristol Plastic Surgery. These surgeons were not directly employed by the organisations but we saw evidence of the doctors practising privilege rights. All but one visiting consultant worked within the NHS maintaining their practice and undergoing revalidation and appraisal at their local trusts.
- Two of the surgeons had a rota for being on call and were available to be contacted out of hours. This was for advice and support for concerned patients who had received treatment at the clinic.

Major incident awareness and training

- In the event of a power failure, the theatre had the use of a back-up power device. This enabled any surgery taking place to be completed safely and effectively. This device had been serviced and monthly checks were seen and completed.
- Fire evacuation procedures were in place and we saw evidence that training in evacuation had recently taken place.
- Guidance on emergencies was readily available and accessible in all consulting rooms and theatres.

Are surgery services effective?

Patient's outcomes were not being monitored and there was no benchmarking against other similar services.

There was no record of any interview notes when recruiting new staff, although all other recruitment checks had been undertaken.

We found the staff were experienced and competent in delivering the service, appraisals were up to date and learning was completed as required.

The medical team had good access to patient information and the multi-disciplinary working between two local trusts was good.

Evidence-based care and treatment

- Staff gave care based on evidence-based guidance, they were aware of this through attending external updates for example on wound care. The staff also maintained their evidence based care through reading journals and NICE guidance; they attended plastic surgery conferences and disseminated learning through the team. They gained links with specialist nurses at the local NHS trusts and sought advice when necessary.
- All patients were treated equally and with discretion regardless of any disability or treatment decisions. Advice and support was given to patients who were required to make changes to their lifestyle in order to receive some treatments, this advice was given in conjunction with the consultants and GP's.
- Cosmetic surgery patients' psychiatric history was discussed during consultation, if the surgeon was concerned the patient was referred to an organisation for psychological assessment.

Pain relief

- Medication and pain relief were not administered to patients in the hospital (with the exception of local anaesthetics) following their procedure patients were given advice on pain relief should they require it.

Nutrition and hydration

- Patients who underwent treatment at this hospital were not required to restrict their food or fluid intake prior to surgery. After the procedure had taken place, patients were offered a hot or cold drink.

Surgery

Patient outcomes

- We did not find any evidence of any patient outcomes being monitored and the service did not benchmark the care and treatment they provided against other similar services.
- There was no auditing of the cosmetic surgery carried out.
- Patient satisfaction surveys were completed; we saw evidence of 10 completed surveys, all of which had rated the service as good to excellent. The service had just added the friends and family question to their survey.

Competent staff

- The lead registered nurse had an up to date appraisal in place, this had been completed by the general manager. Updating of training had been identified in this process. The theatre manager had been receiving one to one meetings although these were not documented; their appraisal was due to be completed by the lead nurse. The theatre manager had recently completed a control of substances hazardous to health (COSHH) course and as a result had updated all the data sheets to reflect this training.
- Any learning was identified at appraisal, staff were also able to request training and courses throughout the year and consideration for these was taken. We were told that requests were granted for appropriate training.
- We reviewed a recruitment record. There was no application form but there was a curriculum vitae. All the necessary recruitment checks had taken place and evidence of qualifications gained. The theatre manager and lead nurse undertook recruitment. However, there was no record of interview notes. We saw evidence that the all the registered nurses had current professional registration with the nursing and midwifery council.

Induction of new staff consisted of a list of subjects the new employee needed to be aware of but these were not competency based.

There was a bank of registered nurses; a core three nurses were used on a weekly basis to maintain their skills and competence in the environment. The bank nurses always worked with a permanent member of the team. All the bank nurses were employed in NHS services elsewhere.

- The manager was able to describe how poor performance was dealt with and the actions that could be taken if required and how to support staff involved and resolve the problem.
- The responsible officer at the clinic oversaw the surgeons. We were told that if concerns were raised about individual practice, this would be reported the individual's responsible officer but there was no documentation to support this practice. However, the responsible officer had the right not to use surgeons he was not confident about or could suspend them from the hospital's own register. Only local anaesthetics were given to patients so anaesthetists were not employed.
- To keep all staff up to date with any changes, the general manager communicated changes both verbally and via email. The theatre manager kept a communication book in theatres all staff would read this when on duty and make comments as necessary.

Multidisciplinary working

- The hospital worked with two local NHS trusts, all the non-cancer patients who received treatment were followed up by their own GP practice for wound care.
- Patients requiring specialist cancer treatments were referred to specialist nurses and consultants. All biopsies of skin lesions were reviewed at the multi-disciplinary skin cancer meetings at a local NHS trust.
- The manager and the administration staff felt there was a good working relationship with the local acute and independent health hospitals. This affected the patient by ensuring that there were minimal delays in pathology analysis and diagnostic imaging results. One example of this was where a biopsy was conducted and results were back in two days with an urgent referral to the GP made due to unexpected findings.
- We were told that the clinic received inappropriate referrals for surgery but they were rare. One recent example was one where a patient was above the weight of the surgical table. The patient was given an apology and the clinic worked to get an appointment at the acute hospital before they left.

Seven-day services

- The consultants operate an on-call rota to enable patients to receive advice out of hours should they require it. The service is open on Monday to Saturday from 8:30am to 5pm offering consultations and surgical procedures.

Access to information

- Information required by the surgeons was available due to good communication links between the NHS hospitals, other independent sector hospitals and Bristol Plastic Surgery. We were told that if there were delays in receiving information they had processes in place to get results faxed or emailed. NHS patients were seen in the hospital with their full NHS medical records and these were returned to the local trust after surgery has taken place. The clinic scanned relevant notes these were then stored onto disc and stored onsite.
- Private patients records were kept on site to be easily accessible, once discharged the records were again scanned and stored onto disc and stored onsite. The notes were stored double locked when the building was empty.
- When consultants transport patient notes to other sites the safe storage of them remained their responsibility.
- Pathology samples were sent to a local NHS trust by courier within 24 hours of being obtained. We were told that most pathology reports and diagnostic imaging reports were with the clinic within two weeks and most of them were posted If there were any delays or an urgent procedure was required, the administration staff had good links with the hospitals and could get information faxed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent to care and treatment was obtained in line with legislation and guidance. All consent forms were signed and dated in the patients' notes we reviewed.

Patients who lacked capacity to make their own decisions on treatment were not cared for at this hospital. Those patients who had mild confusion were well supported within the environment, they were given verbal and written information and advice regarding the procedure and their carer was able to be present during their treatment at the hospital.

Are surgery services caring?

The feedback the service received was positive and this was reflected in the comments made by a patient we spoke with. Patients said the care received was 'fantastic' and that staff were kind and attentive. Support from the clinical staff was available during the procedure if patients required it. Both patients and carers were given verbal post-operatively information and written information.

Compassionate care

- Feedback was regularly collected from patients and their relatives and carers about the care received by staff in the clinic. We looked at several patient feedback forms, all of which were positive. Comments included "there was a good working culture at the clinic, people care about how people feel physically and psychologically" and "You are the kindest and most caring surgeon I have ever met".
- Patients also said in feedback forms that staff were kind, attentive and had gone beyond their expectations.
- A patient we spoke with said that the care received was fantastic and that the surgeon was great. They went on to say that "the staff always put myself and my partner at ease and make sure that no request is too much trouble" and that the care at the clinic had "just been great".
- We were told by a patient that phones were always answered quickly and the staff always answered questions or found someone available who could.
- All patients were given the option of having a chaperone, should they wish. We saw leaflets in the consulting rooms offering a chaperone.
- Patients' privacy and dignity were respected during examination by the use of a screen in the consulting rooms.

Understanding and involvement of patients and those close to them

- All patients were given information post operatively. We saw relatives being included in this sharing of information as an elderly patient having received treatment had exhibited signs of mild confusion. A

patient we spoke with said that their partner was always actively involved in any clinics at the hospital and that they were always treated as well by the staff as the patient.
- If patients felt anxious before their procedure, their relatives were able to accompany them to the pre-operative room.

Emotional support

- All the private patients will receive a telephone call from the lead nurse two to three days after major procedures. The follow up was tailored around the needs and requirements of the patient; they were generally seen seven days post-operative but could be seen as often as the patient required.

Are surgery services responsive?

The service did not have a waiting list and planning to allow for flexibility and choice for patients accessing care and treatment. All complaints were taken seriously and acted upon if required.

A complaints report was provided at the medical advisory committee meetings and was discussed as an agenda item.

There was some service planning in place but we did not see documented evidence of this.

Service planning and delivery to meet the needs of local people

- The two directors of the hospital were surgeons who both worked within the NHS. They worked with two local NHS trusts to provide services for minor surgical procedures, such as the removal of skin lesions.
- Plans were being made with the local clinical commissioning group for the hospital to open another surgical facility north of the city to meet the needs of patients in that area.
- The appointment system was flexible and was able to offer an array of appointment times and days to suit the needs of the patient.
- There was no formal engagement of staff in the planning and delivery of the service. However, the staff we spoke with felt able to have open discussions with the senior staff on an ad hoc basis. The lead nurse was a member of the medical advisory committee and future developments were discussed at the meeting.

Access and flow

- The hospital did not have a waiting list of patients. Surgery was offered in a timely manner. Outpatient appointments and those for surgical procedures were available in the evenings.
- Those patients having skin cancer treatments did not wait for care, all outcomes of the skin cancer surgery were discussed at local hospital multi-disciplinary meetings.
- Operations were not generally cancelled, if this did happen it had been due to the surgeon having an emergency in the NHS. The patients were given another date to return for their procedure.
- Patients were kept informed if the theatre list overran. We witnessed a slight overrun and the next patient was kept fully informed by the theatre staff.

Meeting people's individual needs

- Bristol Plastic Surgery was unable to install a lift to all floors due to the listed nature of the property. The hospital did, however, have a stair lift to the theatre room. For patients unable to use the chair lift the facilities at a local independent hospital were offered to the patient for their procedure. A consulting room was accessible on the ground floor for patients with mobility difficulties. There was a ramp into the building allowing access for patients with reduced mobility.
- The surgery did not have access to a translation service but the staff assured us they would find one should the need arise; this need had not yet occurred at the time of our inspection.
- Their philosophy was to treat everyone as an individual and tailor their care accordingly. One member of staff described an incident where a patient was feeling nervous so took time out of her day to sit with them and reassure them.
- People's views and experiences were sought in the form of a patient satisfaction survey. We saw 10 completed surveys all of which rated the service as good or excellent.
- The consultants informed us that the clinic had open evenings for members of the public to explore the cosmetic services on offer. Potential patients were given advice but there was emphasis on selling the procedures. We saw evidence of these open evenings advertised on the website.

- Patients' needs were assessed as required – for example, in relation to wound care. If required, the surgeons would review and help plan future care. This practice was not monitored.

Learning from complaints and concerns

- A record and learning log of all complaints received was kept. However, the service had received three complaints in the 12 months prior to our inspection. An example of where improvements had been made was that all staff received customer service training following a patient's complaint about the negative tone a member of staff had used when speaking with him.
- Complaints and compliments was an agenda item at every medical advisory committee meeting, the general manager provided a report on patients' feedback and actions were agreed. We saw a complaints policy containing guidance for staff in dealing with a complaint. This policy had recently been updated.
- We were given an example where a patient satisfaction survey was returned with a poor outcome. This was investigated as a formal complaint and the patient received an apology letter.
- There was a patient guide was located in both waiting rooms; this gave details on how to raise a concern or formal complaint. Complaint and compliment leaflets were visible in the waiting rooms; the forms were designed to allow the complainant to remain anonymous if they wished. Patients were also provided with feedback forms that could be placed in boxes. However, visitors or patients could remove the forms, which could potentially breach confidentiality.
- From discussions with all staff members, including the leaders, we found they were all comfortable with raising any concerns and appropriate action would take place as a result.

Are surgery services well-led?

There were no documented visions, values or strategy relating to Bristol Plastic Surgery.

Risk management and governance processes were not embedded within the hospital. There was no risk register in the hospital as no identified risks scored high enough according to their governance policy. Risk assessments had been completed and mitigating actions had been taken but there was no accountability, timeframe, or information on how these actions were going to be implemented.

The leaders of the service were thought of in high regard and there was an open and honest culture, the staff were very positive about working within the service.

Vision, strategy, innovation and sustainability

- Bristol plastic surgery did not have any documented visions or values. It was clear the team were proud of the service they provide. Staff we spoke with was unaware of any set visions or values.
- The directors and general manager had a strategy they were able to communicate. However, no documentation could be presented to show how this was going to be developed, or when it was going to be developed by.

Governance, risk management and quality measurement

- There were two groups who met regularly basis. Management board meetings were held monthly and were attended by two consultants and the general manager. The board discussed the general management of the business. The medical advisory committee (MAC) met bi-monthly and was attended by a consultant, the lead nurse and the general manager. These meetings were to ensure high standards were achieved. The hospital had processes and policies to record, monitor and continually improve the standards of care.
- There was no risk register in the hospital, as no identified risks scored high enough according to their governance policy. Risk assessments had been completed and mitigating actions had been taken but there was no accountability, timeframe, or information on how these actions were going to be implemented.
- It states in the hospital governance policy that a root cause analysis should be conducted for serious incidents. This was not done for the 'never event'. When asked about it, the manager told us that the use of a root cause analysis in a small clinic had been unnecessary.

- Where there had been incidents, risk had not been reassessed. For example, the risk assessment for needle-stick injury was classified as a three (low risk) and was not re-evaluated or updated as a result of the two incidents that had occurred in the hospital.
- To minimise the risk of breaches of confidentiality, the surgery had installed a secure network access in order for them to communicate safely with local health care trusts. Unfortunately, this system required sponsorship from an NHS trust and this had not been secured at the time of the inspection.

Leadership/culture of service

- Leaders within the service were well thought of and described as being open and honest. They were very visible within the surgery and staff felt as though they were able to approach them at any time and had a good working relationship with them. The staff said they were able to discuss any problem or concern with their leaders and staff felt as though they had been listened to. We were given examples where staff were supported by managers during difficult situations.
- We were told of one example where the manager worked on the main reception desk when the clinic was short staffed.
- The staff we spoke with were proud to be working at the clinic and said they strove to provide a high quality of care and good service to the patients.
- Staff described the clinic as a “fantastic place to work” and found all staff approachable and friendly. They were confident to raise issues and ideas with either the manager or the surgeons and felt they would be listened too and comments considered.
- Several members of staff said that as it was a small clinic they were “like a family” and supported one another.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

Action the hospital MUST take to improve

- Have a regular audits of the service provided, monitor patients outcomes and documented evidence of action learning process in place to support the outcomes.
- Identified risks to people who use the services and others must be continually monitored and appropriate action taken when a risk has increased.
- Improve documentation and record-keeping to ensure an accurate and complete patient record is maintained.
- The provider must have an effective recruitment and selection procedure, which should assess the accuracy of the applications and be designed to demonstrate the candidates suitability for the role, while meeting the requirements of the Equality Act 2010**.**

Action the hospital SHOULD take to improve

Action the hospital SHOULD take to improve

- Have a written strategy for the hospital that incorporates its values and vision.
- Ensure that there are clear guidelines for antimicrobial prescribing to ensure good antimicrobial stewardship.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (2)(a) Good Governance Providers must assess, monitor and improve the safety of the services provided in the carrying on of the regulated activity The service did not have regular audits of the service provided, monitor patient's outcomes and documented evidence of action learning to support the outcomes. Identify risks to people who use the services and others, continually monitor and take appropriate action taken when a risk has increased.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services 17(2)(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. Improve documentation and record keeping to ensure an accurate and complete patient record is maintained.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

Regulation 19 (2) Recruitment procedures must be established and operated effectively

The provider must have an effective recruitment and selection procedures which should assess the accuracy of the applications and be designed to demonstrate the candidates suitability for the role, while meeting the requirements of the Equality Act 2010

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
Start here...	Start here...