Soul Care Aesthetics Ltd

Soul Care Aesthetics

Inspection report

Chase House
High Green Court, Newhall Street
Cannock
WS11 1GR
Tel: 01543572838
www.soulcareaesthetics.co.uk

Date of inspection visit: 08 March 2023
Date of publication: 18/04/2023

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 effective?	**Good**
Are services caring?	**Good**
Are services responsive to people's needs?	**Good**
Are services well-led?	**Requires Improvement**

Summary of findings

Overall summary

We had not previously rated this service. We rated it as requires improvement because:

- Managers did not identify, mitigate, or control all risks within the service.
- The service did not follow some of their own policies and the policies were not all aligned with the service.
- Staff did not always action audits and ensure improvements were made.
- Emergency equipment was not checked daily.
- Medicines were not always prescribed or administered in line with national standards.
- Managers did not always have oversight of the issues within the service including poor medicines management, risk management and lack of action from audits.
- Staff had not received safeguarding children's training in line with their policy.
- Staff had not received training on the Mental Capacity Act.

However:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their procedure.
- The service planned care to meet the needs of the patients, considered patients individual needs, and made it easy for people to give feedback. People could access the service when they needed it.
- Staff provided good care and treatment and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available 7 days a week.

Summary of findings

Our judgements about each of the main services

Service		Rating	Summary of each main service
Surgery	Requires Improvement		

Summary of findings

Contents

Summary of this inspection

	Page
Background to Soul Care Aesthetics	5
Information about Soul Care Aesthetics	5

Our findings from this inspection

Overview of ratings	7
Our findings by main service	8

Summary of this inspection

Background to Soul Care Aesthetics

Soul Care Aesthetics is operated by Soul Care Aesthetics Ltd. The service sees patients on a day case basis only, therefore no overnight facilities were present. Facilities included 5 consulting rooms for aesthetic procedures; 1 of which was designated to be used for cosmetic surgery.

The service provided cosmetic surgery for patients over the age of 18; although did offer non-regulated procedures to young people aged 16 to 18. We inspected surgery as a core service.

The service registered with CQC in December 2016. The service has had the same registered manager in post since registration.

The service provided the following regulated activity:

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

Activity – Between August 2022 and February 2023

- The service carried out 253 surgical cosmetic procedures.
- The service has 2 company directors, a clinic manager, registered nurses, operating department practitioner, 2 administration staff and a contracted cleaner.

How we carried out this inspection

We carried out this announced inspection using our comprehensive inspection methodology on 8 March 2023. During the inspection visit, the inspection team, which consisted of an inspector and specialist advisor with oversight of an inspection manager:

- Spoke with the clinic manager, director, consultant surgeon, operating department practitioner and a nurse.
- Spoke with 2 patients.
- Looked at 5 sets of notes.
- Looked at a range of policies, procedures, audit reports and other documents relating to the running of the service.

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 service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The service must ensure that system, processes, and policies are relevant to the service, implemented and monitored (Regulation 17).
- The service must ensure that all risks which are highlighted are mitigated, risk assessed and documented on the risk register (Regulation 17).
- The service must ensure that all medicines are prescribed and administered in line with national guidance (Regulation 12).
- The service must ensure that allergies are documented on the medication charts (Regulation 12).

Action the service SHOULD take to improve:

- The service should ensure that all staff receive safeguarding children's training in line with their policy (Regulation 13).
- The service should ensure that emergency equipment is checked daily (Regulation 12).
- The service should consider training managers at a higher level of safeguarding training.
- The service should consider completing practice emergency scenarios in line with their emergency directives.
- The service should ensure intravenous fluids remain in a locked cupboard (Regulation 12).
- The service should ensure that they audit and monitor the compliance to medicines management (Regulation 12).
- The service should consider using 1 chart in line with their policy to record a patient's pain.
- The service should submit outcome data to the Private Health Information Network in line with the legal requirements set out by the Competition and Markets Authority.
- The service should complete and submit Patient Reported Outcome Measures for all patients who consent both pre- and post-operatively.
- The service should provide training for staff on the Mental Capacity Act.
- The service should ensure that actions found within audits are clearly documented and followed through (Regulation 17).

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement

Requires Improvement

Surgery

Safe	Requires Improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Requires Improvement

Is the service safe?

Requires Improvement

Mandatory training

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

Staff received and mostly kept up to date with their mandatory training. Managers monitored mandatory training and alerted staff when they needed to update it; this was done online annually. Managers gave staff time to complete this within their working hours.

At the time of our inspection 6 out of 8 members of staff had completed 100% of their mandatory training; there was an overall compliance of 85%.

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training included fire safety, moving and handling, infection control, and health and safety.

Safeguarding

Staff understood how to protect patients from abuse. Staff mostly had training on how to recognise and report abuse and they knew how to apply it. However, not all staff had received safeguarding children's training.

Staff received training specific for their role on how to recognise and report abuse. The service had safeguarding processes and procedures in place. At the time of our inspection 7 out of 8 staff were trained to level 2 safeguarding vulnerable adults. The safeguarding lead for the service was the clinic manager; they were trained to level 2. This was not in line with national safeguarding standards which requires at least one person to have level 3 safeguarding training.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. There was an up-to-date safeguarding policy. Staff told us signs of different types of abuse, and the types of concerns they would report or escalate to the safeguarding lead. Staff were able to give an example of when they were concerned about a patient and how they actioned this to keep the patient safe.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Children under the age of 18 did not undergo surgical procedures at this service. Not all staff had

safeguarding children's training. We raised with this the managers who said that this was not a requirement as they did not see children on site. We were told that children were not allowed on site, and if any patients arrived with their children, they were asked to leave and rebook their appointment. However, the safeguarding policy stated that all staff required safeguarding children's training.

The service had an up-to-date safeguarding policy and chaperone policy in place. The chaperone policy stated that all staff needed to have chaperone training; only 1 member of staff had completed this.

Cleanliness, infection control and hygiene

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

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date and completed daily. The service had a cleaner who completed a weekly deep clean including the theatre areas. Staff cleaned equipment after patient contact and labelled it to show when it was last cleaned. The service used "I am clean" stickers and we saw these in use on the day of inspection.

The service performed well for cleanliness. The service completed monthly infection prevention and control audits which included checking the environment, waste disposal and general cleanliness; it was 100% for the last 3 months. They also completed a monthly hand hygiene audit; this was 100% for the last 3 months.

Staff followed infection control principles including the use of personal protective equipment (PPE). We saw that aprons and gloves were worn appropriately and there was adequate stock. Hand sanitiser was available. The theatre had a scrub sink and clinical areas had a handwashing sink and we saw staff wash their hands between contact with patients.

Staff used records to identify how well the service prevented infections. The service had risk assessments and policies for infection prevention and control (IPC). There was legionella policy, daily cleaning check lists, and a clinical local cleaning policy in place.

The service cleaned the theatre daily and between patients. All staff who entered theatre were wearing scrubs. They were not always bare below the elbow. We observed the operating department practitioner (ODP) wearing a watch within the clinical areas. However, it was removed when they washed their hands to start scrubbing for a procedure.

The service had a locked metal Control of Substances Hazardous to Health (COSHH) cupboard where they kept flammable and hazardous items. They had appropriate risk assessments associated with each item.

The service had an autoclave, which was a steam steriliser, to decontaminate all re-usable equipment. All equipment was sterilised by the ODP who had completed training for this. Re-usable equipment was cleaned and re-packaged in line with IPC standards. The service worked towards Health Technical Memorandum (HTM) 01-01 'decontamination of surgical instruments'. Testing of the autoclave was carried out in line with requirements within HTM 01-01. There was no separate 'clean' and 'dirty' room for the processing and decontaminating of equipment. However, as generally only 1 set of equipment was cleaned at a time, the likelihood of cross contamination was reduced.

Both theatres had a portable air conditioning unit which provided the necessary air changes to reduce the chance of infection. It also had a certified ultraviolet light which was antiviral. The air conditioning unit was serviced regularly, and filters were changed when required.

Staff worked effectively to prevent, identify, and treat surgical site infections. Data showed there were 7 suspected infections within the last 12 months prior to inspection. This was a surgical site infection rate of 1.6%; this rate included low suspicion and unconfirmed cases with 2 out of the 7 requiring observation only and no antibiotics. The surgeon told us that they follow national guidelines regarding antibiotic stewardship.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment mostly kept people safe. Staff managed clinical waste well. Staff were trained to use the equipment. However, emergency equipment was not checked daily and risks found were not always acted upon or on the risk register.

The service had suitable facilities to meet the needs of patients and their families. The service consisted of a waiting area, 2 theatres, stock room, 3 treatment rooms, kitchen, bathrooms and a staff area. The waiting area had oversight from the reception desk meaning women and visitors were not left unattended. The stock room was located off the waiting room and was unlocked. It contained intravenous fluids. We raised this at the time of inspection and the fluids were relocated to a locked cupboard immediately.

The service had enough suitable equipment to help them to safely care for patients. However, staff did not always carry out daily safety checks of specialist equipment. The resuscitation equipment was checked on a weekly basis. This meant that there was a risk that it was not fully stocked when required within an emergency. Following our inspection, the service told us that they were completing the checks of the resuscitation equipment daily. All other equipment used within surgical procedures was checked and was within service date and electrical safety tested yearly.

The service had an annual fire risk assessment and fire extinguisher service completed by an external company. They completed an annual practice fire evacuation with the whole team. The service had a log of all maintenance, contracts and equipment within building that needed servicing and maintaining; this was well managed and up to date. The service completed a health and safety audit monthly. It was comprehensive and checked electrical equipment, fire equipment and that annual checks were up to date. However, we saw that in November 2022 the audit highlighted that there were holes within the fire doors and there was no documented action; this was still highlighted within the February 2023 audit with no action. We raised this with the managers who stated that the door was being fixed and it had been raised by the staff member who had completed the audit and discussed within the governance meeting. This was not on the risk register or the fire risk assessment; these were both updated whilst we were on site. The risk register update was brief and did not contain any mitigations for the risk. The mitigation was that this was due to be repaired in March 2023. We were not assured that the service understood the risks and how to mitigate them fully.

Staff disposed of clinical waste safely. Clinical and domestic waste was separated and disposed of appropriately. The service had an external contract for the management of clinical waste.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used National Early Warning Scores (NEWS) observations on all patients and recorded these within the patient's records. We looked at 5 records and saw these were all totalled correctly. The service had a clear process if a patient became unwell or deteriorated during a procedure including contacting the emergency services for an ambulance. There was a policy in place for the transfer of people using the services to the NHS in the event of complications from surgery. There was no service level agreement to transfer ill patients, but the service reported a good relationship with the local NHS hospital.

Requires Improvement

Surgery

All clinical staff were trained in either basic life support level 3 or Immediate Life Support; they were both the same level of life support.

The service did not have a specific criteria for patients to be considered to have their cosmetic procedures. All patients were sent a medical questionnaire to complete before their initial consultation. The surgeon then made a clinical decision regarding a patient's suitability for surgery based on assessment of their medical history and comorbidities and through a verbal discussion during their initial consultation. They also received a pre-operative telephone assessment by the nurse to check their suitability, allergy status, medicines and answer any questions pre-surgery. We were told that if any concerns arose at the pre-operative assessment, they would seek further information from the GP if required. All patients undergoing a surgical procedure were assessed as scoring 2 or under as per the American Society of Anaesthesiologists system for assessing the fitness of patients before surgery. There were no overnight facilities at the clinic. All procedures were performed under local anaesthesia with light sedation if required. The service assessed the patient's risk of bleeding using a modified scoring system. If an abnormal risk score was recorded appropriate action would take place which included injectable blood thinning medication.

Pre-procedure medical assessments enabled the consultant surgeon to consider any psychiatric needs which may impact on the treatment such as body dysmorphic disorder (an anxiety disorder relating to body image). Whilst there was not a specific assessment to identify symptoms of relevant psychiatric conditions, the consultant surgeon demonstrated competency in identifying concerns. We were told that if concerns were identified, the consultant would refer the patient back to their GP for further psychological support and not proceed with surgery. They could also refer the patients for a psychological assessment in they felt this was required. The team had discussed in their August 2022 governance meeting bringing in a mental health screening form pre-operatively but had not yet implemented this.

The staff encouraged patients to stop smoking for 6 weeks prior to and post-surgery.

Patients were given advice about the potential side effects of surgery both written and verbally. They were told who to contact if they became unwell or had any concerns. We were told patients could ring the clinic during opening hours. Each patient was given an out of hours contact number for the surgeon for advice if required.

The service used a surgical safety checklist in theatre based on the World Health Organisation (WHO) recommendations. The WHO surgical safety checklist is a tool used to improve the safety of surgical procedures by ensuring all the theatre operating team conduct the necessary safety checks during the patient's surgical procedure. We observed the WHO checklist being completed well. We found that the WHO Surgical Safety Checklist was completed in all the patient records we reviewed. Staff audited the WHO checklist on the day of surgery and any errors were highlighted to the staff immediately. They also completed an audit of 3 sets of notes every month which included completion of the WHO checklist; we saw these were all completed from December 2022 to February 2023. Following the inspection, the service told us that they were updating their policies in line with the national safety standards for invasive procedures which had been published in 2023. These focussed on changes to the WHO checklist to improve patient safety and team working.

Face to face follow up appointments were scheduled for each patient approximately a week after surgery. In addition, each surgical patient was called the day after surgery to monitor patient progress. If the patient travelled a distance to attend for their surgery, they were advised to stay locally for 24 hours and attend the clinic the following day for a review. The consultant surgeon continued to follow patients regularly for a year post operation.

Staff shared key information to keep patients safe when handing over their care to others. The service completed discharge information for the patient to take away with them, they also informed the patients GP of the procedure that had taken place if the patient consented to do so.

The service told us that due to the low medical needs of the patients, they had not had any emergency scenarios on site. There was an emergency directive which stated that the staff regularly rehearsed emergency procedures. However, when we asked the team if they did practice emergency scenarios, they said that they did not. The managers felt that this was a useful thing to incorporate into their governance meetings and told us they would do this moving forward.

Staffing

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

The service had enough nursing and support staff to keep patients safe. The service employed 1 surgeon, 2 nurses, an ODP, a clinic manager and 2 receptionists. The 2 nurses and ODP worked regular weekly hours assisting in clinic and within theatre. The consultant surgeon, who was also the registered manager, provided medical staffing cover 5 days a week. They were also on call for their patients post-operatively.

The service had low vacancy, turnover, and sickness rates and staff described the team as consistent and stable. They did not use any bank staff.

Each surgical patient was attended to during surgery by a registered nurse or ODP and a consultant surgeon.

All patients were day case patients; there were no handovers required between either nursing or medical staff. The consultant surgeon and nurse remained with the patient until discharge.

The service had recently employed a consultant surgeon with practicing privileges. There was a robust system in place for consultants that are also working within the NHS or within the private sector. The service had a policy in place and collected references and appraisals for the surgeon prior to them operating on site. The consultants were required to complete a practicing privilege application annually. The consultant surgeon monitored their practice through supervision, outcomes, and appraisal documentation.

All staff received an induction to the service. We saw all staff files that we checked had completed checklists and induction booklets.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were paper-based, and all staff could access them easily. All records were kept safe and secure within a locked filing cabinet. All staff were able to access these during the day. We reviewed 5 sets of patient records. We found that they were all complete. They included pre-operative information, surgery notes and consent forms. The consent forms clearly stated the possible risks, complications, and side effects of the specific procedures.

Records were checked by staff after each consultation for completeness and recorded any shortfalls at the time.

The service completed monthly audits of the patient's medical records, where there had been concerns, such as staff not signing documentation, staff were contacted to ensure any errors were rectified. For example, in November 2022, the documentation audit picked up that a member of staff had completed the NEWS incorrectly; this was brought up with them and a teaching exercise was done to ensure full understanding.

Requires Improvement

Surgery

Medicines

The service did not safely prescribe, administer or record medicines safely. However, they were stored safely on site.

Staff did not follow systems and processes to prescribe and administer medicines safely. We looked at 5 medicine charts and they all showed that medicines were not prescribed by a doctor prior to them being given. The medicine chart did not detail the patient allergies, medicine dose or route required. The doctor verbally told the nurse or ODP which medicines to administer and these were documented by the nurse and administered with the surgeon in the room. If patients required medicines to take home, these were not prescribed or dispensed by the consultant surgeon, they were documented by the nurse or ODP and the dose and route were not documented. We raised this on inspection, and they immediately changed their medicine chart to reflect the required standard. We saw evidence that this new medicine chart had since been used for patients and medicines were prescribed and administered effectively. Medicines to take home were checked and given to each patient alongside information about how to take them.

All medicines we checked were in date. Limited quantities of medicines were kept on site at the clinic. These included adrenalin (for liposuction procedures and medical emergencies), local anaesthetic, and analgesia. These were stored appropriately in a locked cabinet located in the surgical procedure clinic room. The ambient temperature was monitored digitally and any out of range results alerted the registered manager via a mobile phone update. This meant that there was always full oversight of the room and fridge temperatures. The key for the medicine's cabinet was held by the registered manager.

Staff checked medicine stock on a weekly basis. Staff reviewed each patient's medicines on pre-assessment and provided advice to patients about their medicines pre and post operatively. For example, patients were advised to stop anti-inflammatory drugs and some vitamins prior to their operation.

Patients were given local anaesthetic only for their operation which was administered by the consultant surgeon. This was an unlicensed solution comprising of 3 medicines prepared by the ODP or nurse. This was drawn out via a 3 way tap for each procedure and stored in a locked fridge for use the following day; this was discarded after 48 hours. There was no policy or protocol for how this solution was stored, managed, and maintained. Following the inspection, the service sent an injectable medicines policy, standard operating procedure for the use of local anaesthetic solution and risk assessments for the use of individual injectables within the clinic. The policies were comprehensive and contained information and references to support the stability of the unlicensed product and its storage for 48 hours; the policies also complied with guidelines and recommendations from the national patient safety agency for promoting the use of injectable medicines.

No controlled drugs were kept on site.

Staff stored and managed all medicines safely. No prescriptions were kept on site. They had a service level agreement with a local pharmacy who managed their medicine stock.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Requires Improvement

Surgery

Staff knew what incidents to report and how to report them. Staff had a good understanding of how to raise concerns and report incidents in line with the incident policy. Staff met to discuss feedback from incidents and there was evidence that changes had been made because of feedback. For example, a patient reacted to sutures and the service informed the suture company and changed their consent forms to reflect that this could happen.

There were 3 incidents within the last 12 months; 2 resulted in cancelled surgery and 1 was a floor within the theatre. These were all fully investigated, and an outcome was shared with the staff within the clinical governance meetings. There were no themes identified through the incident reporting process.

The service had no never events within the last 12 months.

The service had a policy in place for reporting serious incidents, however the service had not had any serious incidents since the service was registered.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The staff could explain the process they would undertake if they needed to implement the duty of candour because of an incident, which was in line with the requirements.

The managers received patient safety alerts and acted upon them when required.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service provided care to patients in line with National Institute for health and Care Excellence (NICE) guidance. The service met cosmetic surgery standards published by the Royal College of Surgeons. The surgeon was a member of the British Association of Body Sculpting (BABS). They met with their peers monthly to discuss outcomes, techniques and to offer support. They submitted data annually to the organisation and looked at complications and outcome measures. The surgeon had also invited members of the BABS to observe their techniques to ensure that they were practising effectively.

The service had a terms and conditions form which all patients completed before their procedure.

The service had a mental health policy in place and patient’s mental wellbeing was discussed during pre-operation checks. Mental health and wellbeing were also discussed with the consultant within face-to-face meetings with the patient. The service shared examples with us of where they had refused surgery due to concerns about a patient’s mental health and had advised them of how they could access additional support.

Nutrition and hydration

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

Patients were not required to be nil by mouth for surgery as it was all performed under local anaesthetic and light sedation if required. The service provided a choice of drinks for patients before and after their surgery. Staff made toast for patients after their procedure if they required.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. However, the pain charts that were used were confusing and not in line with their policy.

Staff assessed patients' pain using 2 different tools; 1 was a tool used for non-verbal patients or children and the other was imbedded with the NEWS observation chart and gave no indication of what the minimum and maximum score was and any associated actions. The policy for pain management stated that they used a pain score from 1-10, however within the NEWS chart, the staff were documenting a score of 0. This meant that it was confusing. However, we observed staff asking patients if they were in pain throughout their procedure and administering pain relief when required. Following our inspection, the service informed us that they were now recording pain only on the NEWS chart.

Staff administered and recorded pain relief, but it was not prescribed by a doctor. This was raised at the time of the inspection and the medication chart was changed to include a prescription box alongside the administration box.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. However, they did not participate in all relevant national clinical audits.

The service did not participate in all relevant national clinical audits. The service did not comply with the Competition and Markets Authority legal requirement to submit private patient episode data to the Private Healthcare Information Network (PHIN). They had issues with the system and had been regularly chasing this up. They had arranged to meet with a representative from PHIN the week after the inspection to enable them to start submitting their data. The service had started to collect information for Patient Reported Outcome Measures for certain procedures. Patients were required to complete a questionnaire prior to and after their surgery. This was required to be submitted to PHIN; the managers were not aware of the requirement to submit this information. They collected it, but they did not use it to look at their outcomes or submit it externally.

The service collected feedback from patients daily, all comments viewed were positive and identified staff by name to thank them. Some of the feedback we reviewed reflected how the surgery had a positive effect on patient's individual morale and wellbeing. We saw the service had received 28 positive reviews for February 2023 and 21 for January 2023; no review was below 4 stars.

Managers and staff carried out a programme of repeated audits to check improvement over time. We saw that most of these had actions which were carried out but not all actions were acted upon. Managers mostly used the information from the audits to improve care and treatment.

The surgeon collected data on their revision rates for each surgery. The surgeon stated that their revision rates were high as they were amenable to revisions to satisfy the patient. They said that they would only perform a revision surgery if they

felt that they could achieve an improved outcome. Their combined revision rate for all their surgery within 2022 was 30%. The surgeon discussed revisions with their peers from the BABS and made amendments to their technique where required. For example, the surgeon had modified their technique in 2021 following a high revision rate for a high facelift. We were told that their revision rate was previously 16.7% and was now 4.6%.

The surgeon was a member of the BABS. This was a group of cosmetic surgeons who all performed body sculpting procedures who met monthly to discuss outcomes, perform peer reviews and complications. Data submitted showed between November 2021 and October 2022 looked at total number of procedures performed, complications of body sculpting procedures, such as uneven contours, laxity of skin, skin discolouration, satisfaction rates and infection. We saw that for this time period, all patients were satisfied with their results. For the high-definition body sculpting procedure, of the 57 performed, there were 13 revisions and 9 of these were classed as severe due to uneven contours; this was the only complication reported for this procedure. However, all patients were reported to be happy with their results.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients. Managers gave all new staff a full induction tailored to their role before they started work. We saw that induction checklists and booklets were completed for all members of staff. All new starters had a period of 12 months on probation.

Managers supported staff to develop through yearly, constructive appraisals of their work. The service ensured that all staff had appraisals. We saw completed appraisals where staff had asked for development, such as a nurse prescriber's course, and this had been arranged.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. The service ensured that regular staff meetings took place and staff were mostly able to attend. Minutes from these meetings were made available for staff to read to ensure consistency with communication.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The service had identified staff who had expressed an interest in further career progression. These staff were supported and enabled to have the time away from their usual duties to undertake this development. For example, the receptionist had expressed an interest in managing the social media for the business. The managers were supportive of this and were funding a course for them to attend.

Multidisciplinary working

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

The service shared examples of when they had liaised with other professionals relating to patient care. If the patient was not physically and mentally fit, then any planned surgery was postponed until the patient had been reassessed and confirmed as fit for surgery. Where, following reassessment, the patient had not been deemed as fit for surgery this was discussed with the patient and the reasons for the service's refusal to undertake surgery clearly explained.

The service liaised with the patients GPs where needed. We were told if they required further information regarding a medical condition, they would contact the patients GP for this and decide on suitability for surgery based on the information given.

Requires Improvement

Surgery

Seven-day services

Key services were available seven days a week to support timely patient care.

The service was open Monday and Tuesday 9am to 6pm, and Wednesday to Friday 9am to 8pm. They were also open 1 Saturday per month 9am to 3pm. The service provided out of hours support to patients on evenings and weekends.

The service had policies in place for the management of a deteriorating patient which included contacting emergency medical services. The service also had established links with their local NHS trust.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support in the service. The service provided health and wellbeing information to patients during the pre-operation assessment discussions. This included advise about the impact of smoking and drinking alcohol on their health.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. However, they had not had up to date training on the Mental Capacity Act.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. However, staff had not completed mental capacity act training. Patients' capacity was assessed by the surgeon informally during the initial assessment. If they felt that they lacked capacity, they did not proceed with booking the patient for surgery.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff had a good understanding of gaining consent from patients before any surgery took place. The service ensured that patients understood the potential impact and risk of their procedure and were given a cooling off period of at least for 14 days between the decision to have surgery and the procedure taking place. Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records. We looked at 5 sets of records and the consent was completed thoroughly within each set of notes.

The service had a mental capacity policy. However, staff did not receive or keep up to date with training in the Mental Capacity Act (MCA). Following our inspection, we saw evidence that all staff had completed their MCA training.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Surgery

Staff were very welcoming when a patient came into the service, drinks were offered on arrival. We observed a surgical procedure where privacy, dignity and respect were maintained throughout.

Patients said staff treated them well and with kindness. Staff followed policies and kept patient care and treatment confidential. Staff understood and respected the individual needs of patients.

Patients were able to have a chaperone for support if required. However, had not all staff had received chaperone training in line with their chaperone policy.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Patient feedback reflect that staff supported patients with anxieties about their surgery and people were made to feel comfortable and at ease before and after their surgery.

Staff and consultants showed empathy to patients when discussions took place relating to their surgery. Staff understood the emotional and social impact that a person's care, treatment, or condition had on their wellbeing and on those close to them. We were told about a patient who they supported after their relative was verbally aggressive within the reception area. The service had a good understanding of the impact of surgery on patients and were involved with patients and those close to them to support their wellbeing.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Staff ensured that patients had the information they needed to make decision relating to their surgery. This was evidenced from the start of the process at the initial consultation where information was gathered, and patients were given time to make decisions about their surgery and ask questions. Staff supported patients to make informed decisions about their care. During the inspection we observed a consultation. Staff gave advice and had an open discussion with the patient, so they were able to make decisions relating to their care.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients were asked to leave feedback which was sent following their appointment via text message. We found that the patients rated the service as mostly 5 stars. We saw over 40 positive testimonials for the service. For example, one review said, "Lovely surgeon, friendly, polite, professional and told me all the information I needed to know and didn't try to push me into anything." Another said "As always, professional, helpful, happy appointment at Soul Care. I would definitely recommend."

Is the service responsive?

Good

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the needs of the patients. Patients could pick the time slot that suited them with a range of appointment times available. There was mostly a 2 week wait for an appointment with the surgeon. There were generally no delays as the service was planned according to the needs of the patients and the length of surgery. This meant that the surgeon could spend the time needed with each patient without causing long delays. The service was open Monday and Tuesday 9am to 6pm, and Wednesday to Friday 9am to 8pm. They were also open 1 Saturday per month 9am to 3pm.

Managers monitored and took action to minimise missed appointments. Managers ensured that patients who did not attend appointments were contacted.

Meeting people's individual needs

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

The service provided private cosmetic surgery care. They did not undertake any surgery on behalf of the NHS or other private providers.

Facilities and premises were appropriate for the services being delivered. There was enough seating in the waiting area and there were several consulting rooms that could be used at one time. All the facilities were located on the ground floor and accessed via a large door. There was a downstairs disabled toilet with a pull cord. The operating table in theatre 2 was adjustable and went low to the ground. Wheelchair users could be seen and operated on within the clinic. There were no manual handling aids within the clinic which meant that patients had to be able to self-transfer pre- and post-surgery.

Managers made sure staff and patients could get help from interpreters or signers when needed. The service did not have a translation service. However, they said that if a patient required a translator, they would ask that the patient brought an independent interpreter along to each booked appointment.

Access and flow

People could access the service when they needed it and received the right care.

Managers made sure patients could access services when needed and received treatment within agreed timeframes and there were no long delays. Surgery was planned with adequate gaps between which reduced delays for patients.

The service did not monitor waiting times as patients were able to book an appointment at a suitable time for them.

The service had previously had issues with surgery being cancelled on the day. They had since introduced payment for the surgery when the pre-operative assessment was taking place. This meant that there was a reduced number of on the day cancellations.

Managers and staff worked to make sure patients did not stay longer than they needed to. The service did not keep patients overnight. They were discharged the same day once they felt well enough after surgery. They were given numbers to call the service if they had any problems post-operatively. They were given a discharge letter which contained information about their surgery, sutures and aftercare required.

The service had a policy and procedure in place for any patients who required transferring to an NHS trust. However, to date this had not been required since the service was registered.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. The service had a process and policy in place for the management of complaints.

The service had received 5 complaints in the 12 months prior to our inspection. They aimed to respond within 20 days. We saw that the complaints had been investigated and responded to. Managers shared feedback from complaints with staff and learning was used to improve the service. For example, a patient was not happy with the results of their surgery following a reaction to the sutures. The service apologised and offered a full refund. They also added this to their consent documentation to ensure that the risk of reacting to sutures was clear.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and discussed them within the clinical governance meetings. This was recorded on the minutes from the meeting, there were discussions relating to complaints and if there were any themes. For example, in February 2023 meeting they discussed 4 complaints; no themes were identified.

Staff knew how to acknowledge complaints and understood the complaints policy. Staff knew how to resolve minor concerns and avoid minor issues escalating into a formal complaint.

Staff could give examples of how they used patient feedback to improve daily practice.

Is the service well-led?

Requires Improvement

Leadership

Leaders generally had the skills and abilities to run the service. They generally understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills.

The service had a staff structure which clearly identified people's roles and areas of responsibility. The clinic was family run and was owned by the consultant surgeon and his wife. The consultant surgeon was also the registered manager, although had recently applied to deregister and the clinic manager had applied to become the registered manager. Both the clinic manager and the registered manager were highly visible within the clinic. Patients were familiar with all staff including management.

The directors and managers mostly had a good understanding of the service and the issues that may arise. During the inspection, we identified issues with the medicines management process, risks and policies. They were very responsive and took immediate action to address some of the issues raised.

The staff told us that directors and managers were visible and approachable to the patients and staff. Staff felt confident to discuss any concerns they had with them and were able to approach their managers directly, should the need arise.

The managers encouraged staff to develop and had examples of where they had supported staff to build on their own confidence and to progress in their roles.

Vision and Strategy

The service had a vision for what it wanted to achieve.

The service aim was to provide a high quality medical and surgical cosmetic service to patients. Their objective was to be a leading provider of cosmetic healthcare services, using the skills and clinical experience of appropriately trained healthcare professionals.

During the inspection, we spoke to the directors of the service, and they reflected on their journey and improvements made within the service. They were very patient focussed and aftercare of the patient was a high priority. They told us that they did not have a strategy to develop the service further as they were happy with the service that was being provided. They did not want to dilute the service with further available procedures. We saw that the business strategy was discussed within their December 2022 governance meeting; this included advertising theatre 1 for external use.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff told us that it was a friendly, open and supportive culture within the service. Staff members worked as a team and socialised outside of work to foster positive relationships. Staff told us that they felt supported, respected and valued. They enjoyed coming to work and were proud to work for the service. Staff referred to their colleagues as 'family'. The staff we met during the inspection were very welcoming, helpful and friendly.

Managers looked after their staff's wellbeing and staff felt managers were supportive to their needs.

Governance

Leaders had a governance process for the service, but it was not always effective. Policies were not always reflective of the service and not always followed and risks were not always identified. However, staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service had service level agreements, and these were well managed.

The service had a process to version control policies and procedures. Records showed policies were regularly reviewed and updated. However, the policies lacked clarity and the service did not always follow their own policies. For example, the chaperone policy stated that all staff members should have chaperone training; only 1 member of staff did. Some policies referred to job titles that did not exist within the service. We raised this with the managers at the time of inspection and they said that they would review all their policies and ensure they were reflective of the service.

The staff completed audits monthly. However, we found that the actions from the audits were not always clear or followed through. For example, the health and safety audit highlighted that the fire door had a hole in it in November 2022 and each subsequent month until February 2023; the action documented was 'there is a hole in the fire doors'. There was no clear action taken each month, no associated risk assessment and it was not on the risk register. We spoke to the managers about this who said that they had arranged for the door to be fixed; they also added the risk to the risk register. However, there were no mitigating actions documented for this risk apart from that the door was being repaired in March 2023. We did see on other audits that actions had been taken. For example, in the building audit, it highlighted that the flooring in reception needed replacing and this was completed in December 2022.

The service held monthly governance meetings. These were chaired by the clinic manager; they had a set agenda which identified what was to be discussed and any actions taken from previous meetings. We looked at meeting minutes between August 2022 and February 2023. We saw that they discussed recent complaints, outstanding actions from the previous meetings and audits. We found that changes were made, and actions were taken. For example, in September 2022, they had a discussion to bring in a pre-operative assessment process; this was implemented immediately, and they have found fewer cancellations following this.

All staff had a good understanding of their role and accountability. All staff received appraisals. The service completed team meetings and staff were given the opportunity to attend; minutes were available if they could not attend.

Management of risk, issues and performance

Leaders and teams generally used systems to manage performance effectively. However, they did not always identify and escalate relevant risks and issues and identify actions to reduce their impact.

The service had a basic risk register in place, but it had not been updated since 2018 and the risks on it were old and lacked detail within the mitigating actions. For example, there was a flood in theatre 2 in July 2022 and the flooring required repair. This had since been repaired and it was still on the risk register. The clinic boiler in 2018 had intermittently broken down, this had been fixed but it remained on the risk register. We were not assured that the managers had a full understanding of the risk register. They completed risk assessments which were comprehensive, had a risk rating and were reviewed annually. There were risk assessments associated to specific surgeries and what could happen and what you would do if a complication happened. However, not all identified risks had an associated risk assessment. For example, the hole in the fire door, which was identified monthly within the health and safety audit, had no risk assessment and was not on the risk register. We were not assured that audits were always used to make improvements and reduce risks.

Managers and staff did not have an awareness of all the risks. A manager told us that their biggest risk was the potential of slips, trips, and falls. We did not feel that they had full understanding or oversight of the risks within the service.

The service had started to collect information for Patient Reported Outcome Measures for certain procedures. Patients were required to complete a questionnaire prior to and after their surgery. This was required to be submitted to PHIN; the managers were not aware of the requirement to submit this information. They collected it, but they did not use it to look at their outcomes or submit it externally.

The surgeon invited independent peers from the British Association of Body Sculpting (BABS) to attend the clinic to observe and appraise their practice and review their results. They wanted peers from different areas to look at the clinic and surgery with a fresh pair of eyes; the aim was to standardise procedures and ensure they were practising effectively. The surgeon had also completed a course on professional behaviours in cosmetic surgery.

Requires Improvement

Surgery

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Data or notifications were consistently submitted to external organisations as required.

The service had arrangements and policies to ensure the availability, integrity and confidentiality of records were in line with data security standards.

Records were paper-based and stored securely. Only staff working at the service were able to access them.

The service had a data protection policy and all staff had 7 out of 8 staff had completed training on data security awareness.

The service completed audits and mostly acted upon actions needed to improve the service.

The service monitored patient results and submitted them to external providers and bodies to appraise their performance and outcomes. These were benchmarked against their peers within the BABS.

The registered managers were aware of how to submit notifications to external providers and there were policies related to this within the service.

Engagement

Leaders and staff actively and openly engaged with patients, staff, and local organisations to plan and manage services.

The service engaged with patients through social media and patient surveys. Surveys were automatically sent to the patients following their appointments. These were discussed with staff and results were displayed within the waiting area. We reviewed results from January and February 2023, and they were all 4 or 5 stars. Comments included "I was put at ease as soon as I arrived" and "Very professional, helpful and happy appointment and Soul Care".

The service had links with the local NHS trust.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The surgeon was a member of the BABS. This was a group of cosmetic surgeons who all performed body sculpting procedures who met monthly to discuss outcomes. They were also setting up their own accreditation scheme to allow them to complete a certification process which is more inclusive of the wide variety of specialities that were performed.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Medicines were not always prescribed or administered in line with national standards.

Regulated activity	Regulation
Surgical procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance • Managers did not identify, mitigate, or control all risks within the service. • The service did not follow some of their own policies and the policies were not all aligned with the service. • Staff did not always action audits and ensure improvements were made. • Managers did not always have oversight of the issues within the service including poor medicines management, risk management and lack of action from audits.