North West Aesthetics Ltd

North West Aesthetics

Inspection report

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
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 rated it as good because:

The service provided mandatory training in key skills to all staff and made sure everyone completed it. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. Staff kept the equipment and premises visibly clean. The equipment and premises kept people safe. The service had enough staff with the right qualifications, skills, training and experience to keep patients safe. The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff gave patients enough food and drink to meet their needs. Staff were competent for their roles and worked well together to benefit patients. Patients could contact the service seven days a week for advice and support after their surgery. Staff supported patients to make informed decisions about their care and treatment. They followed national guidance and ensured that patients gave consent in a two-stage process with a cooling off period of at least 14 days between stages.

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff made reasonable adjustments for patients who accessed the service. People could access the service when they needed it and received the right care. It was easy for people to give feedback and raise concerns about care received.

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Leaders operated effective governance processes, throughout the service. Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact.

However:

The design of the environment did not always follow national guidelines.

Managers monitored the effectiveness of treatment and checked to make sure staff followed guidance but did not have a process to record this.

Patient records were not always comprehensive.

The service was not always inclusive and did not consider the needs of patients whose first language was not English.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good	

Summary of findings

Contents

Summary of this inspection

Background to North West Aesthetics

North West Aesthetics is operated by North West Aesthetics Limited and offers non-surgical aesthetic treatments and hair transplants for private fee-paying adults from a clinic located in Wigan. The premises had a patient reception area and 2 clinic rooms. The service was open Monday to Friday from 9am to 6pm, and 9am to 2pm on Saturdays. The clinic was closed on Sundays. Car parking facilities are available at the rear of the clinic.

The service is registered with the CQC to provide the regulated activities of treatment of disease, disorder or injury and surgical procedures. The service also provides some aesthetic procedures which are not regulated by the CQC. Therefore, at North West Aesthetics we were only able to inspect the services which were subject to regulation.

North West Aesthetics registered with the Care Quality Commission in 2020. The service has had a registered manager in place since initial registration. We have not previously inspected this service.

How we carried out this inspection

We carried out an unannounced inspection of the service. Our inspection team was led by a CQC inspector and included a nurse specialist adviser.

During our inspection we spoke with 5 members of staff, the registered manager and 6 patients.

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 service 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 discussions with people who use the service and all decisions taken are recorded. Regulation 17(2)
- The service must have processes in place to ensure that staff have relevant and up-to-date DBS checks and professional registrations. Regulation 19(1)

Action the service SHOULD take to improve:

- The service should ensure that staff have access to interpretation and translation services and communication aids to support patients whose first language is not English. (Regulation 9)
- The service should ensure it does all that is reasonably practicable to assess the risk of, prevent, detect and control the spread of infections (Regulation 12)
- The service should ensure that there is a process in place for independent review of complaints. (Regulation 16)
- The service should consider training staff to enable them to safely perform the role of a chaperone.

Summary of this inspection

- The service should consider aligning mandatory training requirements to the recommendations of the core skills for health framework.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Surgery

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

Is the service safe?

Good

This is the first time we inspected the service. We rated it as good.

Mandatory training

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

Staff received and kept up-to-date with their mandatory training. The mandatory training was comprehensive and met the needs of patients and staff.

The service had a training log which outlined the training requirements for all staff and the date that training was next due. This log was colour coded so that leaders and staff could easily see when training when next due.

Leaders monitored mandatory training and alerted staff when they needed to update their training. We saw that gaps in compliance were discussed at monthly team meetings and staff were reminded to complete the training as soon as possible.

Data provided by the service showed that compliance rates in February 2023 were:

- First Aid 100%
- Information Governance 86% (one eligible staff member outstanding)
- Medicines Management 75% (one eligible staff member outstanding)
- Mental Capacity Act 86% (one eligible staff member outstanding)
- Coronavirus 100%
- Legionella 100%
- Infection Prevention and Control 100%
- Fire Awareness 100%
- Equality and Diversity 100%
- Autism Awareness 100%
- Learning Disability Awareness 100%
- Deprivation of Liberty Safeguards (DoLS) 86% (one eligible staff member outstanding)

Good

Surgery

The mandatory training requirements were not aligned to the UK core skills training framework. Staff did not receive training in health, safety and welfare, moving and handling, conflict resolution and preventing radicalisation.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

All staff received training specific for their role on how to recognise and report abuse. Managers monitored safeguarding training and alerted staff when they needed to update their training. We saw that gaps in compliance were discussed at monthly team meetings and staff were reminded to complete the training as soon as possible.

Data provided by the service showed that compliance rates in February 2023 were:

- Safeguarding adults' level 1: 100%
- Safeguarding adults' level 2: 100%
- Safeguarding adults' level 3: 85% (one eligible staff member outstanding)
- Safeguarding children level 1: 100%
- Safeguarding children level 2: 100%
- Safeguarding children level 3: 100%

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm, knew how to make a safeguarding referral and who to inform if they had concerns. The service had not made any safeguarding referrals in the last 12 months.

Although the service did not provide care for children, during our inspection, we saw children present in the clinic with adults who had appointments. Staff we spoke with demonstrated understanding of their role in keeping these children safe. All patients who were new to the service were required to complete a pre- consultation form which included age. Staff told us how if they had any doubts about the age of an individual, they would request identification.

The service had policies for safeguarding adults and children dated June 2022 which contained details of how staff could make a safeguarding referral including contact details for the relevant local authority safeguarding team. The policy was comprehensive, outlined staff responsibilities and included information about radicalisation, forced marriage and female genital mutilation. Relevant national guidelines were referenced in the policies and they included some staff training requirements.

The registered manager was the safeguarding lead for the service. They understood their role and responsibilities and knew how to access specialist safeguarding advice if needed.

Information about support for people experiencing domestic abuse was on display in the clinic toilet.

Cleanliness, infection control and hygiene

Good

Surgery

The service did not always control infection risk well. However, 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.

All areas of the clinic were visibly clean and had suitable furnishings which were clean and well-maintained. The service employed a cleaner who attended the clinic daily to clean all areas. We saw completed records of what the cleaner was required to clean which were broken down by room into daily and weekly tasks.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff decontaminating their hands at appropriate intervals and wearing appropriate PPE for clinical procedures.

A handwashing audit had been completed in January 2023 where the hand hygiene practice of all staff was observed. No areas of non-compliance were identified.

Infection prevention and control audits were completed every 3 months. We reviewed the audits from September and December 2022 and saw that the 2 actions identified had both been completed.

All staff had completed training in infection, prevention and control.

Staff completed and recorded monthly temperature checks of water outlets and tap flushing for legionella prevention and management.

The service had an infection prevention and control policy dated June 2022. The policy referenced relevant national guidelines such as Health Technical Memorandum (HTM) 07-01 safe management of healthcare waste and the World Health Organisation (WHO) 5 moments for hand hygiene which staff were expected to follow. The policy also contained information about clinical waste management and sharps injury management.

Surgical instruments used in the clinic were single use and therefore the service did not sterilise any equipment on site.

We observed staff cleaning equipment after patient contact however, there was no process in place for this cleaning to be recorded.

The service did not collect information from patients about blood-borne viruses. Therefore, there was increased risk to the individuals performing procedures who may have exposure to blood and bodily fluids.

We saw the service only had 1 mop which was used for all areas of the clinic and was not colour coded in line with best practice guidelines and the service infection prevention and control policy. In addition, there was no evidence of the mop head being changed regularly and the mop was not stored in line with best practice recommendations. In addition, the service had a brush which was not in line with the service infection prevention and control policy.

Environment and equipment

The maintenance and use of facilities, premises and equipment kept people safe however the design of the environment did not always follow national guidelines. Staff managed clinical waste well.

The service had enough suitable equipment to help them to safely care for patients.

Good

Surgery

Staff disposed of clinical waste safely. We observed staff safely disposing of clinical waste. Clinical waste was stored securely whilst awaiting collection. The service had a contract in place for the safe disposal of clinical waste and maintained a record of consignment notes from the contractor.

All electrical equipment in the clinic had been portable appliance tested (PAT).

There was an emergency pull cord in the patient toilet and staff completed and recorded weekly checks to ensure this was working.

The service had an automated external defibrillator (AED) in the clinic. Staff completed and recorded regular checks of the equipment including the AED pads.

The first aid kit in the clinic was checked monthly by staff and any replacements for out of date stock were recorded on a monthly record log.

All cleaning chemicals were stored in a locked cupboard in the bathroom. The cleaner for the service had completed training in the control of substances hazardous to health (COSHH).

All staff had received training in fire safety. All fire safety equipment in the clinic, including fire alarms and extinguishers, had been serviced by an external provider. Staff also completed weekly visual inspections of fire alarms and fire doors, and monthly visual inspections of fire extinguishers.

A fire drill had been completed in August 2022 with no concerns identified.

A fire risk assessment had been completed in August 2022. Two actions had been identified and both had been completed in a timely manner.

The service had a safe healthcare environment policy dated June 2022. The policy outlined staff responsibilities in relation to maintaining a safe environment and referenced relevant national guidelines and legislation such as the Health and Safety at Work etc Act 1974.

The service has a policy for safety and suitability of equipment dated June 2022. The policy included staff responsibilities and equipment servicing requirements.

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. The service made sure patients knew who to contact to discuss complications or concerns.

All patients who requested treatment were booked in for an initial consultation. Staff told us about situations where patients may be assessed as not suitable for a procedure. However, these decisions would be based on clinical judgement as the service did not have formal inclusion or exclusion criteria. In these instances, patients would be offered other suitable treatments or be directed to another service.

No procedures were carried out under general anaesthetic or intravenous sedation. Local anaesthetic was used for patients who required it.

Good

Surgery

We observed patient consultations and reviewed patient records. We found that staff carried out relevant assessments of patients to make sure they were suitable and fit for procedures. We also saw that staff monitored patient observations before and during procedures and recorded these accurately.

All patients received follow up appointments at set timeframes dependant on the procedure.

The service provided patients with written after care information when they left the clinic. The information included a telephone number so they could contact a clinician 24 hours per day, 7 days per week if they had any concerns.

The service had a policy for the management of sepsis which was dated June 2022. The policy referenced relevant national sepsis guidelines and included sepsis screening tools. The policy stated that it was the responsibility of individual staff members to ensure they had the relevant knowledge and understanding required around the subject of sepsis. At the time of our inspection, sepsis training was not included in the staff mandatory training requirements and we did not see that any staff had undertaken any sepsis training.

The service had a policy for medical and clinical emergencies dated June 2022. The policy outlined staff responsibilities in an emergency and included the Resuscitation Council UK guidelines for adult and paediatric basic life support.

The service had a policy for patient transfer to the NHS dated June 2022. The policy outlined staff responsibilities if a patient became unwell or deteriorated. In addition, there was a policy for sharing care and treatment which contained details about when patient information could be shared with other healthcare providers and how this must be done in accordance with national guidelines and legislation.

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. Managers regularly reviewed and adjusted staffing levels and skill mix and gave staff a full induction.

The service had enough staff to keep patients safe. All staff worked set days in the clinic. The clinic appointments were arranged dependant on the availability of staff to ensure that patients were safe. For example, at the time of our inspection, the number of hair transplant appointments had been reduced as 1 hair technician was on maternity leave.

Any planned absences were monitored by leaders and covered by existing staff or appointment availability was reduced to maintain safety.

The service had no vacancies.

The service did not use any bank or agency staff.

All staff had received an induction and staff said the induction was helpful and tailored to their needs.

The service had a staffing policy dated June 2022. The policy outlined the process and responsibilities for determining safe staffing numbers, induction and appraisal requirements for staff.

Records

Staff kept records of patients' care and treatment however these were not always detailed. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Good

Surgery

Staff could access patient records easily.

Records were stored securely. At the time of our inspection, the service was in the process of moving from paper to electronic records. This was being done in a staged process to ensure that it was done safely.

The service had a record keeping policy dated June 2022 which outlined staff roles and responsibilities in relation to record keeping.

Discharge letters were not provided to patients or shared with patients' GPs. However, all patients had access to a 24-hour telephone line where further advice and information could be obtained if needed.

Not all records were comprehensive. Initial patient consultations were not always recorded and therefore the information provided, discussions about fees and care plans were not always available. However, documentation of procedures and follow up appointments was comprehensive and accurate. When antimicrobials were prescribed, the clinical indication, dose and duration were recorded.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff completed medicines records accurately and kept them up-to-date. We reviewed patient records and found that medicine prescriptions and administration were recorded clearly and accurately. Allergies were recorded for all patients.

All prescriptions were documented in a record book and signed out by the prescriber and another member of staff. Although the service did not perform any formal audit of prescribing, the record book meant that all prescriptions could be easily tracked to individual patients and stock numbers were monitored closely.

Staff learned from safety alerts and incidents to improve practice. The service was subscribed to safety alerts and these were delivered to a central mailbox to ensure they were reviewed regardless of staff absence. Actions taken as a result of safety alerts were recorded.

Staff involved in handling medicines were required to complete training in medicines management.

Staff performed monthly stock checks of the medicines which were held on the premises. This included a check of expiry dates. We saw the records of these checks for the last 6 months and no issues were identified.

Staff returned out of date medicines to a local pharmacy for safe disposal. The service kept records of the medicines that were destroyed, these included the signature of the individual who accepted the medicines at the pharmacy.

The service had 2 fridges. Fridge temperatures were checked daily by staff. The expected temperature range was included on the form and staff we spoke with demonstrated they understood what action to take if the temperature was outside of the required range. We reviewed records and saw there were no temperature breaches.

One member of staff was registered with the Nursing and Midwifery Council (NMC) as a non-medical prescriber. However, they did not prescribe any medicines in their role in this service.

Good

Surgery

The service had a policy for antibiotic usage dated June 2022. The policy referenced relevant up-to-date national guidelines such as the National Institute for Health and Care Excellence (NICE) guidelines for surgical site infections and included information about antimicrobial stewardship. However, although the policy directed staff to use an antibiotic formulary, it did not outline which formulary should be used.

The service had a medicines management policy dated June 2022 which referenced relevant guidelines and legislation such as The Human Medicines Regulations 2012. The policy outlined staff responsibilities for ordering, receiving, storing, administration and disposal of medicines.

The service had a policy for medicines prescribing dated June 2022. The policy outlined staff responsibilities in the safe prescribing of medicines and referenced relevant national guidelines and legislation.

No controlled drugs were stored or used by North West Aesthetics.

The service did not have any provision in place for pharmacy support.

Incidents

The service managed patient safety incidents well. Staff understood how to recognise and report incidents and near misses. Processes were in place for investigation of incidents and sharing lessons learned with the whole team. When things went wrong, staff understood their role in applying duty of candour. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff and leaders demonstrated they understood their role in applying duty of candour.

Staff had not received training about incident reporting. However, staff we spoke with demonstrated a good understanding of identifying and reporting incidents and near misses.

We reviewed the service incident log and saw there were no incidents reported in the last 12 months.

The registered manager told us that incidents would be discussed at monthly team meetings, however, as there were no incidents, we were not able to see any evidence of this. In addition, there was no standard agenda for team meetings.

Although we were not able to review any incident investigations or see any lessons learnt, the inspection team observed the open nature of the staff and leaders and how they all demonstrated that patient care and safety was their priority.

The service had a duty of candour policy dated June 2022. The policy outlined staff responsibilities in applying duty of candour and referenced relevant national guidelines and regulations.

The service had a policy for significant events, adverse events and near misses dated June 2022. The policy included definitions of incidents, the roles and responsibilities of staff and referenced up-to-date, best practice national guidelines and legislation. A blank incident reporting form was also included in the policy.

The service had an effective process in place for monitoring of safety alerts received through the Central Alerting System.

Is the service effective?

Good

Surgery

Good

This is the first time we inspected the service. We rated it as good.

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 but did not have a process to record this and any feedback given to staff.

All the policies within the service were in date and referenced up-to-date national guidelines or legislation.

All staff knew how to access policies.

During our inspection we saw staff delivered care and treatment in line with national guidelines and that leaders and staff were keen to ensure that they were providing safe and effective care.

The registered manager was a member of the British College of Aesthetic Medicine (BCAM) and the British Association of Hair Restoration Surgery (BAHRS). This membership provided access to a large network of colleagues in the Aesthetic industry and up-to-date clinical trends and guidelines.

Although leaders informally monitored practice, this was often not recorded. For example, the registered manager told us they regularly reviewed consent forms to ensure they were fully completed. However, this process was not recorded.

Nutrition and hydration

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

During our inspection, staff offered every visitor to the clinic drinks on entry and during their stay.

Patients who underwent lengthy procedures such as hair restoration surgery were offered a choice of food when they arrived in the clinic and staff ordered food in to meet the needs and preferences of the patient.

Patients told us they were offered drinks every time they attended the clinic and that staff were focused on supporting the wellbeing of patients.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

We observed staff assessing patients' pain during procedures and saw that they took appropriate action to manage pain.

Patients told us that during procedures, staff monitored their pain levels and administered treatment when needed. They also said that staff gave helpful aftercare advice to manage pain and discomfort.

Patient outcomes

Staff monitored the effectiveness of care and treatment but did not have a system in place to demonstrate their oversight of this.

Good

Surgery

The registered manager, who was also the only Doctor at the service, did not formally collect, monitor or audit patient outcome data. However, each patient attended a follow up appointment where surgical outcomes and any complications such as infections were recorded in patient notes. The service had not experienced any surgical complications, poor outcomes or post-operative infections in the last 12 months. In addition, the service had not made any referrals to NHS services for complications or emergencies.

In 2022, the service completed an audit of transection rates. In hair transplant surgery, transection is the accidental cutting or harming of the hair graft. The British Association of Hair Restoration Surgery (BAHRS) consider a transection rate of below 10% acceptable but recommend that surgeons should aim for less than 5%. The audit showed a partial transection rate of 2.9% and a total transection rate of 1% which was much better than the recommended standard.

We did not see that any other clinical audit had been performed by the service and staff were unable to tell us of the results of any audits.

The service did not participate in any national accreditation schemes, benchmarking or audits. The service did not submit data to the Private Healthcare Information Network (PHIN).

All patients we spoke with were happy with the outcome of the treatments they had received.

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 however, this was not always done in a timely manner.

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.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers made sure staff received any specialist training for their role. Staff who performed clinical procedures had undertaken formal training in sclerotherapy, hyperhidrosis treatment and hair restoration surgery.

There is currently no mandatory accredited training requirement for hair transplant surgery in the UK. However, a General Medical Council (GMC) licensed doctor must perform the surgical steps of the procedure. The doctor who performed hair transplant procedures at the clinic was GMC registered. The Cosmetic Practice Standards Authority (CPSA) recommend that doctors who perform hair transplant procedures complete specialist training and apply to be added to the GMC specialist register. The doctor was not on the specialist register. However, all staff who took a part in hair transplant surgery had taken part in training and observed practice.

One registered clinician who worked for the service was registered with the Aesthetic Complications Expert (ACE) Group. This registration provided access to new, evidence-based guidelines, help and advice for practitioners, training, workshops and journal articles.

The surgeon did not hold Royal College of Surgeons (RCS) certification but was a member of BAHRS and BCAM.

Good

Surgery

The service had a process for the management of concerns about staff performance or competence which was outlined in the quality management and good governance policy. When we spoke with staff and leaders, they understood their responsibilities if any concerns about staff competence or performance were identified. In addition, some staff had additional jobs in other services. The registered manager had the details of the employers so that any serious or immediate concerns about competence and safety could be shared.

The 2 clinicians working for the service were appropriately registered with the General Medical Council (GMC) or the Nursing and Midwifery Council (NMC) and were up-to-date with revalidation requirements.

During our inspection, we were told that staff received appraisals at least every 12 months, and these were recorded and included areas for development. The appraisal form included opportunities for development and areas for improvement. Following our inspection, we requested appraisal data from the provider. Of the staff eligible for an appraisal, only 50% had received an appraisal in the last 12 months. However, staff told us that they had informal daily discussions with the registered manager.

Multidisciplinary working

Staff worked together as a team to benefit patients. They supported each other to provide good care.

During our inspection, we observed staff groups with different skill sets carrying out assessments and consultations together to ensure a multidisciplinary approach to patient care.

Staff met regularly to discuss patients and improve their care.

All patients we spoke with told us that they thought staff worked well together to provide good care.

Seven-day services

Patients could contact the service seven days a week for advice and support after their surgery.

The clinic was open Monday to Saturday and closed on Sundays. The opening hours of the clinic had recently been extended to provide some appointment availability after 5pm.

The service offered an aftercare helpline 24 hours per day, 7 days per week staffed by the clinical staff in the service for patients who had undergone procedures and may be concerned or need further advice.

Health promotion

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

Staff collected information about lifestyle during initial consultations to allow them to tailor the advice given to patients. Health promotion advice was included on the aftercare sheet provided to patients after a procedure.

Some information leaflets about healthy lifestyle were on display in the clinic.

Staff demonstrated they understood the importance of a healthy lifestyle in relation to the care and treatment that they were providing.

Good

Surgery

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 and ensured that patients gave consent in a two-stage process with a cooling off period of at least 14 days between stages. They understood how to support patients.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff made sure patients consented to treatment based on all the information available. All patients we spoke with said they were given enough information to enable them to make informed decisions and that they were given a cooling off period of at least 2 weeks before attending for treatment.

The service had a consent policy dated June 2022. The policy contained relevant information about written and verbal consent, capacity to give consent and withdrawal of consent, and referenced relevant national guidelines.

The service had a mental capacity policy dated June 2022. The policy referenced relevant guidelines and legislation such the Mental Capacity Act 2005.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and the Mental Capacity Act 2005 and they knew who to contact for advice.

All staff were required to complete and kept up-to-date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS).

Staff demonstrated good understanding in consent processes. This included the need for an appropriate cooling off period in accordance with the Cosmetic Practice Standards Authority to allow patients to consider the information they were given at their initial consultation before going ahead with any treatment.

Is the service caring?

Good

This is the first time we inspected the service. We rated it as good.

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.

The reception area was open which meant that conversations could be overheard by other patients in the waiting room. However, we observed staff taking patients who wished to speak privately or have sensitive conversations into the clinic room to maintain privacy and confidentiality.

Good

Surgery

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for all patients.

The clinic room doors were made of frosted glass. During intimate procedures, we saw that staff also used temporary screens in front of the doors to maintain the privacy and dignity of patients.

The clinic reception had music playing during opening hours which reduced any risk of patient consultations in clinic rooms being overheard.

The service had a dignity and respect policy data June 2022 which outlined how staff were expected to treat patients, visitors and other staff members. The policy included relevant legislation such as the Equality Act 2010 and took account of protected characteristics.

All patients we spoke with said that staff treated them with kindness and respected their privacy and dignity.

Emotional support

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

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 observed staff providing appropriate support to patients who were emotionally distressed.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

All patients we spoke with said that staff were compassionate and supported their emotional needs.

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. We observed patients and relatives being provided with relevant information during consultations.

Patients told us how they found staff to be very knowledgeable and that they were always supported to make informed decisions about their care and treatment.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The service carried out patient satisfaction surveys and patient outcome surveys to gather feedback. Patients could also leave online reviews for the service.

The service provided each patient with terms and conditions which clearly outlined fee structures and timescales, and information about how to raise concerns or complaints.

All the patients we spoke with gave positive feedback about the service.

Good

Surgery

Is the service responsive?

Good

This is the first time we inspected the service. We rated it as good.

Meeting people's individual needs

Staff made some reasonable adjustments to help patients access services, however the service was not always inclusive.

The service worked with a wide variety of patients and staff said there were no adult groups or protected characteristics they would not consider for treatment.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

All staff were required to complete training in Autism awareness and Learning Disabilities.

The registered manager had plans to replace the current autism awareness training with the newly introduced Oliver McGowen training module.

Staff demonstrated a good awareness of protected characteristics.

All areas of the clinic were accessible for wheelchair users or those with mobility difficulties.

Staff had received inhouse training in assessing the psychological needs of patients. Staff demonstrated a good understanding of their responsibilities and knew how to respond to patients who may need further support. We saw examples where staff had been concerned and had acted appropriately.

The service did not have a policy for access to translation and interpretation services for patients whose first language was not English. The registered manager had access to a telephone interpretation service for patients whose first language was not English. However, not all staff knew how to access this service. In addition, the service did not have access to services to support patients whose first language was British Sign Language (BSL).

Access and flow

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

Managers monitored waiting times and made sure patients could access services when needed. The service also held a cancellation list so that patients had the opportunity to be seen sooner if an appointment was cancelled.

We asked the service for the number of appointments they cancelled for non-clinical reasons in the last 12 months, but this information was not collected. They did monitor how many appointments were cancelled or not attended by patients. The service had introduced a text appointment reminder 24 hours prior to appointments for all patients. Staff told us that this had reduced the number of patients who did not attend their appointment.

Good

Surgery

All patients who received treatment in the clinic received a follow up appointment. The timescale of this was dependant on the procedure. In addition, staff gave patients a contact number which they could call 24 hours per day 7 days per week if they had any concerns.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service had a process in place to treat concerns and complaints seriously, investigate them and share lessons learned with all staff. The service did not have a system for referring unresolved complaints for independent review.

The registered manager, who was responsible for managing complaints, had completed training in complaints management. Staff we spoke with had a good understanding of the complaints processes within the clinic and how to manage a complaint.

Patients, relatives and carers knew how to complain or raise concerns. Complaints information was on display in the reception area. This included complaint forms and a box where patients could submit complaints or feedback. The terms and conditions provided to patients included information about to provide feedback and how to make a complaint.

We reviewed the complaints log for the last 6 months and saw that the service had received no complaints.

The service had a policy for the management of complaints dated June 2022. The policy outlined the process for making a complaint, how they should be recorded and timescales for responses to complaints. The policy stated that unresolved complaints could be escalated to the Cosmetic Redress Scheme for independent review. However, following our inspection, we identified that the service was not a member of the Cosmetic Redress Scheme. We discussed independent review of complaints with the registered manager and they were not able to tell us how this would be accessed.

Is the service well-led?

Requires Improvement

This is the first time we inspected the service. We rated it as requires improvement.

Leadership

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

Throughout our inspection, the registered manager demonstrated they had the skills and ability to run the service. They understood and managed the priorities of the service and any issues which arose.

All staff spoke very highly of the service leaders and how approachable and visible they were.

The service had a fit and proper persons: directors policy dated June 2022. The policy outlined the information the service was required to hold on file for each director which was aligned to regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We reviewed the documents which were held on file by the service and found that all required documents were available.

Good

Surgery

The registered manager had a deputy if they were unavailable to ensure that leadership and governance was maintained. In addition, the service had recently employed another registered clinician so that clinical activity and oversight could also be maintained.

Vision and Strategy

The service had a vision for what it wanted to achieve but did not have a strategy to turn it into action.

The service had a mission statement and 5 key objectives which was on display in the clinic. The registered manager told us this was recently reviewed to ensure it was still current.

Not all staff were aware of the mission statement and objectives, but they all spoke passionately about providing safe, patient centred care and we saw they demonstrated this during our inspection.

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.

All staff that we spoke with said they felt supported and valued by service leaders and other staff. They told us they felt able to speak up if they had any concerns. During our inspection, we observed the respectful and supportive relationship between the staff and leaders present in the clinic and how they worked very well together for the benefit of patients. All staff told inspectors how much they enjoyed working for the service.

Staff we spoke with said they felt equality and diversity were promoted within the service and that all staff were treated fairly and equitably.

The service had a policy for the management of bullying and harassment dated June 2022. The policy outlined how staff could raise concerns and how these would be managed by the clinic manager or medical director.

The service had an equality and diversity policy dated June 2022. The policy outlined how the service promoted equality and diversity and was committed to providing an inclusive environment and culture for all patients, visitors and staff. The policy included roles and responsibilities for all staff in relation to recruitment and every day working in the clinic and referenced relevant legislation.

The service had a policy for fees dated June 2022, which outlined how patients should be informed of fees and when they were expected to pay. The policy outlined processes which staff must follow to ensure they provided patients with the necessary information about payment. During our inspection, we saw all patients were entitled to a free initial consultation so that they could make an informed choice before receiving with a treatment.

Governance

Leaders did not always operate effective governance processes, throughout the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss the performance of the service.

The processes in place to govern the service were well organised and all staff had an awareness of these processes. Although we saw that staff followed processes to keep people safe, the registered manager was not always able to demonstrate how they maintained oversight of this.

Good

Surgery

Although both clinical staff members were appropriately registered with the relevant regulatory body, evidence of this was not available on the day of our inspection and leaders did not have a formal process or policy for regularly checking the registration status of these individuals.

We reviewed patient records and observed patient consultations. We saw that staff obtained patients' consent appropriately. However, staff did not always record the details of initial patient consultations comprehensively. Therefore, the registered manager was not able to demonstrate how they were assured that records were comprehensive or that consent was obtained appropriately.

The service had an audit programme which was planned out for a 12-month period and each audit was allocated to a staff member. However, the planned audits were checklists, such as legionella tap flushing and AED checks, rather than audits to measure performance against a local or national standard. As the registered manager was the only Doctor in the service, we saw they were often monitoring standards but not recording this in the format of an audit. For example, the Doctor reviewed all hair transplant patients post operatively and documented any complications or infections in the patient's records. Therefore, although there was no formal audit of complications or infection rates, they were able to demonstrate there were no infections or complications in the last 12 months.

At the time of our inspection, the registered manager told us they did not have any formal key performance indicators (KPIs). However, following our inspection, some KPIs were identified for the next 12 months which included monitoring of patient outcomes.

The service had a chaperone policy dated June 2022. The policy outlined the role of the chaperone and situations when a chaperone should be considered. The policy also stated that chaperones should have had training to understand the role expected of them. Although staff that we spoke with demonstrated an understanding of who could act as a chaperone, we did not see that any staff had been offered or had undertaken chaperone training.

The registered manager held monthly team meetings and invited all staff to attend. We saw the registered manager circulated meeting minutes to all staff after the meeting. We reviewed team meeting minutes and saw leaders reminded all staff to complete required training and regular tasks such as fridge temperature checks. As there were no incidents or complaints prior to our inspection, we did not see evidence staff discussed these during meetings and there was no standard agenda template. However, staff and leaders we spoke with reported an open culture where they would discuss any concerns. All staff were able to access policies easily. Policies were stored electronically but up-to-date paper copies were also available in the clinic in the event of an IT or power failure.

The service had a comprehensive list of policies and all policies were in date and had planned review dates. All policies contained version control to enable staff to see what changes were made when polices were updated.

The service had a policy for quality management and good governance dated June 2022. The policy referenced relevant national guidelines and legislation.

The service had a whistleblowing policy dated June 2022. The policy outlined staff responsibilities and the process for raising concerns internally and to external regulators.

All staff were clear about their roles and responsibilities within the clinic and where they could find further information or support if needed.

Good

Surgery

Management of risk, issues and performance

Leaders did not always identify and escalate relevant risks and issues and identify actions to reduce their impact. They had some plans to cope with unexpected events.

The service had a business continuity plan dated June 2022. The policy outlined the procedures which staff should follow in the event of unexpected events such as staffing shortages, IT failure or failure of electrical supply. However, throughout the policy there were sections for important telephone numbers such as electricity, gas and water suppliers but these sections were all blank. Therefore, in the event of an emergency, there was a risk staff would not know who to contact which would cause unnecessary delay and risk.

There was no back-up generator available in the event of a power outage so some procedures would not be able to continue. The registered manager told us that they had recently ordered a new extractor which was portable and chargeable which would mean that hair surgery would not be affected by a power outage.

The design of the environment did not always follow national guidance. The clinic room where hair transplant surgery was performed did not have appropriate ventilation in line with Health Technical Memorandum (HTM) 03-01. The room did not have a ventilation system and windows could not be opened.

An enhanced Disclosure and Barring Service (DBS) check had been carried out for all staff who worked for the service. However, we saw that an existing DBS certificate dated 2017 had been accepted for a new member of staff. The registered manager did not have a process in place to ensure staff had up-to-date DBS checks.

There was no formal process in place for the clinicians in the service to take part in peer review or to receive any feedback on their clinical performance outside of the GMC and NMC revalidation process.

We reviewed the service's risk register. All the risks that had been identified were graded in terms of likelihood and consequence in line with the service's risk assessment policy. Each risk had identified control measures, a named responsible person and a date for review. All risks were recently reviewed, and any changes were documented.

The service contracted an external provider to perform annual health and safety risk assessments in the clinic. The last assessment was completed in August 2022 and the overall risk level was recorded as low. All identified actions were complete. In addition, staff also completed a health and safety checklist each month to ensure standards were maintained. These included cleanliness, lighting, fire safety, electrical safety and the control of substances hazardous to health (COSHH). We saw these were fully completed for the last 6 months and no issues were identified.

The service contracted an external provider to perform an annual legionella risk assessment. The last assessment was completed in September 2022 and no areas of non-compliance were identified.

All staff had completed a display screen equipment (DSE) risk assessment to ensure they could safely use the DSE within the service.

The service had a risk assessment policy dated June 2022. The policy outlined the process for risk identification, assessment, mitigation and ongoing monitoring. There was a clear structure for risk grading to support staff and leaders to understand which risks were greater than others.

Good

Surgery

Information Management

The service collected reliable data. Staff could find the data they needed, in easily accessible formats. The information systems were integrated and secure.

At the time of our inspection, the service was moving across from paper patient records to electronic records. The registered manager told us how this process was staged to ensure that all staff were trained in the use of the new system and that it was introduced safely.

All paper and electronic records were stored securely.

All staff were required to complete training in Information Governance.

The service was appropriately registered with the Information Commissioners Office (ICO).

The service had a policy for the safe handling and disposal of staff and patient records in the event of business closure. The policy was in date and outlined how records would be managed if the business ceased trading, or it was purchased by another provider.

The service had a data retention policy dated June 2022 which outlined processes relating to data storage, retention and disposal. The policy referenced relevant regulations such as the General Data Protection Regulation (GDPR). The service also had 2 separate GDPR policies for staff data and patient data. In addition, the service had an information governance policy dated June 2022 which contained information about Caldicott principles and the ICO.

Engagement

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

The service collated patient feedback in the form of two questionnaires; a patient satisfaction questionnaire and a patient outcome questionnaire. We reviewed the results of the December 2022 questionnaires. The service scored highly in terms of satisfaction and outcomes and patients described the service as above expectation.

Leaders told us they had not carried out a staff survey. However, all the staff we spoke with told us of the supportive and open relationship they had with service leaders and how they felt able to speak up and make suggestions for service improvement when needed. In addition, we saw the registered manager collected and recorded staff suggestions and opinions during team meetings.

The registered manager had engaged with other services in the local area which offered other procedures to patients. During our inspection, we saw patients being directed to these services when they needed or wanted procedures which were out of scope of this provider.

The service had a policy for acting on feedback which was dated June 2022 and outlined how patient satisfaction data was collected.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services, but leaders had no plans in place for future improvements.

Good

Surgery

Although we saw throughout our inspection that leaders and staff were open to learning and improvement, we did not see that any plans were in place for future learning or quality improvement.

Staff told us they were encouraged by leaders to share ideas for service improvement.

Staff had not received training in quality improvement.

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 Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The service did not always carry out regular checks to ensure that employees were off good character and that, when required, they had up to date registrations with professional bodies.

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service did not always maintain accurate, complete and contemporaneous records in respect to each service user, including decisions taken in relation to the care and treatment provided.