Ziering London Clinic

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	**Requires improvement**
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Requires improvement**

Overall summary

Ziering London Clinic (One Health) is operated by Curis Healthcare Limited. Facilities include one main theatre, two clinic rooms used for hair transplant operations, consulting rooms, a two-bedded recovery area and a three-bedded ward with overnight stay facilities.

The service provides cosmetic surgery such as breast enlargement and hair transplants, as well as non-surgical interventions.

The service was inspected three times before, in February and March 2018 and on 12 June 2019. During the June 2019 inspection, we served a warning notice and identified breaches in Regulation 12(Safe Care and Treatment)and Regulation 17(good governance)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.We inspected this service using our focused inspection methodology to re-inspect the safe and well-led domains only to determine if improvements had been made. We looked at processes around mandatory training, infection control, environment, culture and leadership. We carried out the unannounced focused inspection on 30 October 2019.

Summary of findings

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

Services we rate

Our rating of this hospital stayed the same. We rated it as Requires Improvement overall. Our rating for safe and well led stayed the same as requires improvement. Our rating for effective, caring and responsive remain unchanged as these domains were not inspected this time.

At the last inspection in June 2019 we identified following actions the provider must take to meet the regulations:

- The provider must have systems to monitor staff compliance with mandatory training.
- The provider must ensure there are effective systems to control infection risk well.
- The provider must ensure there are effective systems to safely record and store medicines, including controlled drugs and emergency medicines on resuscitation trolleys.
- The provider must have effective systems for the maintenance of facilities, premises and equipment to keep people safe.
- The provider must ensure they are auditing their compliance with Association of Anaesthetics of Great Britain and Ireland (AAGBI) and Association for Perioperative Practice (AfPP) guidance for nursing and theatre staffing.
- The provider must ensure leaders have effective governance systems in place.
- The provider must ensure practising privileges are reviewed according to their policy.
- The provider must review the safeguarding policy to reflect the requirements of the Care Act 2014 (Chapter 14) statutory guidance.
- The provider must ensure there are regular and effective staff meetings or forums to support staff.
- The provider must ensure there is an open reporting culture in relation to incidents and shared learning from complaints and incidents.
- The provider must ensure it is meeting requirements under Regulation 20 (Duty of Candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in June 2019 we identified following actions the provider should take to make improvements in relation to safe and well-led:

- The provider should embed a culture of using the World Health Organisation (WHO) Surgical Safety Checklist in a meaningful way for all surgical procedures, including hair transplant procedures.

  The provider should have effective systems for disposal of medicines.
- The provider should amend the admission policy to reflect what senior staff reported on the day of inspection regarding body mass index (BMI) limits for patients treated at the clinic.

At this inspection, we found following areas the provider still needs to improve:

- Not all premises were visibly clean, and we found dust on high surfaces. The provider did not monitor the standards of cleaning carried out by the external company. However, the service had made improvements to control infection risk since our last inspection and had strengthened their own systems for the maintenance of facilities, premises and equipment within the theatre.
- Although there was now a functioning medical advisory committee (MAC) and the provider had reviewed the practising privileges of all doctors, they still did not follow their own policy and reviewed these outside of the MAC.
- Leaders had re-established governance processes which operated throughout the service. However, we were unable to comment on the effectiveness of this system as it was at an early stage of implementation. We were also concerned the registered manager may not have sufficient allocated time to focus on governance and operational duties.

However, we found provider had made improvements in the following areas:

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

Summary of findings

- Staff understood how to recognise and report abuse. Since the last inspection, staff had received training on safeguarding adults and children level two. The provider had updated the safeguarding policy which reflected the requirements of the Care Act 2014 (Chapter 14) statutory guidance.
- Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction. The provider had assessed compliance with Association for Perioperative Practice (AfPP) and Association of Anaesthetics of Great Britain and Ireland (AAGBI) guidance. All staff had in-date basic life support training (level two) and five staff had immediate life support training.
- The service now used systems and processes to safely record and store medicines.
- The service managed patient safety incidents well. Staff recognised incidents and near misses but did not always report them or grade them appropriately. Managers investigated incidents and there was now a system to share learning from incidents with staff. The service used monitoring results to improve safety. Staff collected safety information.
- At the time of the last inspection, a safer surgical checklist based on the World Health Organisation (WHO) guidance was used for cosmetic procedures only and the service did not use the WHO checklist for hair transplant procedures. Since the last inspection, this had now been implemented for hair transplant procedures too.
- The provider had amended the admission policy to reflect body mass index (BMI) limits for patients treated at the clinic.
- 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 centre had made improvements to the risk management system and engaged with staff regarding improving the service.

Following this inspection, we told the provider it must take action to comply with the regulations and it should make other improvements, even though a regulation had not been breached, to help the service improve. We issued the provider with two requirement notices which affecting the Ziering London Clinic. Details are at the end of the report.

Nigel Acheson

Deputy Chief Inspector of Hospitals (London and South)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	**Requires improvement** 	Cosmetic surgery was the only activity carried out in the service. As this was a focused inspection, our overall rating for this service stayed the same. We rated safe and well led as requires improvement.

Summary of findings

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Requires improvement

Ziering London Clinic

Services we looked at

- Surgery

Summary of this inspection

Background to Ziering London Clinic

Ziering London Clinic (One Health) is now operated by Curis Healthcare Limited. The service opened in 2014, providing hair transplants, cosmetic surgery and non-surgical cosmetic interventions. In January 2017, the clinic began functioning as a cosmetic surgery provider, providing operations such as breast enlargement, hair transplant and liposuction. It is a private clinic in London. The clinic accepts referrals from GPs, lead referrals from third party companies and self-referrals from patients living in London and internationally. The service does not provide services to NHS-funded patients or patients under the age of 18.

At the time of this inspection, the director of clinical services was the registered manager and had been in post for five months. The company director was the nominated individual.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector, and a specialist advisor with expertise in theatre nursing and infection control. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection.

Information about Ziering London Clinic

The clinic provides cosmetic surgery and is registered to provide the following regulated activities:

- Surgical Procedures

During the inspection, we visited the whole clinic, including the reception, waiting areas, theatre, two-bedded post anaesthesia care unit (PACU), the ward and consultation rooms. We spoke with seven staff including registered nurses, medical staff, an operating department practitioner, and the registered manager. During our inspection, we reviewed seven sets of patient records.

We inspected this service using our focused inspection methodology. The service was inspected three times before, in February and March 2018 and on 12 June 2019. We carried out an unannounced inspection on 30 October 2019 to see if the provider had made the improvements we required them to make from the previous inspection in June 2019.

Activity (June 2019 – October 2019):

- There were 423 procedures performed in the reporting period. There were 12 inpatient episodes of care recorded at the clinic. All were privately funded.
- The most common procedures carried out were: breast augmentations (321).
- There were five doctors working at the clinic under practising privileges. The service employed four registered nurses, two healthcare assistants and two receptionists, as well as having its own bank staff. The registered manager was the accountable officer for controlled drugs (CDs).

Track record on safety (July 2019 – October 2019):

- No never events
- 16 incidents: 13 clinical and three non-clinical incidents
- No serious injuries
- No incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA)

Summary of this inspection

- No incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA)
- No incidences of hospital acquired Clostridium difficile (C.diff)
- No incidences of hospital acquired Escherichia coli (E-Coli)
- 14 complaints

Services provided at the hospital under service level agreement:

- Clinical and general waste collection
- Confidential waste collection
- Cleaning services
- Fire alarm & lighting servicing
- Fire extinguisher checks
- Portable appliance testing
- Air conditioning
- Pest control
- Gas boiler maintenance
- Legionella risk assessment
- Water cooler maintenance
- Fixed electrical testing
- Laboratory testing
- Equipment servicing
- Private ambulance services
- Blood specimen testing
- Supply of linen and provision of laundry

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

Our rating for safe stays the same, we rated it as **Requires improvement** because:

- Not all premises were visibly clean, and we found dust on high surfaces. The provider did not monitor the standards of cleaning carried out by the external company. However, the service had made improvements to control infection risk since our last inspection and had strengthened their own systems for the maintenance of facilities, premises and equipment within the theatre.

However, we found following areas the provider had improved since our last inspection:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to recognise and report abuse. Since the last inspection, staff had received training on safeguarding adults and children level one and two. The provider had updated the safeguarding policy which reflect the requirements of the Care Act 2014 (Chapter 14) statutory guidance.
- Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction. The provider had assessed compliance with Association for Perioperative Practice (AfPP) and (AAGBI) guidance. All staff had in date basic life support training.
- The service now used systems and processes to safely record and store medicines.
- The service managed patient safety incidents well. Staff recognised incidents and near misses but did not always report them or grade them appropriately. Managers investigated incidents and there was now a system to share learning from incidents with staff. The service used monitoring results to improve safety. Staff collected safety information.
- At the time of the last inspection, a safer surgical checklist based on the World Health Organisation (WHO) guidance was used for cosmetic procedures only and the service did not use the WHO checklist for hair transplant procedures. Since the last inspection, this had now been implemented for hair transplant procedures too.
- The provider had amended the admission policy to reflect body mass index (BMI) limits for patients treated at the clinic.

Summary of this inspection

Are services effective?

Requires improvement

This was a focused inspection of safe and well led only.

The current rating for effective is from the previous comprehensive inspection report published on 18 September 2019.

Are services caring?

Good

This was a focused inspection of safe and well led only.

The current rating for caring is from the previous comprehensive inspection report published on 18 September 2019.

Are services responsive?

Good

This was a focused inspection of safe and well led only.

The current rating for responsive is from the previous comprehensive inspection report published on 18 September 2019.

Are services well-led?

Requires improvement

Our rating for well-led stays the same, we rated it as **Requires improvement** because:

- Although there was now a functioning medical advisory committee (MAC) and the provider had reviewed the practising privileges of all doctors, they still did not follow their own policy and reviewed these outside of the MAC.
- Leaders had re-established governance processes which operated throughout the service. However, we were unable to comment on the effectiveness of this system as it was at an early stage of implementation. We were also concerned the registered manager may not have sufficient allocated time to focus on governance and operational duties.

However, we found following areas the provider had improved since our last inspection:

- Managers in the service had the right skills and abilities to run a service providing high-quality sustainable care. Staff felt supported by their managers.
- The provider promoted a universally positive culture which supported and valued all staff. All staff had their appraisals.
- 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 centre had made improvements in regard to the risk management system and engaged with staff regarding improving the service.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Requires improvement

Surgery

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

Are surgery services safe?

Requires improvement

The main service provided by Ziering Clinic London was cosmetic surgery.

Our rating for safe stayed the same. We rated it as **requires improvement.**

Mandatory training

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

- There was mandatory training for staff who worked at the clinic. Training included infection prevention and control level two, data protection and information governance, medical gas awareness, equality, diversity and human rights, fire safety, basic life support (level two), safeguarding for children (level two) and safeguarding for vulnerable adults (level two). At the last inspection in June 2019, we found the mandatory training of all surgical staff employed by the clinic was not in date. The provider had made improvement in this regard. We found evidence there was 100% compliance and all staff now had up-to-date training.
- Doctors with practising privileges at the hospital were required to provide annual assurance of mandatory training completion. We saw evidence of this in the files we checked.
- There was a 'sepsis consideration and management policy', dated December 2017. The provider told us that sepsis was covered as part of local training. We saw evidence of in-house sepsis awareness training sessions provided to all relevant staff.

Safeguarding

Staff understood how to recognise and report abuse. Staff had received training on safeguarding adults. Since the last inspection, the safeguarding policy had been updated and reflected the requirements of the Care Act 2014 (Chapter 14) statutory guidance.

- The clinic did not treat anyone under the age of 18. They had a policy for safeguarding patients from abuse, updated in June 2017. At the last inspection we found the safeguarding policy did not reflect the requirements of the Care Act 2014 (Chapter 14) statutory guidance, or detail procedures which offered us assurance the provider had a safeguarding system that would identify, respond and manage safeguarding allegations in a way that would safeguard people from harm. At this inspection we found the provider had updated their safeguarding policy.
- There was a separate female genital mutilation (FGM) policy, which was in date and comprehensive.
- The manager informed us that safeguarding was part of the clinic's mandatory training. At the last inspection we were told that staff had undertaken safeguarding vulnerable adult and safeguarding children level one and two training, but this was out of date. This had been rectified and all staff now had up-to-date safeguarding training.
- The new registered manager was the safeguarding lead for the service and had completed safeguarding vulnerable adults level three training.

- Staff we spoke with demonstrated an awareness of safeguarding procedures and how to recognise if someone was at risk or had been exposed to abuse.
- We observed appropriate safeguarding referral contact details were displayed in clinic and treatment rooms and staff could direct us to them. Since the last inspection, the clinic had not reported any safeguarding concerns to the local authority and no safeguarding notifications were recorded by the CQC.
- Senior staff told us they ensured professional registration, fitness to practice, and validation of qualification checks were undertaken for all staff. All staff files we reviewed at the time of the June 2019 inspection had relevant Disclosure and Barring Service (DBS) checks.

Cleanliness, infection control and hygiene

Not all premises were visibly clean, and we found dust on high surfaces. The provider did not monitor the standards of cleaning carried out by the external company. However, the service had made improvements to control infection risk since our last inspection and had strengthened their own systems for the maintenance of facilities, premises and equipment within the theatre.

- At the last inspection, we found the service did not always take all necessary measures to control infection risk well. We noted some areas were not always fully clean and staff did not always take all appropriate measures to prevent the spread of infection. At the time of this inspection, we found the provider had made some improvements to control the risk of infection. However, we still found dust on high surface areas. For example, on window frames and on curtain railings. This was not compliant with the Health and Social Care Act 2008:Code of practice on the prevention and control of infections.
- The provider had changed the external cleaning company since our last inspection. The registered manager informed us cleaners would clean all areas every evening. However, we found visible dust on high surface areas and in the corners of some areas outside of the theatre. For example, on curtain rails in the recovery area, high wall beadings and window frames in the ward, top of cupboards in the staff changing room, on the top of the fluid warming cupboard, and in the corridor joining the theatre and recovery. The staff changing room floor was cluttered with shoes and clogs and was not clean. We also found grime and dust in the medicine fridge. We were not assured the provider monitored the standards of cleaning carried out by the external company.
- At the last inspection, in the main theatre, we found visible dust and sticky pink residue on the main storage trolley, as well as two other storage trolleys with visible dust in the storage cupboard. We also found visible blood on diathermy foot pedals (a machine for cutting of tissue during surgical procedures). A remnant of what appeared to be human tissue (fat) was also visible on the main storage trolley. The operating trolley arm supports had remnants of sticky tape present. These issues presented an infection control risk. Following our last inspection, the provider informed us trolleys had been removed and new trolleys had been ordered. At this inspection, we saw the new trolleys in use and there was no visible dust within the theatre area.
- At the last inspection, we found discrepancies in the theatre cleaning checklists. At this inspection, we found staff were carrying out the daily theatre cleaning every day and documenting this correctly.
- The registered manager informed us that since the last inspection, the theatre was deep cleaned on 12 July 2019 and the next deep cleaning was scheduled for January 2020. The provider had increased the deep cleaning frequency from annually to every six months. We were assured the provider had taken appropriate actions to address the infection control risk within the theatre.
- At the last inspection, we found daily cleaning checklists were completed intermittently. There were no checks completed for several areas and days when the provider told us the clinic was open. At this inspection, we found the provider had made improvements in this regard and all cleaning checklists were completed correctly. Since the last inspection, the registered manager had introduced the use of green 'I am clean' stickers and we found staff were using these effectively. This provided assurance that equipment was clean and ready to use.
- The clinic carried out quarterly environmental audits. We saw actions identified as a result of July and November 2019 audits. For example, resurfacing of the flooring by the sink in the theatre was listed as an action.
- Between July 2019 and October 2019, the provider reported 12 surgical site infections (SSIs). Since the last

inspection, the registered manager had been proactively monitoring the surgical site infection rate and challenged a consultant with higher SSI rates to change his practice.

- There were dispensers with hand sanitising gel situated in appropriate places around the unit, including the main entrance to the unit and inside clinical rooms. The seven-step guidance for effective hand washing was displayed above hand washbasins. Hand washbasins were equipped with soap and disposable towels. We checked various dispensers and all were full. The clinic carried out monthly hand hygiene facilities audits. Between July 2019 and October 2019, all staff observed were compliant with good hand hygiene practice.
- We observed all clinical staff would change into blue or black scrubs style uniform and adhered to 'bare below elbows' (BBE) dress code. We observed most clinical staff adhered to this at all times. However, we found the surgeon carrying out the theatre list on the day of the inspection had a skin plaster /bandage below the elbow and would not have been able to adhere to aseptic scrubbing techniques. At this inspection, we found that though adequate supplies of personal protective equipment (PPE) including gloves and aprons were available, the glove dispensers in the recovery and ward were empty and only one size glove box was available for staff on nursing desks. The registered manager informed us they had received new stock on the day of inspection and the dispensers would be refilled.
- Between July 2019 and October 2019, the clinic had no reported cases of meticillin resistant staphylococcus aureus (MRSA). MRSA is a bacterium that can be present on the skin and can cause serious infection. The department also reported no cases of MSSA (meticillin susceptible staphylococcus aureus. This is a type of bacterium that can live on the skin and develop into an infection, or even blood poisoning. There were also no reported cases of Clostridium difficile (a bacterium that can infect the bowel and cause diarrhoea, most commonly affecting people who have been recently treated with antibiotics).

Environment and equipment

The provider had effective systems for the maintenance of facilities, premises and equipment to keep people safe. Staff managed clinical waste adequately.

- All clinical areas and the main theatre were on ground floor and there was step-free access. All clinical areas we observed were suitable for their intended use. At the last inspection, we found the environment in the main theatre did not meet expected standards. For example, the flooring below the scrub sink had visible stains and there were cracks on floor joints. We found rust on trolleys within the main theatre and the instrument trolley had rusty wheels. In addition, the storage trolley adjacent to sink had dust and visible rust on the top and on the wheels. Following last inspection, the provider replaced the trolleys and we saw those new trolleys in use. The provider informed us they were obtaining quotes and looking for a date to resurface the floor by the sink in the theatre.
- At the last inspection, the main theatre temperature was not compliant with health building notice (HBN) 26 for facilities for surgical procedures. This was resolved following the last inspection. At the last inspection, that provider's 'general work programme 2019' showed the theatre's thermometer gauge for the air handling system would be obsolete from end of 2019. The provider was considering installing a new thermometer handset as a result.
- The clinic had the relevant emergency resuscitation equipment in recovery. An additional defibrillator was available in the reception area. We saw the defibrillator was checked regularly. At the last inspection, we found resuscitation trolley checks were done intermittently. We also found the emergency medicines contents checklist did not match with the contents of the box itself. At this inspection, we found this had been resolved and all checks were done correctly. We were assured staff would have access to the equipment or medicines needed in an emergency.
- Piped oxygen was not used within the clinic. There were enough supplies of oxygen cylinders and there was evidence regular checks had been carried out. At the last inspection, we found the oxygen cylinders within the patient admission room and the hair transplant room were free standing. There were also several medical gas cylinders that were stored in a cupboard on different shelves that were not secured and thus posed a safety risk. Following the last inspection, evidence was submitted that demonstrated oxygen cylinders had been secured to the wall and medical gas storage had been improved within the cupboard. At this inspection, we saw evidence of this.

- At the last inspection, staff informed us the provider was slow to act on issues relating to building amenities. At this inspection, we found staff were satisfied that the provider responded to any environmental issues quickly. Since the last inspection, all fire extinguishers had been serviced and were in date.
- At the last inspection, all portable equipment we checked had been recently serviced and labelled to indicate the next review date. All equipment was serviced annually by an external company. Since the last inspection, the provider had bought a fluid warming cupboard and a warm air machine. We found both of these items had not been safety tested. Following inspection, the provider had these tested and evidence of testing was submitted. We also found two suction machines had safety checks that expired in September 2019.
- All sterile items utilised in the clinic for pre and post-operative care were single use. Reusable instruments were used for liposuction. These were decontaminated and sterilised off-site by an external company under a service level agreement (SLA). Staff told us there were no issues with this arrangement and processes were in line with national guidance, such as the Department of Health Technical Memorandum on decontamination.
- Clinical waste disposal was provided through an SLA with an external provider. We observed safe systems for managing waste and clinical specimens during the course of inspection.
- We observed sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. Sharps containers within the clinic were dated and signed when assembled and not overfilled. However, they were not always temporarily closed when not in use.
- A legionella risk assessment had been carried out (legionella is a term for a particular bacterium which can contaminate water systems in buildings) and there were no actions to follow up from this.
- The provider informed us relevant control of substances hazardous to health (COSHH) risk assessment had been carried out. This ensured flammable substances within the clinic were kept locked and stored safely.

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. Since the last inspection, the clinic had introduced the WHO checklist for hair transplant procedures.

- There was an admission policy. Staff we spoke with told us they would not accept patients under 18 years old, patients with major medical issues (such as cancer) or mental health conditions, or patients with a body mass index (BMI) of 38 or over. At the last inspection, we found the BMI criteria was not recorded in either the pre-admission criteria policy or surgery contraindications/preoperative considerations document provided to us, which stated patients should have a maximum BMI of 35 and 30, respectively. Since the last inspection, the clinic had updated the pre-admission criteria policy and included this BMI criteria.
- Consultations for procedures were completed face to face, with the lead clinician assessing and examining the patient and explaining their treatment options, the risks and the expected outcome of treatment. All patients were asked to complete a medical history and health questionnaire before consultations or procedures.
- Surgical procedures were performed under local anaesthetic or total intravenous anaesthesia (TIVA), which is used for maintenance of general anaesthesia by intravenous infusion, without the use of inhalation agents. The anaesthetist was required to remain with the patient until the patient was awake and orientated after each procedure where TIVA was used. The anaesthetist was trained in advanced life support (ALS).
- Patients' clinical observations such as pulse, oxygen levels, blood pressure and temperature were monitored in line with National Institute for Health and Care Excellence (NICE) guidance CG50 'Acutely ill-Patients in Hospital.' A scoring system based upon these observations known as a national early warning score (NEWS) was used to identify patients whose condition was at risk of deteriorating. Patient notes we examined contained guidance for staff on the NEWS scoring system, and detailed the actions required if the score indicated deterioration. Staff we spoke with were familiar with using the NEWS tool and how to escalate concerns. Since the last inspection, the clinic had introduced a NEWS audit tool. The July 2019 audit of 20 set of notes showed NEWS was completed correctly in 100% of cases.

- We saw evidence within patient notes of risk assessments relevant to the patient's needs having been carried out. Between July 2019 to October 2019, 100% of patients had been assessed for the risk of venous thromboembolism (VTE). Most patients did not stay overnight at the service and did not require pressure ulcer risk assessment.
- Theatre staff used a safer surgical checklist based on the World Health Organisation (WHO) guidance. The surgical safety checklist for patients was intended for use throughout the perioperative journey, to prevent or avoid serious patient harm. By following the checklist, health care professionals can minimize the most common and avoidable risks endangering the lives and well-being of surgical patients. The provider completed monthly audits of the WHO checklist. In September 2019, the audit of five sets of notes showed 100% compliance with the WHO checklist. All seven patient records we examined contained completed WHO checklists. At the last inspection, we were not assured all stages of the WHO checklist were completed as intended. At this inspection, we followed a patient through their procedure and saw the WHO checklist was completed effectively. We observed the 'sign in' and 'sign out' stages were completed as part of an interactive process as intended.
- At the last inspection, we found hair transplant surgeons were not using the WHO checklist at all. Following that inspection, the provider informed us that this had now been implemented for hair transplant procedures and provided a template they intended to use for this purpose going forward. At this inspection, we reviewed three sets of notes for hair transplant and saw the WHO checklist was completed.
- At the last inspection, senior leaders were unable to provide assurance they were always compliant with Association for Perioperative Practice (AfPP) guidance in relation to theatre staffing as they did not audit this. Following the last inspection, the provider had reviewed the staffing arrangements and informed us the number of staff scheduled to work each theatre list was individually assessed based on the surgeon need, the make-up of the list and the requirements of the patients. In general, the skill mix included: a surgeon, an anaesthetist, a registered anaesthetic assistant practitioner, two scrub practitioners and one circulating health care assistant (HCA). On the day of inspection, we found the clinic to be compliant with this.
- At the time of the last inspection, we were informed the theatre scrub nurse would at times perform a dual role for major procedures, which was not in line with the provider's standard operating procedure (SOP) for staffing the theatre. Since the last inspection, the provider had considered the use of a surgical first assistant (SFA) and acknowledged the difference between this role and the role of a scrub practitioner. We were assured the scrub practitioners were aware of their limitations and capabilities. The provider stated for any major procedures, an SFA was required. An SFA was used for major surgery and longer procedures. If the surgeon requested an assistant, this was provided in addition to a scrub nurse.
- There was a two-bedded recovery area. At the last inspection, we were not assured the provider was monitoring its compliance with association of anaesthetics of Great Britain and Ireland (AAGBI) staffing for a post anaesthesia care unit (PACU), which states a PACU should provide one-to-one care. Following last inspection, the provider had reviewed its recovery staffing. There was one registered nurse for first stage recovery where all patients were one-to-one. For second stage recovery before the next patient was delivered from theatre, there was one recovery nurse and one coordinator who was a registered nurse. A snap shot audit of over five days in July 2019 was submitted to us, which showed the flow of patients between theatre, recovery and ward. The audit demonstrated there was only one patient at a time in recovery and there was one-to-one care.
- Since last inspection, the provider had reassessed emergency on-call cover and reflected on this. There were no changes following this reflection and the on-call after theatre lists consisted of one circulator, one scrub and one anaesthetist.
- After each operation, the patient was moved to the recovery area for at least 90 minutes, before being stepped down to a ward area (for up to four hours), before being discharged. The provider's discharge policy stated patients must wait a period of at least 60 minutes post-procedure after minor operations and for at least three hours following total intravenous anaesthesia (TIVA). Each patient was required to leave the premises with a chaperone, unless agreed beforehand, with the patient signing a disclaimer. We observed this was adhered to on the day of inspection.

- Patients were able to contact staff at the clinic for support at any time. They were given a telephone number to call following their procedure, which was manned by a member of clinic staff 24 hours a day, seven days a week.
- Overnight stays were facilitated for those not fit or ready for discharge, those who elected to stay overnight, or for patients from further afield. The service confirmed overnight stays were rare, with 21 patients staying overnight between July 2019 and October 2019. Patients staying overnight were cared for by a nurse and resident medical officer (RMO). The RMO was trained in advanced life support (ALS).
- The clinic did not provide high dependency or intensive care. There were emergency crash alarms available in the recovery areas. In an emergency situation, the standard 999 system was used to transfer the patient to an NHS hospital. The clinic also had a contract with a neighbouring NHS trust to transfer patients for critical care facilities. The clinic had arrangements with two local private ambulance companies for less urgent transfers. In the year leading up to our inspection, there had been no such unplanned transfers to another hospital. There was a staff rota of the on-call system was for any unplanned returns to theatre.
- Pre-operative assessment included testing patient's blood values and haemoglobin levels, sent to an external laboratory. Operations were not performed if blood results were outside of normal range. The clinic had a service level agreement (SLA) with a private company for fast turnaround of blood sampling. At this inspection, we were informed that the clinic no longer performed bariatric surgery and would not require blood transfusion, however the same external company was able to provide blood in an emergency. All patients had preoperative blood tests in line with National Institute for Health and Care Excellence (NICE) guidance.
- The provider told us that staff were encouraged to monitor signs of infection and sepsis during the procedure and before discharge, as well as monitoring for symptoms as part of the wound care process post-surgery.
- There was formal psychological assessment of patients in all the patient records we looked at. It is a requirement of the Royal College of Surgeons that the consultation identifies any patients who are psychologically vulnerable and they are appropriately referred for assessment. The provider informed us that all patients were screened pre-operatively.
- There were appropriate building indemnity arrangements in place to cover all potential liabilities.

Nursing and support staffing

Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction. Since the last inspection, the provider had reviewed its compliance with the Association for Perioperative Practice (AfPP) guidance. All staff had in date basic life support training.

- At the time of inspection, the clinic directly employed one full-time equivalent (FTE) and one part-time bank receptionist, who shared front of house and administrative duties. There were also one FTE office administration manager and one FTE patient co-ordinator.
- Clinically, they employed one FTE director of clinical service, two theatre scrub nurses, one recovery registered nurse, one FTE ward nurse and one FTE healthcare assistant (HCA), who worked between the theatre and recovery area.
- At the time of this inspection, the clinic had a vacancy for two FTE operation department practitioners (ODPs)/ registered nurses. The clinic used bank ODPs to cover these positions. The clinic was in the process of recruiting into those posts and had advertised for the ODP posts.
- The registered manager informed us that to cover any staff absence, they always used same bank members of staff to assist with continuity of care.
- The recovery nurse was immediate life support (ILS) trained and was supported by an ALS trained anaesthetist covering the theatre list for the day. All staff had up-to-date basic life support training.
- In the case of an elective overnight stay, an agency nurse would be used. In the case of an emergency overnight stay, the nursing and operating department staff who had taken part in that day's theatre list remained on call to return to the theatre in case of emergency.
- We observed the nursing handover of patients between theatre and recovery and found it to be comprehensive and clear.

- All surgical days at the location were planned in advance to ensure the registered nurse was on duty and available.

Medical staffing

The service had enough medical staff.

- Consultants who worked at the clinic were required to maintain current practising privileges in line with the local practising privileges policy to be eligible to work on site. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital. Medical staff with practising privileges had their appraisals and revalidation undertaken by their respective NHS trusts or an independent appraiser. There was a responsible officer who worked for the provider organisation who completed appraisals for those doctors without a substantive NHS post.
- Since the last inspection, the provider had reviewed the practising privileges of all consultants and there were now five consultants with practising privileges at the clinic. There were 12 doctors that were no longer working at the clinic and would only attend if any of their patients required a revision procedure. One anaesthetist and one surgeon would work the entire theatre list on any given day. These medical staff were clinically responsible for the patients under their care and were required to review their patients following the operation. We were told all operating staff would remain at the clinic or at a nearby hotel until the patient had left the premises. In the event of an overnight stay, a regular resident medical officer (RMO) was used through an agency, working 9pm until 8am.
- The amount of follow-up consultations would depend on the procedure. Patients had access to their assigned patient coordinator before, during, and after their procedures. Surgical advisors at the clinic called the patient 48 hours after the procedure to check in with them and confirm the follow-up appointment dates. Staff were automatically prompted to make follow-up appointments on the electronic system.

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.

- The clinic used electronic and paper records for patient information. All paper records were scanned and stored electronically. All records containing patient information were stored in a locked filling cupboard, and electronic records were password protected.
- Information was shared with GPs if patients gave their consent. Patients received a discharge letter after surgery that they could share with their GP.
- We reviewed five patient records and found them to be complete, comprehensive and legible. We found minor inconsistencies in discharge documentation. A monthly records audit was part of the service's audit programme. The audit of September 2019 highlighted that one patient had a photographic ID and a GP summary missing. Actions were taken to inform staff of the importance of ensuring that the GP summary was received on time and the photographic ID matched the patient details.
- The records included the procedure carried out and details of any implants used. Staff recorded the serial number of the implant in the patient's records and patients signed a consent form relating to the implant registry.
- A theatre register was kept, with details of all surgical procedures carried out in the theatre. All entries were clear and legible.

Medicines

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

- There was a 'medicine management policy', dated November 2018. The policy clearly described obtaining, prescribing, recording, handling, storage and security, dispensing, safe administration and disposal of the medicines held at the clinic. At the last inspection, we found medicines were not managed according to the provider's own policy. Since the last inspection, the provider had made improvements and medicines were managed in line with national medicines management guidelines.
- There was a service level agreement (SLA) with a local pharmacy for the supply of medicines.
- The clinic had obtained a controlled drugs (CD) license from the Home Office in October 2017. The registered manager was the new control drug accountable officer (CDAO). Controlled drugs were stored in a locked cupboard and policy stated they should be checked

daily by two nurses. At the time of the last inspection, we found an expired controlled drug in the CD cupboard and saw CD checks were done intermittently. At this inspection, we found the provider had made significant improvements in this regard. We spot checked the log and found no gaps in the checks since the time of the last inspection. All CDs were now in date.

- At the last inspection, we were concerned a large stock of CDs was kept in the theatre CD cupboard without an appropriate risk assessment to mitigate the risk of theft or misuse of these CDs. At the time of this inspection, we found the provider had risk assessed this and there were daily checks of the CD cupboard in theatre**.**
- Medication fridge temperatures were monitored daily. We checked the records and found these to be completed correctly.
- At this inspection, we found there was now a pharmaceutical waste bin within the building to discard expired medicines or CDs. This was an improvement since our last inspection.
- There was an antibiotic prescribing policy which stated: 'One Health only provide antibiotics for true infections. NICE guidance CG74 states that an antibiotic should be prescribed where surgical site infections are suspected, with consideration of local resistance patterns and the results of microbiological tests when choosing an antibiotic.' However, we found all patients were given a broad-spectrum antibiotic following surgery, which was not in line with local policy or national guidance. The clinic had not reviewed or audited this practice since their last inspection in 2018.
- Medicines were stored securely in locked cupboards and keys were held by the registered nurse on duty. We saw evidence medicines were checked daily to ensure they were in date. All the ambient non-controlled medicines we checked were in date.
- The clinic carried out a monthly medicines management audit. We saw evidence of a medicines management audit completed between August and September 2019, in which all checks were completed and no concerns were found.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses but did not always report them or grade them appropriately.

Managers usually investigated incidents there was a system to share learning from incidents with staff. Managers ensured actions from patient safety alerts were implemented and monitored.

- The clinic did not report any never events between July 2019 and October 2019. Never events are serious incidents that are entirely preventable as guidance or safety recommendations providing strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- No serious incidents (SIs) were reported between July 2019 and October 2019.
- Between July 2019 and October 2019, the clinic reported 16 incidents. Out of these 16, 13 were clinical incidents and three were non-clinical incidents. Out of these 13 clinical incidents, three related to consent and implant variations made on the day of surgery, two related to results not being available inpatient notes, two were related to implants identified prior to surgery (which were resolved immediately) and two were related to implants returned to the supplier as they ruptured during a procedure. The provider informed us there were no clinical incidents that had resulted in any harm to patients. The non-clinical incidents were related to missing equipment, missing staff belongings and broken furniture and kit. All non-clinical incidents were resolved, and no trends were noted. We saw staff meeting minutes where these incidents and lessons learned were discussed. For example, the provider had changed the implant supplier, and improved patient communication by implementing an e-system for emails and a text service to ensure patients had read communications sent by the clinic.
- The clinic had a policy to guide staff on how to report any incidents. We saw evidence incidents were reported using paper forms, which were supplemented by an additional form that graded incidents by severity and likelihood of harm. We saw all issues identified at the last inspection had been reported as incidents.
- Staff we spoke with were aware of how they would report incidents. The registered manager informed us learning from incidents was shared with staff verbally, in meetings and by email. At the last inspection, we were not assured there was an open reporting culture and that there was any shared learning from incidents. At this inspection, we found there had been regular staff

meetings where incidents were discussed with the team. We saw minutes of four sets of staff meetings where incidents and learning was shared with the wider team.

- The Duty of Candour (DoC) 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. This means providers must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. The provider told us there were no reported incidents which met this threshold.
- The clinic had systems for receiving, disseminating and acting on patient safety alerts from the Medicines and Healthcare Regulatory Agency (MHRA). We saw evidence where alerts were forwarded to relevant staff for information or in order to take appropriate actions.
- **Safety Thermometer (or equivalent)**
- **The service use monitoring results to improve safety.**
- The clinic, unlike NHS trusts, was not required to use the national safety thermometer to monitor areas such as venous thromboembolism (VTE). However, services are required to have equivalent systems. The clinic reported no incidences of VTE in the reporting period. As patients rarely stayed overnight, pressure ulcers were not likely to occur.

Are surgery services effective?

Requires improvement

This was a focused inspection of safe and well led only. We did not inspect effective at this inspection.

The current rating for effective is from the previous comprehensive inspection report published on 18 September 2019.

Are surgery services caring?

Good

This was a focused inspection of safe and well led only. We did not inspect caring at this inspection.

The current rating for caring is from the previous comprehensive inspection report published on 18 September 2019.

Are surgery services responsive?

Good

This was a focused inspection of safe and well led only. We did not inspect responsive at this inspection.

The current rating for responsive is from the previous comprehensive inspection report published on 18 September 2019.

Are surgery services well-led?

Requires improvement

Our rating for well-led stayed the same. We rated it as **Requires improvement**.

Leadership

Managers in the service had the right skills and abilities to run a service providing high-quality sustainable care. Staff felt supported by their managers, as there was now stability at the level of the registered manager.

- The company director was the nominated individual. The director was supported by head of finance, clinical consultant, marketing executive and a team of clinical and non-clinical staff. The clinical service manager was responsible for the overall day-to-day running of the clinic. At the last inspection, we found there had been instability at this level for the five months prior to our inspection, with two candidates being appointed and

then dismissed. The new clinical service manager had been in the post since the last inspection in June 2019 and staff felt there was now stability. They felt supported by their managers.
- Staff informed us senior leaders were visible and approachable. All staff told us they felt assured things had improved now that there was a new manager.
- Since the last inspection, the new registered manager had met with all staff and reinstated the monthly meetings with all staff.
- At the last inspection, there was no effective medical advisory committee (MAC) and there was a lack of medical leadership. At this inspection, we found the provider had reinstated the MAC.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action.

- Since the last inspection, the provider had changed the holding company and was now operated by 'Curis Healthcare Limited'. The company vision was: 'To provide high quality, safe, regulated and affordable aesthetic surgery'. A strategy was in place about how the clinic would achieve this. The service aimed to provide a well-led clinical team that were patient welfare and safety focused, delivering a caring service to patients, chaperones and relatives.
- Staff across the clinic were broadly aware of the clinic's vision, with knowledge of developments such as the recruitment of more permanent staff. However, detailed information on the vision and strategy were not included specifically in staff training or at their induction.

Culture

The provider had made improvements in promoting a universally positive culture that supported and valued all staff.

- At the last inspection, we received mixed feedback from staff in relation to culture. Some staff told us they enjoyed working at the clinic. However, most staff said they were not encouraged to raise concerns openly and if they did so, senior managers would not respond to those concerns in a timely fashion. At this inspection, we found the senior managers had taken these concerns on board and made improvements. All staff spoke positively regarding the management team and they felt able to raise any concerns. The company director would visit the clinic once a week and staff told us the registered manager was part of the nursing team and was approachable.
- The new registered manager had introduced clinical supervision and staff welcomed this opportunity for discussion and aiding their professional development.
- We saw evidence in patient records to show the centre provided patients with a statement which included the terms and conditions of the service and outlined the fees relating to treatment.

Governance

Leaders had re-established governance processes which operated throughout the service. However, we were unable to comment on the effectiveness of the system as it was at an early stage of implementation. The provider was not reviewing the practising privileges pf consultants as per their own policy. We were also concerned the registered manager may not have sufficient allocated time to focus on governance and operational duties.

- The provider had made some improvements with governance since the last inspection and re-instated the governance meetings, which were held every three months. We found there was senior oversight regarding governance processes and learning was shared amongst staff at the service. We saw the July and October 2019 combined governance report, which reported on the clinical outcomes, incidents and complaints. The registered manager informed us there were regular interactions between the company director and the registered manager to discuss governance issues, but these were not minuted. We were unable to comment on the effectiveness of this system as it was at an early stage of implementation.
- Since the last inspection, the provider had re-established the medical advisory committee (MAC). We saw minutes of August 2019 meeting and the terms of reference. We were informed by the registered manager that all practising privileges had been reviewed. Though the provider had reviewed the practising privileges of all doctors, they still did not follow their own policy and had reviewed these outside of the MAC. We were therefore not assured there were sufficient governance arrangements to monitor any surgeons employed at the clinic.

- We were concerned the registered manager may not have sufficient allocated time to focus on governance and operational duties as they were part of the clinical team. The registered manager was on the clinical rota for most days in the three weeks prior to our inspection.
- The staff we spoke with told us that since the last inspection, there were regular staff meetings where aspects of governance such as incidents, risk and learning were discussed. We saw minutes of four staff meetings held by the new registered manager since the time of our last inspection.
- 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.

Managing risks, issues and performance

Leaders had made improvements since last inspection and used systems to manage performance effectively. They identified and escalated relevant risks and issues and took actions to reduce their impact. They had plans to cope with unexpected events.

- There was an annual governance work programme and risk register. Each risk had a grading depending on the severity of the risk. Each risk had a nominated lead responsible for review and a target date. At the last inspection, we found the provider risk register was not reviewed regularly and not all the risks identified were on the risk register. At this inspection, we found this had been rectified. We saw an updated risk register and we were assured senior staff were monitoring and reviewing risks regularly, as per their own policy.
- Since the last inspection, the provider had updated the policy for safeguarding patients from abuse and it was fit for purpose and referenced all current national guidelines. We were assured staff knew how to protect patients from potential abuse or report any concerns appropriately.
- At the last inspection, we were not clear how incidents, complaints and operational issues were shared with staff as there were no regular team meetings. Staff felt unsupported. At this inspection, we found the provider had made improvements. Feedback from staff was positive and they now felt supported by the management. There were monthly regular meetings where incidents, complaints and operational issues were discussed. We saw evidence of this in four sets of meeting minutes.
- Staff informed us incident reporting was now encouraged and the registered manager was keen to receive feedback on any areas of concern. They told us that the provider was responsive to concerns they raised.
- The clinic conducted local audits relating to infection control, documentation, fasting and surgical site infection. Though there were no central log of action plans from these audits, we saw these audits were discussed at the team and governance meetings.
- The provider submitted data to the Private Healthcare Information Network (PHIN). At the time of the last inspection, the service told it was in the process of preparing to collect data in relation to Quality Patient Reported Outcome Measures (Q-PROMS). However, we were not provided with any collated information or indication of how many patients had completed Q-PROMS. At this inspection, the provider informed us that between October 2018 and October 2019, 232 Q-PROMS had been submitted. The national data was not yet available for this period at the time of our inspection, and therefore we were unable to benchmark their performance against other services.
- There was an emergency generator as part of the building facilities provided by the premises provider, with a back-up supply which allowed for 30 minutes use to ensure patient safety.
- All employed surgeons performing cosmetic surgery had professional indemnity insurance. We saw evidence of this in staff records at the June 2019 inspection.

Managing information

The clinic collected information to support its activities.

- There was an 'information management, Caldicott guidance and data protection' policy, which referenced appropriate national guidance.
- All initial patient contact was recorded on a computerised system. All notes from the day of treatment were recorded on paper patient notes, which were tailored to each specific treatment. Once treatment was completed, these notes were scanned onto the patient record and the hard copy was stored in a locked filling cupboard.
- Patients received a discharge letter with clinical information after surgery. The letter could be shared with the GP if the patient wished to do this.

- Since the last inspection, all staff had received information governance training.

Engagement

Since the last inspection the provider had made improvements and now engaged with patients and staff regarding improving the service.

- Patients and relatives were asked to complete a provider feedback questionnaire about their experience. Patients were also able to provide feedback via the clinic website and email. The clinic told us they also engaged with the public through their social media channels. Patients were able to add comments to their website page.
- Since the last inspection, patients were invited to participate in the charity function which was held in an external environment.
- Between July and October 2019, the clinic received 105 survey responses from a possible 424 patients, representing 25% of patients. Of these respondents, the majority said they would recommend the clinic as a place to be treated (98 patients).
- Staff told us that since last inspection, there had been improvement around team meetings and there were monthly regular team meetings. A fundraising activity for staff was arranged in October 2019 for a charity that supported women with mental health issues and female victims of domestic violence.
- Since the last inspection, the provider had made improvement regarding appraisals. Though some staff had their appraisal with the previous manager, the new manager had appraised all staff again and had set developmental objectives. Feedback from staff at the June 2019 inspection indicated they did not see any value in the appraisal process as not all staff had developmental objectives set. Staff feedback was more positive this time.

Learning, continuous improvement and innovation

The centre had made some progress in their approach to quality improvement.

- The clinic had made some improvements in response to reasonable challenge from internal or external sources regarding quality improvement, governance and safety.
- The provider responded to areas identified at the June 2019 inspection and made improvements in relation to medicine management, mandatory training, recruiting staff, reviewing clinical outcomes, incident reporting and clinical supervision.
- The provider was submitting data to PHIN and the British implant registry. The provider was submitting data for Q-PROMS.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that they are compliant with the Health and Social Care Act 2008:Code of practice on the prevention and control of infections and there are effective systems to control infection risk well, including assurances from the external cleaning company.
- The provider must follow their local policy of reviewing the practising privileges and the scope of practice of all medical staff.

Action the provider SHOULD take to improve

- The provider should continue to embed governance processes introduced and should have effective systems to provide assurance.
- The provider should review the clinical workload for the registered manager to ensure they have sufficient protected time for governance and leadership duties.
- The provider should consider reviewing their practice of prescribing of antibiotics to bring this in line with national policy.

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 15 HSCA (RA) Regulations 2014 Premises and equipment (1) All premises and equipment used by the service provider must be; (a)Clean.

Regulated activity	Regulation
Surgical procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance (1) Systems and processes must be established and operated effectively to ensure compliance with the requirements in this part. (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to – (a) assess, monitor and improve the quality and safety of their services provided in the carrying on of the regulated activity. (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.