First Trust Hospital

Quality Report

Durton Lane
Preston
PR2 5LD
Tel: 01772 860884
Website: www.firsttrusthospital.org

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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?	**Good**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Requires improvement**

Overall summary

First Trust Hospital is operated by Anaster Limited. The hospital has 14 bedrooms, nine of which are en-suite.

The hospital provides cosmetic surgery including breast augmentation, rhinoplasty (nose correction surgery) and lipoplasty (removal of fat through a cannula) to adults. The provider did not see anyone under 18.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced inspection on 5 and 6 November 2019.

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

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

Summary of findings

- The service did not always control infection risk well. There was no set criteria that determined which patient was screened for methicillin-resistant staphylococcus aureus.
- Staff did not always complete and update risk assessments for each patient and removed or minimised risks.
- The emergency resuscitation box was out of date and medicines were not handled or stored in line with Medicines and Healthcare Products Regulatory Agency guidance.
- The service did not follow best practice when completing the World Health Organisation surgical safety checklist.
- Staff did not always keep detailed records of patients' care and treatment, for example we found incomplete records
- We found no evidence that staff advised or referred patients to lead healthier lives.
- Information systems were not always reliable – for example, World Health Organisation checklist audits were based on document audits and not observational audits.

However:

- The service had enough staff to care for patients and keep them safe. Staff had received training in key skills, understood how to protect patients from abuse, and managed safety well. The service managed safety incidents well and learned lessons from them.
- Staff provided appropriate care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Patients were supported to make decisions about their care and had access to useful information. All records we reviewed showed patients were given a 14-day cooling off period. Staff worked well together for the benefit of patients, and key services were available seven days a week.
- Staff treated patients with compassion and kindness. We saw friendly interactions between patients and staff. Staff respected all the patients' privacy and dignity and took account of their individual needs. They provided emotional support to patients. We saw staff reassuring anxious patients who were waiting for surgery.
- The service planned care to meet the needs of the patients. Staff took account of patients' individual needs and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Ann Ford

Deputy Chief Inspector of Hospitals (North)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	**Requires improvement** 	Surgery was the only activity at the hospital. We rated this service as requires improvement because both the safe and well-led domains were rated as requires improvement. We found effective, caring, and responsive to be good. The service used bank and agency to staff the ward and theatres.

Summary of findings

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Requires improvement

First Trust Hospital

Services we looked at
Surgery

Summary of this inspection

Background to First Trust Hospital

First Trust Hospital is operated by Anaster Limited. The hospital opened in April 2005. It is a private hospital in Preston, Lancashire. The hospital accepts self-funding patients for a range of cosmetic operations – for example, breast augmentation and rhinoplasty.

At the time of the inspection, a new manager had recently been appointed and was registered as the registered manager with the CQC in November 2018.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, another two CQC inspectors, and a specialist adviser with expertise in surgery. Ann Ford oversaw the inspection team, Deputy Chief Inspector of Hospitals (North).

Information about First Trust Hospital

The hospital has one ward and is registered to provide the following regulated activities:

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

During the inspection, we visited the ward, recovery area, waiting room and theatres. We spoke with 14 staff including registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with four patients and two relatives. We reviewed 10 sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital has been inspected once before in July 2016. At the time of inspection, we found that the hospital was meeting all standards of quality and safety it was inspected against.

Activity (July 2018 – June 2019)

- There were 1,723 inpatient and day case episodes of care recorded at the hospital.
- 24% of patients stayed overnight.

Track record on safety

- 0 Never events
- 15 Clinical incidents: 12 no harm/ low harm, 3 moderate harm, 0 severe harm, 0 death
- 0 serious injuries
- 0 incidents of healthcare-associated Methicillin-resistant Staphylococcus aureus (MRSA),
- 0 incidents of healthcare-associated Methicillin-sensitive staphylococcus aureus (MSSA)
- 0 incidents of healthcare-associated Clostridium difficile (c. difficile)
- 0 incidents of healthcare-associated E-Coli
- 7 Complaints

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal
- Interpreting services
- Laundry
- Maintenance of medical equipment

Summary of this inspection

- Pathology and histology
- Blood transfusion services
- Legionella testing
- Confidential waste
- Infection prevention control auditors
- Decontamination
- Pharmacy

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 

We rated safe as Requires improvement because:

- The service did not control infection risk well. Staff did not always use equipment and control measures to protect patients, themselves, and others from infection.
- Staff were not trained in safeguarding level 1 safeguarding children as per the intercollegiate guidelines.
- Staff did not have systems in place to assess the psychological state of patients identified with psychological concerns, so that they could remove or minimise risks.
- Staff did not complete all elements of the World Health Organisation surgical safety checklist in line with guidance.
- Records were not stored securely and were incomplete.
- The service did not always use systems and processes to safely prescribe, administer, record and store medicines.
- When things went wrong, staff did not always offer patients suitable support.

However:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- All staff we spoke with understood how to protect adults from abuse. Staff were provided with level two safeguarding training for vulnerable adults.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- 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 bank and agency staff a full induction.
- The service managed patient safety incidents well. Staff reported incidents. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- Managers ensured that actions from patient safety alerts were implemented and monitored.

Are services effective?

Good 

We rated it as Good because:

Summary of this inspection

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.
- Staff gave patients enough food and drink to meet their needs and improve their health. Staff followed national guidelines to make sure patients were informed about fasting before surgery.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements.
- The service made sure staff were competent for their roles. We reviewed staff files that showed staff were assessed against a competency framework. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Doctors, nurses, and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.
- Consent was a two-stage consent process which followed national guidelines. All 10 consent forms we reviewed were completed and signed. Patients were given 14day cooling-off period to ensure they had time to make an informed decision about their treatment.

However, we also found the following issues that the service provider needs to improve:

- Policies did not have version numbers on them and therefore we were not assured if the policy was the most up to date version.
- Practical support and advice to lead healthier lives was limited, staff asked about smoking and alcohol consumption, but they did not signpost patients and did not have any information to support patients with becoming healthier.

Are services caring?

Good

We rated it as Good because:

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

Summary of this inspection

- Staff provided emotional support to patients, families, and carers to minimise their distress. They understood patients' personal, cultural, and religious needs.
- Staff supported and involved patients, families, and carers to understand their condition and make decisions about their care and treatment.

Are services responsive?

Good

We rated it as Good because:

- The service planned and provided care in a way that met the needs of referred patients.
- Due to the nature of the service the hospital did not admit patients with complex needs. The service provided a translation service, a hearing loop service, and leaflets in large font for those visually impaired.
- People could access the service when they needed to and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients was timely.
- It was easy for people to give feedback and raise concerns about care received, complaints were appropriately investigated in with their policy.

Are services well-led?

Requires improvement

We rated it as Requires improvement because:

- Leaders did not always operate effective governance processes, throughout the service. For example, we found no assurance to support that the WHO checklist followed best practice.
- The service collected data to inform change, however, the service carried out limited observational audits and therefore audits were based on documentation which we found did not always identify gaps in clinical practice.
- Staff identified and escalated relevant risks to senior managers and actions were identified to reduce their impact. However, clinical risks were not always identified such as the need for psychological assessments or storage of medical gases.

However

- Leaders were visible and approachable in the service for patients and staff. They supported staff to develop their skills.
- 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.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Requires improvement

Surgery

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

Are surgery services safe?

Requires improvement

We rated safe as **requires improvement.**

Mandatory training

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

The hospital set a target of 100% compliance rate for completion of mandatory training. At the time of inspection 90% of staff had completed training. The remaining 10% was due to new starters not completing the training yet.

Compliance rate for mandatory training for medical staff was 93% at the time of inspection. The hospital manager informed us that one of the two members of staff who had not completed mandatory training was on leave and the other was midway through completion.

Mandatory training was delivered through workbooks. There were 19 modules to complete, which included information governance, aseptic technique, and duty of candour. Staff were asked to complete workbooks on a two-yearly basis. Senior managers felt workbooks ensured staff had access to the knowledge and information they needed immediately and could use them as a reference guide.

The hospital manager held mandatory training records for all staff working at the hospital, including bank staff.

Staff received annual training on sepsis management, including the use of sepsis screening tools. All staff had completed this training at the time of inspection.

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 for vulnerable adults, and they knew how to apply it.

The hospital's safeguarding policy was in date and available to staff on the intranet.

Staff knew how to identify adults at risk of, or suffering, significant harm. All staff we spoke to were able to articulate what constituted a safeguarding concern, and this was in line with the hospital policy. Staff knew how to make a safeguarding referral and who to inform if they had concerns. In the first instance, staff would report concerns to the hospital manager who would inform the safeguarding team at the local authority.

Any safeguarding concerns were reported through the online incident reporting form.

Staff always had access to a named or designated professional for advice during opening hours. The matron and hospital manager acted as safeguarding leads. They were both trained to level 4 safeguarding vulnerable adults. All staff we spoke with were aware of who this was and how they could be contacted.

Staff had not come across female genital mutilation but had received training about it. They were aware of what it was and how to escalate any concerns they had.

There was a chaperoning policy in place and staff were aware of and understood how to implement the policy. We saw posters displayed across the ward to inform patients of this service.

Requires improvement

Surgery

The hospital reported having no safeguarding incidents between June 2018 and October 2019.

All staff were provided training in level two vulnerable safeguarding adults in line with the intercollegiate guidelines. The hospital reported that 90% or eligible staff had completed the training. However, staff were not trained in safeguarding children level 1.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. The service did not abide by their uniform and infection prevention control policy. Staff did not always use control measures to protect patients, themselves, and others from infection.

We observed clinical practice that did not reflect NICE CG74 guidance. For example, theatre staff wore scrubs outside the hospital when going for breaks. This was raised with the hospital manager at the time of inspection, who agreed it was not in line with theatre guidance and the hospital uniform policy, which stated that theatre staff wearing scrubs should not leave the hospital building. The manager assured us this would be addressed with staff.

The service reported 14 surgical site infections out of the 1,453 breast surgical procedures carried out between July 2018 and June 2019. This equated to 1%, which was a small proportion of patients compared to the number of surgical procedures carried out at the hospital. Surgical site infections were audited every four months. The hospital also carried out root cause analysis investigations to understand the reason for the infection.

As part of the admission pathway, staff confirmed with patients if they had been screened for MRSA. On inspection, staff were unaware of the MRSA screening criteria. However, post inspection evidence of the MRSA criteria was supplied, and staff were informed of the policy and standard operation procedure detailing the criteria.

We observed staff removing cannulas from patients without using aseptic technique and without wearing gloves. According to the infection prevention policy, staff undertaking cannulation must adhere to using an aseptic technique and the use of gloves is advised. This was raised with the manager, who said this would be addressed through training and meetings.

Equipment and the premises were visibly clean. Deep cleaning was carried out by housekeeping staff. They followed a checklist to ensure all areas were cleaned appropriately.

Environmental audits were readily available and completed every three months. An action plan was in place to address areas of concerns after the audit took place. We saw from the action plan, these were followed up and completed.

The decontamination of some equipment such as surgical equipment was not completed on site. All equipment that was not disposable such as surgical instruments were sent to be decontaminated and sterilised. The hospital had an SLA with a nearby NHS hospital. There was a clear system for decontamination, staff told us the service level agreement ensured equipment was returned on time.

The maintenance manager had a system in place to ensure that the asset register was up to date. This meant the service was able to track which pieces of equipment needed to be serviced and when. Most of the equipment we saw in theatres (including anaesthetic equipment) and the ward areas had been appropriately checked and serviced.

There were sufficient hand gel dispensers on the wards with signage reminding patients, visitors, and staff to clean their hands.

The sharps bins we saw were not overfilled and were correctly labelled. All bins were dated with the date they were first used.

The service carried out ward level and theatre hand hygiene audits, the results of which were displayed on the ward. Hand hygiene audit results varied between January and August 2019, results showed between a 92% - 100% compliance rates. However, we observed during the inspection that staff did not always wash their hands between patients on the ward. This was raised on inspection with the manager.

The maintenance manager carried out legionella checks on a weekly basis. We reviewed temperature records of the hot and cold outlet between January 2019 – November 2019 and found all checks had been completed.

Patients were not admitted if they had an infection, if they were found to have an infection on the day of surgery, they would be placed at the end of the theatre list and the theatre would be deep cleaned.

Requires improvement

Surgery

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe.

There were two theatres in total, attached to the ward, which meant patients could be escorted without having to go through public corridors.

All theatres were laminar flow (a system that filters air coming into the theatre to try and reduce wound infections). The theatre ventilation system had recently received a refurbished due to previous issues with the airflow in theatres. The service also had a comprehensive planned preventative maintenance programme to ensure airflow in theatres were suitable.

We saw that the equipment used in theatres, including anaesthetic equipment, had been safety checked and were regularly serviced.

Recovery area was clean and housed two bays, we saw that each bay had an alarm to alert staff if additional support was needed. The recovery area was opened from 7.30am until the last patient left. They were staffed appropriately.

The environment was appropriate for the level of surgery undertaken at the hospital. We saw each bay had suction and monitoring equipment for example machine to measure blood pressure and pulse.

Daily anaesthetic checklist was completed to ensure all anaesthetic equipment was present and available. We checked records that showed they were completed on the day of inspection. All waiting areas had an adequate number of seats and televisions to keep patients and their families occupied. All beds on the ward and in recovery had call bells within patient reach.

Staff carried out daily safety checks, the resuscitation trolley located in theatre had completed records demonstrating daily, weekly, and monthly checks had been completed.

The maintenance manager ensured equipment was maintained and was serviced to make sure they were safe to use. Any maintenance issues were reported to the manager who logged them as incidents and checked their progress. For example, we saw the generator had been tested every month and logged by the maintenance manager.

Electrical equipment we checked had been serviced and logged on a register. The register was monitored by the maintenance manager who arranged for servicing of equipment.

The hospital was locked. Patients and visitors could only enter when authorised by staff.

Instruments, equipment, and implants complied with the Medicines and Healthcare protection Regulatory Agency requirements. They were managed so that any product failures were reported to the appropriate regulatory authority. The hospital held a register for implants and recorded the details of each implant they used. The maintenance manager used a register to track all equipment, during the safety huddle we saw staff discuss the traceability of implants.

The hospital managed waste well, for example waste was segregated into different colour coded bins. Waste was regularly collected by a third-party provider.

The provider had worked with the fire safety regulators to ensure they met the fire safety regulations. At the time of the inspection, fire safety signage and extinguishers were available. All routes we checked were unobstructed and staff were all aware of where fire safety equipment was.

However, weighing scales used to weigh patients to check their body mass index and to calculate the amount of medication required for surgery had not been calibrated. This was raised at the time of inspection and the manager assured the team they would be checked.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient and removed or minimised risks.

Surgeons contacted the patient's general practitioner for their past medical history to ensure the patient was suitable for surgery. However, in ten patient notes we reviewed, five patient case notes contained information from their GPs that showed the patient had a history of depression, low moods, or anxiety. None of these patients had received a psychological assessment or had been referred for one. There was no documentation that showed the consultant or the nurses at the hospital on the day of surgery had reviewed the patient's mental health or queried this with the referring surgical provider. Staff we spoke with said they never assessed their patient's

psychological state as they assumed this was done at the preoperative appointment. This was raised with the manager at the time of the inspection who was going to escalate this to medical director as they were unaware this was a requirement needed to be completed locally. The provider was unable to demonstrate a pathway for patients that may benefit from further psychological assessments or input from a trained psychologist, this was not in line with Cosmetic Surgery Standards 2016.

During the inspection, we observed that the service did not comply with all elements of World Health Organisation checklist. The time out was not in line with best practice as time out should be completed prior to the patient being prepped and draped and prior to knife to skin.

The sign in was not completed appropriately. Staff told us that this was completed when the patient was collected from their room. In all procedures we observed we saw that the surgeon arrived in to theatre when only the surgical site could be viewed after prep and draping and immediately started operating. This was raised on inspection.

Although, we found all the patient rooms had functioning oxygen ports, if a patient was to become ill on the corridor or anywhere in the hospital, staff did not have access to oxygen immediately as set out in the resuscitation guidelines (2015). Oxygen was not available on the resuscitation trolley. This was raised on inspection. The hospital manager advised oxygen would be situated on the resuscitation trolley moving forward.

However, the theatre team conducted a team brief, which discussed all patients on the list and planned the list accordingly.

The hospital had an admissions policy setting out an agreed criterion for admitting patients to the hospital. Patients were referred to the hospital by an external provider. Prior to admission each patient underwent a risk assessment with their consultant and/or a pre-assessment nurse. This was in line with the Royal College of Surgeons standards for cosmetic surgery 2016.

The hospital only accepted patients who were deemed fit for surgery. Patients were only admitted if they had an American Society of Anaesthesiologist (ASA) grade 1 and ASA grade 2. This is a subjective assessment of a patient's fitness before surgery.

Staff used nationally recognised tools to identify deteriorating patients and escalated them appropriately. For example, we saw National Early Warning Scores 2 documented in 10 patients records we reviewed.

On the day of the procedure, all patients were seen by the surgeon and the anaesthetist. This gave patients another opportunity to discuss any questions or concerns.

Staff we spoke with said they assessed patients on the day of surgery for venous thromboembolism (VTE). This was in line with NICE guideline CG92 which states all patients admitted into hospital should be risk assessed for VTE and a further risk assessment should be carried out for those with reduced mobility. From notes we reviewed, all patients had a VTE assessment and were provided with compression stocking aids.

The ward had a sepsis board that held information about sepsis and the Sepsis Six pathway (a set of six tasks to be completed within an hour of identifying probable sepsis). Staff had never come across a patient with sepsis but had the information to support them in line with NICE guideline [NG51] Sepsis: recognition, diagnosis and early management, quality standard five, which states sepsis should be considered for all people including those stratified as at low risk. Staff had access to flowcharts, a care bundle and screening protocols. .

A service level agreement was in place with a nearby NHS trust to support the transfer of a deteriorating patient. Staff followed a clear pathway to transfer deteriorating patients to a neighbouring hospital. On inspection we reviewed the patient transfer documentation which showed a clear pathway for staff to follow in the event a patient deteriorated.

Staff had access to a major haemorrhage policy, this was displayed on the ward, in recovery and theatre. The pathway details of how to deal with the bleed and how to ascertain blood.

Patients were given information about aftercare, we saw information in the patient notes that confirmed this was given to each patient. The information contained out of hours contact numbers if they had a complication and how to look after their wound.

Staff received all preoperative information and patient specific implants/equipment two days prior to the procedure. This was so that staff at the hospital could check everything was in place for the procedure and patient.

Patient name, date of birth, surgery site, allergies and skin marking were all checked pre- operatively and clearly documented in the patient's surgical notes so that the traceability of equipment post-surgery was available.

Nurse staffing

The service had enough nursing and support 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 bank and agency staff a full induction.

Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency, and locum staff a full induction.

Staffing levels, we observed were in accordance with the Association for Perioperative Practice guidelines. Theatre staffing levels were planned in advance to ensure safe levels were maintained. We reviewed nursing staff rotas that showed that the manager calculated and reviewed the number and grade of nurses and healthcare assistants needed for each shift in accordance with national guidance in theatre and surgical ward such as safe staffing for nursing in adult inpatient wards in acute hospital [SG1] (2014).

The ward displayed information on staffing. We saw that the number of nurses and healthcare assistants on all shifts matched the planned numbers.

Due to the nature of the service, the hospital had employed a core number of staff. The rest of the nursing team were either agency or bank. At the time of inspection, the hospital manager informed us they had reduced their agency staff usage over the last 12 months. The hospital reported using between 92% - 96% bank and agency staff during August 2018 and July 2019. In some months only, bank staff was used.

All new members of staff underwent an induction programme, the programme provided them with a foundation of knowledge and skills to begin fulfilling their role. Staff on the first day undertook an orientation of the hospital, basic and emergency procedures and fire exists. In addition, staff were provided with a mandatory training booklet which must be completed within 3 months of commencing employment.

The hospital reported a 2% sickness rate between August 2018 and June 2019, this was due to long term sickness.

Medical staffing

The service had enough medical 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 locum staff a full induction.

We spoke to four medical staff who told us that they felt well supported and happy.

The service reported having 15 Surgeons and 20 Anaesthetist who had practicing privileges granted.

Where patients were sedated, a second staff member who was trained in anaesthetics was always present. Their main role was to monitor the patient was present during the procedure.

Patients were admitted and treated under the direct care of a surgeon and medical care was supported 24/7 by onsite resident medical officers.

Resident medical officers provided daily medical services and dealt with routine and emergency situations when the surgeon was not available. During out of hours, the RMO escalated any emergency to the on-call surgeon. However, the hospital did not stipulate that medical practitioners performing surgery were required to be within 30 minutes of the hospital. Therefore, we were not assured that the consultant performing surgery were able to attend to their patient with 30 minutes.

Resident medical officers received a local induction when starting work at the hospital.

Absences due to sickness or holiday were covered by an alternative resident medical officer.

Records

Requires improvement

Surgery

Staff did not always keep detailed records of patients' care and treatment. Records were clear but were not always up-to-date and stored securely

Records were clear, easily available but they were incomplete. Staff kept detailed records of patients' care and treatment. However, they were not stored appropriately.

The service used a combination of electronic and paper-based records. Of the 10 records we reviewed across the patient pathway we found information was not complete in 5 of the 10 records. The date, surgeon's name, GMC number, the time the cannula was inserted and the time it was taken out were absent.

All patient records we reviewed contained ongoing monitoring and care planning arrangements. The records gave opportunity for nursing staff to record their actions and the care they had delivered to the patients that day.

Records containing patient sensitive information were left on an open shelf in the nurse's room. The room was left open and was not always occupied with a member of staff. It was therefore accessible to patients.

Staff left the computer unattended after reviewing patient details. We found on five occasions staff had left the computer open and patient information was visible when entering the room.

Pre-operative assessment records were received prior to the day of admission. Staff told us they would always ensure records were available before the day of surgery.

Care summaries were put together and sent to the referring surgical provider for them to send to the general practitioner. In all the notes we reviewed, we saw documentation detailing the surgical procedure and the care received. The service ensured details of any cosmetic implants were reported to the national breast and cosmetic register. This was so that they can be traced in the event of a product recall or safety concerns relating to the implant.

We saw in records where patients were prescribed antibiotics, the clinical indication, dose, and duration of the treatment was documented.

The service carried out record audits on a quarterly basis, between March 2018 and May 2019 compliance rate varied between 73% and 100%. We saw evidence of actions taken to address those who did not complete records appropriately.

Medicines

The service did not always use systems and processes to safely prescribe, administer, record and store medicines. For example, one nurse left the treatment room to prepare a dose of medication. However, the prescription was not signed. This was brought to their attention and the prescriber was contacted immediately prior to administering.

During our inspection we observed that two controlled drugs, for two different patients, were not signed out of the controlled drugs' register. We explored this with staff who advised us they had planned to do this later. This is not in accordance with best practice guidance. We saw that discharge medicines were not appropriately documented when supplied. This was not in line with the hospital's medicine policy.

The hospital acquired medicines through a service level agreement with a pharmacist. We found the staff were distributing medication without labels that stated they were from the First Trust Hospital.

Oxygen cylinders needed to be available in an emergency. We found one cylinder behind the nurses' station on the corridor this was not stored appropriately and could be accessed inappropriately.

During our inspection we observed that all cupboards holding medicines were left open with medicines prepped and drawn up in the anaesthetic room. This was raised with the theatre staff on inspection, who addressed our concerns immediately.

We found that an adult cardiac pulmonary resuscitation box was out of date. It was labelled with use before October 19. We saw a second box behind the out of date box which was in date. However, in an emergency there was a risk that the box would be used. We escalated this to the provider and this box was removed whilst we were onsite.

Requires improvement

Surgery

The main storeroom has items stored on the floor because the room was too small to store everything. We raised this at the time of our inspection who informed us this was under review.

Bedside lockers were used if people needed to self-medicate. However, all the keys to these cupboards were not securely locked away. This meant anyone could gain access to them and to patient's personal belongings.

The service did not always make sure medicines given to patients on discharge were recorded in line with their policy. We checked seven medication prescriptions and found only two prescriptions contained the correct information. This meant that it was not possible to check which medicines had been supplied.

Allergies were clearly documented in surgical documentation.

Notes contained evidence of communication with the General Practitioner and private surgical referrer to ensure the hospital received an up to date medication history.

Fridge temperatures were taken daily. This was seen from daily records. Staff knew what to do when the temperature went out of range. There was a standard operating procedure in place to guide staff when the temperature was out of range.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised but did not always offer suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff recognised what constituted as an incident and reported them through the reporting systems. Managers investigated incidents and shared lessons learned with the whole team. Managers ensured that actions from patient safety alerts were implemented and monitored.

Feedback from investigations of incidents, were disseminated through team meetings and morning briefs. For example, the hospital had recently updated nursing care to reflect lessons learnt from incidents and complaints during 2018.

The management team were aware of when to make statutory notifications to the CQC and this was detailed in the incident management policy.

From June 2019 and April 2019, the hospital reported no never events for surgery. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at national level and should be implemented by healthcare providers. Each never event has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.

The service had a Duty of Candour policy which was in line with the appropriate regulation. The Duty of Candour is a regulatory duty that relates to open 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. Duty of Candour should be discharged if the level of harm to a patient is moderate or above.

Staff we spoke with were aware of the duty of candour regulations, they could provide us with examples of when they would use this such when surgery was cancelled or running late. However, in one incident where Duty of Candour was applicable we did not find evidence that a patient was offered suitable support.

Are surgery services effective?

Good

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. The wards had up to date copies of the Nursing and Midwifery Council's Professional standards of practice and behaviour for nurses, midwives, and nursing associates available for staff.

Requires improvement

Surgery

A system was in place to make sure policies and procedures were up to date. All policy and process updates were reviewed by the Medical Advisory Committee, once they were approved they were cascaded to the hospital team.

The service provided care and treatment based on national guidance and evidence-based practice. For example, when reviewing entries in 10 patient records we saw that staff followed national cosmetic standards and guidance when caring for patients.

The service used the American Society of Anaesthesiologists (ASA) Physical Status Classification System to establish a patient's fitness to be given an anaesthetic for a surgical procedure.

The service took account of the Association for Peri-operative Practice guidelines on accountable items and ensured theatre equipment such as swabs were counted before and after surgery to check that no items had been retained.

Managers checked to make sure staff followed guidance through auditing and discussing best practice in safety huddles.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. For example, staff used a national early warning score system to manage unwell patients in line with National Institute for Health and Care Excellence Guidelines 50 - Acutely ill adults in hospital: recognising and responding to deterioration (2007).

However, we found policies were not updated with version numbers and we were unable to determine if the policy was the most up to date version. The service had not noticed this issue which suggested the governance structure around reviewing policies was not robust.

The service did not ensure that cosmetic pre-operative assessments included appropriate discussions with the patients about body image before surgery was carried out.

Nutrition and hydration

Due to the nature of the surgery carried out at the hospital, there was no requirement to use special feeding and hydration techniques. We saw that patients were offered a drink and biscuits following surgery.

Staff followed national guidelines to make sure patients fasted before surgery in accordance to the Royal College of Nursing, and the European Society of Anaesthesiology (endorsed by the Association of Anaesthetists of Great Britain & Ireland) guidelines Perioperative fasting in adults and children).

Staff fully and accurately completed patients' fluid and nutrition charts where needed.

Patients were able to order food once they had recovered from surgery. Menus were available in each room and offered a large variety of options. The service took into account the religious and cultural needs of patients with additional dietary requirements.

Pain relief

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

Recovery staff asked patients post operatively if they were in any pain. This information was conveyed to the ward staff during handover.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individuals' needs and best practice. We saw pain scores were documented in the patient notes we reviewed.

However, the service did not conduct a pain audit to assure themselves patients were appropriately assessed for pain and were given pain relief in a timely manner.

Patient outcomes

Due to the nature of the service the hospital only reported data to two national audits. We saw evidence of data being submitted to the Private Healthcare Information Network (PHIN) and Breast Implant registry.

After each operation list all patients' notes were placed onto the computer system, so that completed files could be sent back to the provider. Breast implant information was put on to the Breast Implant register.

The service audited surgical outcomes, data provided by the hospital reported less than 3% of patients had a post-operative wound infection within 30 days of surgery for non-implant surgery and 12 months for surgery with implants.

Requires improvement

Surgery

The hospital completed an annual audit programme which ensured they regularly reviewed the effectiveness of the care and treatment they delivered. Audits included Post-operative nausea and vomiting, hand hygiene, National Early Warning Score and Waste management.

Audits were well documented with outcomes and recommendations. Where issues had arisen, the hospital was able to evidence how they improved the service. For example, the post-operative nausea and vomiting audit identified when a particular medication was given to patients, it caused them to feel nausea. As a recommendation, staff were looking at a different medication.

Another audit around waste management prompted senior managers to improve the signage around the hospital to remind staff about how to dispose of waste correctly.

There were 1,723 inpatient stays following surgery between July 2018 and June 2019. There were 3 unplanned returns to theatre.

The prosthesis and implant audit showed overall compliance rate was 72%. This meant the hospital was not assured the person checking the new prosthesis and implants against documentation held for prosthesis and implant matched the labels on the products. As a result, the hospital implemented a number of actions to improve compliance. For example, checking implants was discussed at every team brief since the audit, to remind staff of the importance of completing them. We also were shown the implant register kept by the manager, who did spot checks to ensure they were completed. We were told the process was going to be re-audited to check compliance.

Competent staff

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

Bank and agency staff underwent an induction. Staff files contained a checklist demonstrating that they had completed health and safety and mandatory training, had reviewed corporate policies, and had a local induction.

The hospital manager kept staff competency files. Competencies included blood transfusion, intravenous therapy, and medicines management. We saw that these files were up to date and completed.

The ward had different notice boards which provided information for staff. This included infection prevention, sepsis and safeguarding.

Cosmetic surgeons carrying out cosmetic surgery had the sufficient operative exposure in the area of certification as recommended by the Royal College of Surgeons.

The service ensured all first assistants for surgeons were appropriately qualified and competent. We reviewed two staff files that evidenced the appropriate certification and competencies framework.

The hospital manager said all applications made by surgeons and anaesthetist were reviewed by the medical advisory committee. The hospital had a practising and privileges policy that detailed the checks required before a doctor was given rights to work at the hospital. We were told during the meeting, the skills, relevant experience, and exposure to the procedures carried out by the medical practitioner were discussed. However, in the last three MAC minutes we saw that staff had granted practice and privileges but there was no evidence of the discussion had to determine why the medical practitioner was granted practice and privileges section.

Where intravenous sedation was used, the hospital manager said the appropriate evidence in training in sedation and competencies in airway management and resuscitation were checked and held on file, we reviewed two files and saw that they had been completed. There was a compulsory requirement for anaesthetic staff to have completed advance life support, this must be current and held on file.

All medical practitioners were required to submit a copy of their most recent appraisal. This was so the hospital manager was assured those providing care did not have any limitations to their practice and worked in line with the guidelines for the provision of Anaesthetic services and the Royal College of Surgeons.

The hospital manager kept a log of all General Medical Council registration numbers and checked they were able to practice as cosmetic surgeons before they were granted practicing privileges.

Multidisciplinary working

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

Requires improvement

Surgery

There were clear discharge arrangements for patients having surgery.

Care was delivered and reviewed in a coordinated way when different teams across the hospital. For example, handover between the recovery team and ward staff was thorough and concise.

Seven-day services

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

The surgical wards were staffed 24 hours a day when patients stayed overnight.

Health promotion

Staff did not give patients practical support and advice to lead healthier lives. When asked they advised this was done at the pre-operative assessment.

During the pre-operative assessment carried out by the nurse, patients were assessed for general health issues and asked about smoking, alcohol, and other lifestyle choices. However, in all records we reviewed there was no documented evidence that staff discussed support.

There were no leaflets across all patient areas, informing patients about different health promotion topics.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff we spoke with said they did not admit patients who lacked capacity but would immediately escalate to the matron if they felt a patient lacked capacity.

The service had a policy in place covering mental capacity, consent, and best interests. This was important as it meant that there was a clear process for staff to follow when documenting consent, a best interest decision or reviewing capacity.

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Regular consent audits were completed and reported at the Medical Advisory Committee. Compliance rate varied between 85% - 100%. An action plan was in place to address non-compliance.

Consent followed two stage process in line with the Royal College of Surgeons standards for cosmetic surgery standards. Signed and dated consent forms were present in all 10 records we checked. These forms detailed the risks and the benefits of the surgery.

We saw that patients were given a 14-day cooling off period so that they had sufficient time to make an informed decision as set out in the Royal College Surgeons professional standards for cosmetic surgery.

Compliance rate for mental health training for all staff was 87% at the time of the inspection. Seven members of staff required this training: two were on maternity and five staff members of staff had recently started.

The compliance rate for mental health training for Medical Staff is 93% with two members of staff outstanding, one was on maternity leave and one staff member was in progress.

Are surgery services caring?

Good

Caring means that staff involve and treat you with compassion, kindness, dignity and respect.

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. For example, doors were closed when they were delivering personal care.

Patients said staff treated them with kindness and provided reassurance when they felt nervous. Patients gave positive feedback about the service in the patient survey. Patients had left positive comments and the staff we met spoke highly of the nursing and medical staff.

Staff supported patients using the service to be mobile and independent post-operatively, we saw patients were helped to get out of bed and left to get ready with the reassurance staff were nearby.

Requires improvement

Surgery

Patients were greeted at reception and asked to wait in the waiting area to be collected by staff. We observed staff talking to patients as they took them to the ward. They instigated a friendly conversation which initiated a nice rapport with their patient.

Staff followed the hospital privacy and dignity policy that promoted five objectives, these included staff understanding dignity, adhering to ensuring patients privacy, promoting equality and diversity, personal care and preventing and responding to any discriminatory behaviour towards patients.

Emotional support

Staff provided emotional support to patients, families, and carers to minimise their anxiety. Staff discussed with us the importance of providing patients emotional support when they were nervous about surgery. For example, we observed three staff members providing reassurance and comfort to patients in a pleasant manner.

However, we saw no evidence of staff providing information relating to counselling services if this was needed. There were no leaflets or information to help patients if they requested this. Staff did not know who to signpost patients to or where to obtain leaflets about counselling services.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, to make informed decisions about their surgical procedure.

We listened to conversations between staff and patients and heard staff answer questions and explain differently to those that did not understand certain elements of their care plan.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Are surgery services responsive?

Good

We rated it as **good.**

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of the patients who were referred to them by the referring surgical provider.

The service provided cosmetic treatment that reflected the needs of the population they served. Patients were able to access appointments at a time that suited them.

Facilities and premises were appropriate for the services that the hospital delivered. The hospital management team met regularly with external providers to improve the patient experience so that the service met the needs of the local people. For example, they had previously met with an external provider to discuss the timeless of preoperative notes. As a result, this had improved the quality of the information they received in the preoperative notes.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff told us that the pre-assessment team would flag in advance whether any patients had individual needs, such as a disability or mobility issues in advance of surgery. Such patients would usually be operated on first, to reduce their waiting times.

The service booked an interpreter for patients who did not speak English. The service could also arrange sign language interpreters.

The service had robust discharge planning documents in place to support staff to check that patients had the right information for post-surgery care. In records we saw staff had completed a discharge tick list to confirm all aspects of the discharge had been completed. This included a letter to their general practitioner, leaflets about wound care and arrangements relating to transport.

Access and flow

People could access the service when they needed it and received the right care promptly. Due to the nature of the service the, the hospital did not monitor waiting times from referral to treatment and arrangements to admit, treat and discharge patients. All patients we spoke with said they experienced no problems with accessing the service.

Requires improvement

Surgery

The service had cancelled 27 operations between January 2019 and November 2019, (less than 1% of all visits to the operating theatre). All cancellations related to patients not being fit for surgery after being assessed by the nurse or surgeon on the day of surgery.

We attended a team brief meeting (this occurred once a week). The meeting was attended by the senior team and used to review the list for the following week. The team discussed a range of topics including the length of procedures, staffing, concerns and equipment requirements.

Theatres were booked by the cosmetic surgery companies. Surgery started from 9am. The hospital policy stated no elective surgery would be scheduled in after 7 pm.

Theatre staff could prescribe take home medicines in theatre to help timely patient discharge.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Learning from complaints and concerns were discussed in monthly meetings and any learning shared. For example, the senior team identified a theme in complaints and as a result changed the staffing structure to support staff and patients.

There was a complaints policy in place which staff adhere to. Were reviewed four complaints. These were acknowledged by the matron and responded to in 28 days.

However, where complaints were classified as a stage two complaint, the review was not completed by an external independent adjudication service. Patients were referred to a company owned by one of the company's directors which meant they were not independently reviewed.

Are surgery services well-led?

Requires improvement

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.

During conversations with managers, we saw they were focused on patient care and staff wellbeing. We heard of examples where the management team put in place wellbeing meetings to support staff through challenging times. This was so that staff did not feel they were not supported by the leadership team.

The leadership team across the service had a comprehensive knowledge of current priorities and challenges and acted to address them. For example, the fire safety action plan was consistently visited at governance meetings to keep it at the forefront. The hospital was now compliant with the fire safety report.

There were regular staff huddles and briefings on the ward and in theatres to ensure that frontline staff received all relevant information about the hospital.

The leadership team said staff were given development opportunities. This was supported by 75% of staff who reported receiving development opportunities in the staff survey.

The hospital met the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors are fit and proper to carry out this important role. We looked at the senior management team's employment files, which were completed in line with the FPPR regulations.

Vision and strategy

The service had an aim which incorporated the hospital vision.

The hospital did not currently have a strategy in place for achieving the priorities and delivering good quality sustainable care. There were plans to develop this with staff so that they felt they were contributing to the vision, values, and direction of the hospital.

Culture

On inspection staff told us they felt respected and were encouraged to work as a team. This was reflective in the

staff survey results. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, and staff could raise concerns without fear.

All staff were expected to complete e-learning on equality and diversity. The team was a diverse team who worked well together. Staff survey results showed 95% of staff said they did not experience bullying at work. We raised concerns regarding the 5% of staff who had reported bullying with the senior team who were aware of the issues and showed evidence of the actions they had taken.

All the ward and theatre staff we spoke with were proud of the team work and collaboration within the service.

Freedom to Speak Up had been introduced. The provider had a freedom to Speak up board and staff as Freedom to Speak up guardians. Staff could raise concerns.

The equality and diversity policy referenced all the protected characteristics such gender reassignment, maternity, and pregnancy.

Governance

The arrangements for governance and performance management were not fully clear or do not always operate effectively. There has been no recent review of the governance arrangements, the strategy, or plans. For example, at the time of the inspection senior managers were unaware of the requirement to complete local psychological assessments to ensure patients did not have any mental health concerns.

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 but leaders did not always follow best practice. For example, we saw that the WHO checklist did not follow best practice set out by the Royal College of Surgeons.

However, the service had made significant improvements to the concerns raised around fire safety. We found the hospital manager and the team had completed all but two actions on the action plan. The outstanding actions were around electrical fittings which were due to be completed the week after our inspection.

The hospital held a daily morning briefing attended by ward staff. This was mirrored in theatres. This provided an opportunity for all managers to share patient information, any changes to theatre list, incidents, best practice, or equipment issues.

There was a regular monthly senior team brief meeting. We reviewed the minutes from three team briefs between September and October and found there was good attendance. Staff discussed theatre lists, risks, incidents, complaints, implants, and theatres. There were also discussions about infection prevention control, waste management and equipment.

Notice boards in staff rooms on the ward displayed various information including reports, incidents, compliments, and information cascade from the team brief.

The hospital manager was assured that surgeons carrying out cosmetic surgery had the right level of valid professional indemnity insurance in place. Documentation to prove this was valid was required prior to being granted practising privileges.

The service had a comprehensive system in place to monitor practising privileges. The medical advisory committee reviewed all new applications for practising privileges. Information on each surgeon and anaesthetist was kept on file at the hospital. This included their General Medical Council registration, appraisals, indemnity insurance, and disclosure and barring service checks. We reviewed eight practising privileges records and these all contained appropriate and up to date documentation.

All medical practitioners involved in cosmetic surgery were required to submit their annual appraisal and keep accurate information about their personal performance in line with national guidance on appraisal for doctors. This was reviewed by the medical advisory board and only then was the right to practice be granted or renewed. In the hospital 12 of 15 consultants were on the specialist register and the remaining three evidenced certifications in reconstructive plastic surgery and experience of the procedures carried out.

The senior management team met regularly with third party providers to discuss performance, governance, and patient safety.

Managing risks, issues, and performance

Requires improvement

Surgery

Risks, issues, and poor performance were not always dealt with appropriately or quickly enough. For example, the hospital did not review or follow up patients who had be referred to them with mental health concerns.

The risk management approach was applied inconsistently or was not linked effectively into planning processes. We found risks such as spread of infection was not a priority amongst staff and this was not picked up by leaders.

However, the service had an audit plan for the year ahead, which clearly set out what audits needed to be completed, when and in what frequency. Audits included, amongst others, infection prevention, record keeping, surgical safety checklist and consent.

The service had systems to manage unexpected events such as power cuts and floods.

The ward had a team board were various information could be displayed, including information cascade by the executive team. Information included hospital risk register, team brief notes and a newsletter.

There were monthly clinical governance meetings in which surgical risk issues were discussed. From the minutes we reviewed, these meetings were well attended and included the theatre manager and other senior leads and executives from the hospital.

The hospital had recently invested in replacing the airflow system in theatres. This had been on the risk register as a health and safety risk as well infection control issue.

Managing information

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

Electronic data was appropriately safeguarded and only accessible to authorised staff.

Managers had access to a range of information to support them with their management role. This included information about personnel, service management and reports.

Engagement

The hospital sought patient feedback through surveys. Patients were asked to complete a patient satisfaction survey post-surgery. They were also asked to leave any suggestions of improvements in the suggestion box which was placed in reception.

A bi-monthly newsletter was put in place to ensure staff, had access to up to date information about the hospital. This was implemented to improve engagement between staff and managers. As senior managers recognised that staff felt communication was poor and said so in the staff survey results.

Learning, continuous improvement and innovation

Senior managers invested in staff to improve skills. For example, staff had the opportunity to work with neighbouring hospitals to improve knowledge, they attended aesthetic conferences and managers attended management conflict courses.

However, the organisation does not react sufficiently to risks identified through internal processes, but often relies on external parties to identify key risks before they start to be addressed. For example, our inspection identified gaps in surgical practice, which had not been identified prior to our visit.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that staff adhere to infection prevention practices to reduce the risk of spreading infection and surgical site infections.
- The provider must ensure that there is a system in place to ensure patients undergo a psychological assessment to identify those who are vulnerable.
- The provider must ensure medicines are handled or stored in line with Medicines and Healthcare products Regulatory Agency.
- The provider must ensure they carry out the World Health Organisation checklist in line with best practice.

Action the provider SHOULD take to improve

- The provider should ensure there is a set criteria that determines which patient was screened for methicillin-resistant staphylococcus aureus.
- The provider should ensure patients are invited for a face to face discussion and this is documented in line with Duty of Candour. Regulation 20.
- The provider should ensure version numbers on polices are available to indicate they are the most up to date version.
- The provider should ensure oxygen is immediately available and stored appropriately.
- The provider should ensure they promote healthy living to support patients with lifestyle changes.
- The provider should ensure all weighing equipment is calibrated.
- The provider should ensure stage 2 complaints are reviewed by an external independent adjudication service.

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
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not have effective infection prevention control processes in place to reduce the spread of infection. The provider did not have effective processes in place to ensure patients had a current psychological assessment prior to surgery. The provider did not have effective systems in place to store and handle medicines in line with Medicines and Healthcare protection Regulation Agency. Regulation 12 (1) (i)

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have effective systems records were stored and handled securely. The provider did not have effective systems in place to ensure all elements of the surgical safety checklist was completed. Regulation 17 (1)(2)(a)