Alexandra Health Care Limited

Alexandra Private Hospital

Inspection report

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

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires Improvement
Are services caring?	Insufficient evidence to rate
Are services responsive to people's needs?	Good
Are services well-led?	Inadequate

Summary of findings

Overall summary

Alexandra Private Hospital is an independent hospital which provides cosmetic surgery to self-funding patients. We carried out an unannounced comprehensive inspection of surgery services at this location on 11 October 2022.

This is the first time we have rated this service. We rated it as inadequate overall because:

- We were not assured all staff had completed training in key skills. The service did not always control infection risk well. Equipment was not always regularly checked and maintained to keep patients safe from harm. Risk assessments were not always tailored to meet the needs of the patients using the service and did not routinely complete NEWS scores during the pre-operative assessment. Records were not always comprehensive and up to date. The service did not always use systems and processes to safely prescribe, administer, record and store medicines.
- We were not assured managers monitored the effectiveness of the service and the outcomes of patient care and treatment.
- Leaders did not always have the skills to identify whether they had appropriate governance to support processes and did not have effective processes. The service did not have an assured process to for managing performance in a timely way or to assess and monitor risks.
- The service did not have a strategy for how the service planned to achieve the vision or measures to identify if the vision had been achieved.

However:

- The service had enough staff to care for patients and keep them safe. Staff showed an understanding of how to protect patients from abuse. The service managed safety incidents appropriately and learned lessons from them.
- Staff provided care and treatment in line with national guidance and legislation, and made sure staff were competent. Staff assessed patients pain and post-operative nausea and vomiting regularly. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. They followed the two-stage consent process.
- Although we observed minimal patient and staff interaction, what we did observe indicated staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet patients' individual needs and made it easy for people to give feedback.
- Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and staff were committed to improving services continually.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Inadequate 	This was the first time we have rated this service. We rated the service as inadequate overall. We rated safe and well-led inadequate, requires improvement for effective and good for responsive. Unfortunately we did not have sufficient evidence to rate caring.

Summary of findings

Contents

Summary of this inspection

Background to Alexandra Private Hospital

Alexandra Private Hospital is operated by Alexandra Health Care Limited. It is a private hospital located in Chesterfield. The hospital facilities include 21 beds which are split between 2 floors; however, the service mainly utilise the 10 beds that are located on the second floor. There are also 2 theatres on the ground floor, 1 of which is mainly used by a third party for their procedures. There are also consultation rooms on the first floor where patients will receive their pre-operative consultations.

The hospital only provides cosmetic surgery for self-funding patients. The hospital also offers non-regulated cosmetic procedures and cosmetic dental procedures. We did not inspect these services.

The service currently has 3 registered managers in place, 2 of which have been in this position since the service registered with the CQC in October 2010.

Alexandra Private Hospital has been inspected 5 times since they were registered. The most recent inspection was a focused follow up in January 2017. The service has never previously been rated as this was before we had the powers to rate independent specialist services which provide cosmetic surgery.

The service is registered to provide the following regulated activities:

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

How we carried out this inspection

We completed an onsite visit to the service on 11 October 2022. The inspection team consisted of a lead inspector and a specialist advisor in surgical services. The inspection team was overseen by Sarah Dunnett, Head of Hospital Inspection. On the day of inspection, there were no theatre lists running, however we still visited the ward, theatres and clinical assessment rooms. We spoke with 5 staff, including members of the management team, nursing staff, healthcare assistants and reception staff. We spoke with 1 patient and their accompanying relatives. We reviewed 12 sets of patient records, 3 of which were only at the pre-operative assessment stage.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

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

Action the service MUST take to improve:

Summary of this inspection

- The service must ensure that the standards of documentation are sufficient to provide assurance that all risks are suitably identified and acted upon. **Regulation 12 Safe care and treatment.**
- The service must ensure patients are not exposed to risk of harm through the use of out of date medicines. **Regulation 12 Safe care and treatment.**
- The service must ensure patients are not exposed to risk through the use of out of date consumable equipment. **Regulation 12 Safe care and treatment.**
- The service must ensure all staff have received the required training to deliver the care and treatment to patients. **Regulation 18 Staffing.**
- The service must ensure their systems and processes are robust enough to identify when patient safety is being compromised. **Regulation 17 Good governance.**
- The service must ensure their systems and processes identify when documentation does not meet the needs of patients when identifying and reducing risk. **Regulation 17 Good governance.**
- The service must ensure their systems and processes are robust enough to assess, monitor and improve the quality of the services provided to patients. **Regulation 17 Good governance.**
- The service must ensure their systems and processes are robust enough to assess, monitor and mitigate risks relating to the service they provide for patients. **Regulation 17 Good governance.**

Action the service SHOULD take to improve:

- The service should ensure that staff follow appropriate infection prevention and control practices to minimise the risk of infection to patients. **Regulation 12 Safe care and treatment.**
- The service should ensure their systems and processes are robust enough to identify when service level agreements are no longer meeting the needs of the service and update accordingly. **Regulation 17 Good governance.**
- The service should ensure that staff consistently record accurate NEWS scores when performing observations on patients. **Regulation 12 Safe care and treatment.**
- The service should consider improving processes for identifying and managing patients who may be experiencing toxicity as a result of local anaesthetic.
- The service should consider how they assure themselves that patients consenting for cosmetic surgery are in line with the Royal College of Surgeons recommendations.

Following this inspection, we issued the service with a Section 29 Warning Notice as we found significant improvement was required in relation to the safe care and treatment of patients and the governance systems and processes that support this. The Section 29 Warning Notice has given the provider until 31 October 2022 to make the significant improvements we have identified.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Inadequate	Requires Improvement	Insufficient evidence to rate	Good	Inadequate	Inadequate
Overall	Inadequate	Requires Improvement	Insufficient evidence to rate	Good	Inadequate	Inadequate

Inadequate

Surgery

Safe	Inadequate
Effective	Requires Improvement
Caring	Insufficient evidence to rate
Responsive	Good
Well-led	Inadequate

Are Surgery safe?

Inadequate

Mandatory training

The service provided mandatory training in key skills to all staff. However, we did not receive compliance data which evidenced everyone had completed it.

Staff told us they received and kept up-to-date with their mandatory training. After the inspection we requested data which demonstrated staff kept up-to-date with their training. We received information which stated all staff were required to complete mandatory training and a list of topics this included. However, we did not receive compliance information of staff who had completed this training. We were therefore concerned that the service were not assured all staff were in date with their training which meant staff may not have the update knowledge and skills to provide safe care and treatment.

Staff told us the mandatory training was comprehensive and met the needs of patients and staff. Managers told us they monitored mandatory training and alerted staff when they needed to update their training. Mandatory training was provided by an external company and was a blend of electronic and face to face training. When face to face training was organised, managers would try to ensure as many staff as possible were able to complete this.

Training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia was included in the safeguarding training. However, we did not receivecompliance information of staff who had completed this training. We were therefore concerned that the service was not assured all staff were in date with their training and therefore were not adequately trained in meeting the needs of patients with complex needs.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, we were not assured that all staff had training on how to recognise and report abuse and they knew how to apply it.

Inadequate

Surgery

Staff told us they received training specific for their role on how to recognise and report abuse. We requested information after the inspection to demonstrate staff had completed their safeguarding training. Information received showed safeguarding was part of the mandatory training requirements. However, we did not receive compliance information of staff who had completed this training. We were therefore concerned that the service was not assured that all staff received safeguarding training and fully understood how to keep patients safe from avoidable harm and abuse.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff discussed examples relevant to the service where they had identified concerns around patients who were potentially vulnerable, and actions taken to manage this.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were aware of the lead for safeguarding at the hospital and would discuss any concerns with them. The safeguarding lead was trained to level 3 and demonstrated an in-depth knowledge and awareness of safeguarding all issues and had formed links with the local authority.

Staff followed safe procedures in the rare occasions that children visited the hospital. The hospital rarely had children accompany an adult to the hospital as patients were discouraged from having visitors on the ward. However, if a child did accompany an adult during an appointment, staff were aware of safeguarding procedures and would know what to look for and escalate their concerns to the safeguarding lead.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. The service used systems to identify and prevent surgical site infections. However, staff did not always use equipment and control measures to protect patients, themselves and others from infection. Equipment and the premises were visibly clean; however they did not always use an effective process to demonstrate it was clean and ready for use.

All areas were visibly clean and had suitable furnishings which were clean however, they were not always well-maintained. We observed a theatre table in the second theatre which had been repaired with black tape. This meant decontamination processes may not be effective.

The service generally performed well for cleanliness. Audit information for January to July 2022 showed the wards achieved a 96% compliance with cleanliness and the theatre areas achieved 99% compliance. Both audits identified staff communal areas as areas which required additional focus on cleanliness. Within the ward areas, soap dispensers and rubbish being left in patient rooms were areas which required additional focus. Follow up audits were not expected to be completed until December 2022.

Staff used records to identify how well the service prevented infections. Staff risk assessed patients during the pre-operative assessment for risk of infection which included MRSA and COVID-19. These would be tailored further to information provided by the patients about the risk of infection. Staff told us since the service opened, they had never had a patient develop MRSA.

Staff mainly followed infection control principles including the use of personal protective equipment (PPE). We observed minimal amounts of practice during our inspection, however we observed a staff member attending to a wound without following infection, prevention and control (IPC) principles. Adequate amounts of PPE were provided for all staff around the hospital, which included face masks for staff, visitors and patients to utilise.

Inadequate

Surgery

We observed staff demonstrating good hand hygiene measures in accordance with the World Health Organisations (WHO) five moments for hand hygiene. However, we observed a member of staff undertaking clinical activities who was not bare below the elbow which was an infection risk. The service completed hand hygiene audits which showed between July to September 2022, theatre hand hygiene compliance was recorded between 94 to 95%. The ward area recorded a compliance of 98% on the hand hygiene audit completed between January to July 2022. Action plans identified areas which required further education and improvement.

Staff were required to clean equipment after each patient contact, and we saw products in all areas to enable staff to do this. However, we did not always observe that equipment was labelled to show when it was last cleaned.

The service had an agreement with the local acute hospital for decontamination of surgical equipment which was reusable. We reviewed surgical sets within the theatre storeroom and found they had all successfully gone through the sterilisation process and the outside wrapping was not compromised.

The service regularly flushed all water outlets and recorded this. We reviewed the flushing log between July to September 2022 and found no gaps within this.

Staff told us they worked effectively to prevent, identify and treat surgical site infections. No incidents had been raised in relation to any infection and staff told us infections were rare.

Environment and equipment

The design, maintenance and use of premises and facilities kept people safe. However, we were not assured equipment was regularly checked and maintained to ensure people were kept safe.

All rooms had patients call bells which staff would ensure were within patient reach. As there were no patients admitted on the day of inspection, we did not observe the timeliness of how quickly staff responded. The patient call bell and emergency buzzer had both an audible and visual alarm which went through to the staff office on the ward.

The design of the environment followed national guidance. The hospital facilities were over 4 floors, with the patient rooms being located on the top 2 floors. Each floor was accessible by stairs or a lift. The theatre facilities were on the ground floor. All patient rooms were single, en suite rooms.

Staff told us they carried out daily safety checks of specialist equipment. Staff told us daily checks were completed on all specialist equipment including resuscitation equipment, refrigerators and the difficult airway trolley. However, this was recorded digitally. At the time of the inspection, the hospital was experiencing difficulties with the IT equipment and we were unable to review at the time. Information received after the inspection showed the service had regularly completed checks of the medicine refrigerators between July to September 2022. No areas of concerns had been identified. Unfortunately, we did not receive the information to support regular checks of the resuscitation equipment had been undertaken. We were therefore concerned that the service was not assured that regular checks were conducted on all items of equipment which meant resuscitation equipment may not be working effectively or some equipment may be missing during a patient emergency.

All of the hospitals electrical equipment was on a rolling schedule for electrical safety testing which staff told us was due in April each year. The equipment we reviewed had not undergone the essential tests in April this year and we raised this with the managers of the service. Managers were expecting equipment to undergo testing and had been trying to

organise this with the third party who completed this. However, electronic messages sent to the managers had indicated this could be extended to a 2-year schedule rather than an annual test. The service had not updated their processes to reflect this at the time of our inspection and equipment had not been updated with this on the stickers. The anaesthetic machines had recently been serviced by the company who produced them.

The service had enough suitable equipment to help them to safely care for patients. However, we found a large amount of consumable equipment items which were out of date. Equipment which was found to be out of date included endotracheal tubes and laryngeal masks which are used for managing airways when undergoing surgical procedures or when a patient deteriorates and has trouble breathing for themselves. A box full of sutures used to close wounds, cannulas which are inserted to deliver fluids and medicines and a box of caps used on the end of cannulas.

Staff mostly disposed of clinical waste safely. However, we were not assured that anatomical waste was always disposed of in line with recommended timescales. Staff provided conflicting accounts of how quickly anatomical waste was collected and how this was stored prior to collection. Staff confirmed anatomical waste was not refrigerated prior to disposal which meant this would need to be collected and disposed of within 24 hours (72 hours if over the weekend in accordance with Environmental Agency, Healthcare waste appropriate measures for permitted facilities, published 2020, updated in 2021). Information received after the inspection showed the policy informed staff on the need for appropriate containers to be used for anatomical waste, however there was no specific guidance in the policy on timelines for collection and disposal. We were therefore not assured anatomical waste was disposed of in line with national requirements.

Assessing and responding to patient risk

Staff mainly completed risk assessments for each patient and removed or minimised risks. Staff identified and acted upon patients at risk of deterioration. The service made sure patients knew who to contact to discuss complications or concerns. However we found staff did not routinely complete a NEWS score during the pre-operative assessment and risk assessments were not always tailored to the patients using the service.

Staff mostly used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The service used the original version of the national early warning score (NEWS) to assess patients for the risk of deterioration. We reviewed 12 sets of notes in total (3 who had undergone the pre-assessment stage and 9 sets of notes for patients who had received their surgery). We found staff consistently completed a NEWS score for patients post operatively and these were mostly accurate. We did observe 1 set of notes which had an inaccurate NEWS score as this had not taken into account the drop in oxygen saturations, although this would still have indicated the patient was low risk for deterioration.

In all 12 sets of notes, we found patients only had their blood pressure, pulse and oxygen saturations completed during the pre-operative assessment, however no NEWS score was calculated due to the incomplete set of observations. This meant staff did not have a baseline NEWS score which could be used as a comparison post operatively which may impact identification of a deteriorating patient. .

Staff completed risk assessments for each patient on admission. Patients who attended the service were mainly admitted for day surgery and would be discharged the same day. This meant only a small number of risk assessments were completed routinely and were rarely updated during admission. This included manual handling, pressure damage risk assessment, infection control, mental health risk assessments and post-operative vomiting risk. If any risks were identified, staff would put a plan in place to mitigate the risk during their admission.

Staff knew about and dealt with any specific risk issues. The service had comprehensive venous thromboembolism (VTE) risk assessments which also assessed the risk of bleeding post operatively to aid the risk assessor to decide on treatment

options. We found 5 out of 9 sets of notes we reviewed only had the top of the form completed which indicated the patient was having surgery. In the remaining 4 we found nothing had been completed on the form. We raised this with the managers at the end of the inspection. The managers told us only patients who did not require any medicines for thrombosis prophylaxis were accepted for surgery, therefore staff did not believe the remainder of the risk assessment was required. In addition to this, all patients were given anti-embolism stockings to wear during admission and patients who underwent a procedure which was over an hour long had intermittent compression boots applied to prevent the formation of deep vein thrombosis (DVT). The risk assessments therefore were not tailored to meet the needs of the patients using the service as they did not identify which patients required additional preventative measures to be implemented to reduce the risk of bleeding and blood clots following surgery.

The service did not directly have 24-hour access to mental health liaison and specialist mental health support. However, in the rare occasions that a patient required mental health support, staff would transfer the patient to local acute where they could access the support. This had not happened since the service opened. The thorough mental health risk assessments implemented had improved the recognition of those who had experienced mental ill-health and aided identification of suitability for admission to the service.

The service had a strict exclusion criteria which all staff adhered to. This clearly identified groups of patients who would not be accepted for surgery due to them being potentially high risk.

The service was considered to be a level zero provider (ward level care only) as they did not have additional systems or processes on site to support patients who deteriorated, for example they did not have a critical care outreach team or high dependency unit on site. The service had a service level agreement for patients to be transferred to the local acute hospital if they deteriorated.

Staff completed the World Health Organisation (WHO) 'five steps to safer surgery' checklist for procedures. We also reviewed 9 sets of notes and reviewed the WHO checklists for each patient. Of the 9 forms we checked, 7 of the forms had been fully completed and the remaining 2 did not have the sign out section completed on the document. The service completed audits of their WHO checklist completion; information received after the inspection showed the most recent audit completed between January to July 2022 demonstrated a 96% compliance. Sign out was identified as an area which required additional focus on for improvement.

Staff shared key information to keep patients safe when handing over their care to others. In a recent case of a patient who was transferred out, we observed key information had been prepared for the accepting service which accurately indicated the risks and concerns related to the patient's condition. Staff also told us they would share key information with patient's GPs if the patient gave them consent.

In the event of a patient needing to stay overnight, shift changes and handovers would include all necessary key information to keep patients safe.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

Inadequate

Surgery

The service had enough staff to keep patients safe. Managers accurately calculated and reviewed the number and grade of staff needed for each shift. Staff told us when lists were planned, staffing would be rostered on for the duration of the operating list as well as identifying staff to potentially complete a night shift in the event of a patient not being recovered in time to be discharged.

Staffing levels could be adjusted according to the needs of patients. Staff told us if patients were identified as requiring additional support, additional staff could be added to the roster to work. However, this was a rare occurrence.

The number of nurses and healthcare assistants matched the planned numbers. On days when operations were taking place, actual staffing always met the planned staffing. To overcome any last-minute sickness, additional staff would be contacted to see if they could be on standby.

The service had low vacancy rates, turnover rates and sickness rates. No concerns were raised in relation to staffing availability at the service.

The service had their own bank of staff. Staff told us they had their own bank of staff members which committed to shifts when operating lists were scheduled. In addition to this, staff would be scheduled to work to provide follow up care for patients in accordance with their discharge arrangements. This arrangement was successful for the service and they never had any concerns about not filling shifts.

Managers made sure all new staff members had a full induction and understood the service. Induction details were recorded within staff files once completed.

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.

The service had enough medical staff to keep patients safe. Patients were admitted for their treatment under a named consultant with the relevant experience and expertise in that area of care and treatment. Consultants led and delivered the surgical service at the hospital under practicing privileges. The service had 5 consultants employed under practicing privileges.

On days when operations were being performed, the service employed a resident medical officer (RMO). The RMO would be available for the complete duration of the operating list and until the last patient was discharged. In the event a patient required an overnight stay, the RMO would also stay onsite providing immediate medical care if required. There was 1 main RMO who covered the service with additional RMOs available to cover if required.

On days the service was operating, the consultant who had operated would be available for any follow up care if required. In the event of patients staying overnight, consultants would be within 30 minutes of the service and would attend to support the RMO with any concerns if required.

Records

Staff kept records of patients' care and treatment. However, records were not always comprehensive or up-to-date, but they were stored securely and were easily available to all staff providing care. Staff recorded all cosmetic implants on the Breast and Cosmetic Implant Registry (BCIR).

Inadequate

Surgery

Patient notes were not always comprehensive. However, all staff could access them easily. We reviewed 12 sets of notes (9 of which were for patients who had surgery and the remaining 3 were for patients undergoing the pre-operative assessment stage). We found records were now printed documents which were colour coded and were no longer photocopies of documents. Pink documents related to pre-operative assessments, yellow for peri-operative notes and blue were post-operative records. Not all records had the required elements completed, for example we did not find evidence of discharge notes being completed for 7 out of the 9 complete set of notes we reviewed. In one set of notes where a patient was identified with lower oxygen saturations, there was no evidence within the care notes to demonstrate what action was taken. Not all of the risk assessments within the patient documents were fully completed. This meant there was incomplete information stored within patient files which could impact ongoing care and treatment requirements for patients.

Not all of the notes we reviewed met the professional standards set by the General Medical Council or the Nursing and Midwifery Council. We found entries did not always have a printed name with the signature. Some entries were not always legible making it difficult to ascertain the care and treatment which was provided by staff. We observed an episode of care where the member of staff did not complete contemporaneous notes.

There were no delays in staff accessing their records. Records were all stored on site and did not leave the hospital. These were easily accessible should a patient return for further surgery.

Records were stored securely. Records were stored in a filing cabinet in the reception for patients attending for a consultant or pre-operative assessment which were locked and only accessible to authorised staff. Patients who were admitted for surgery had their records stored in the ward office.

All patients who underwent breast augmentation had their implant details entered onto the implant registry.

Medicines

The service did not always use systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. We observed pre-printed medicine charts for 9 patients which had analgesia, anti-emetic and anti-inflammatory medicines recorded as standard. These were all signed by the consultant in charge of their care. There were areas where additional medicines could be prescribed in response to individual needs. We did not observe any patients being administered medicines during our inspection, however we saw staff had signed when medicines had been given to patients.

Staff provided advice to patients and carers about their medicines. Staff provided patients with information about any medicines they were taking home with them when they discharged from the hospital after their procedure. Take home medicines were dispensed by an external service.

Staff mostly completed medicines records accurately and kept them up-to-date. We reviewed nine medicine administration charts for patients and found most of them had all details completed. We did however find one chart which did not have the patients weight or allergies completed. Weight and allergies was key information required on a medicine chart to prevent the patient being prescribed medicine which could make them unwell, but also to prevent over or under-prescribing of medicines.

Staff did not always store and manage medicines and prescribing documents safely. We reviewed the storing of controlled drugs and found these to be stored correctly and accurately. However, patients were exposed to the risk of

harm due to the presence of out of date medicines which were available for staff to use on patients. This included an adrenaline autoinjector found on the resuscitation trolley on the wards. There were also eye drops which were found in theatre 2 which were out of date. These out of date medicines were found in different medicines storage locations across the services. Therefore, we were not assured the service had an assured process to prevent the administration of out of date medicines or an assured process for expiry date monitoring. We immediately raised these issues with the registered managers who ensured they were immediately removed from the area and replaced with in date medicines.

Staff learned from safety alerts and incidents to improve practice. These were reviewed by the managers and distributed if relevant to the service.

We observed a significant amount of local anaesthetic (Lignocaine) in the drugs cabinet in theatres. Staff told us they conducted a large number of procedures under local anaesthetic. However, staff were not aware of the potential toxicity issues which could arise from this and there were no posters within the theatres promoting awareness. We were not aware of any specific 'shock boxes' or immediate reversal packs for toxicity being available in the department.

The service had an antimicrobial policy which was due for review in November 2022. The policy guided staff to ensure antimicrobials were prescribed according to best practice with a stop or review date being indicated and all prescriptions had an indication documented.

Following our inspection, we had concerns raised with us that the accountable officer for controlled drugs (CDAO) had not provided controlled drug incident occurrence reports for 2021/22 and also quarter 1 of 2022/23. During our inspection, no incidents had been raised in relation to the management or administration of controlled drugs. However, as part of the Controlled Drugs (Supervision of Management and Use) Regulations 2013, confirmation of no such incidents is also a requirement and should be reported as per the regulations.

Incidents

Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team. When things went wrong, staff apologised and gave patients honest information and suitable support. However, the service did not grade their incidents but treated all incidents with the same level of response and seriousness.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with the service's policy. There were 3 incidents reported at the service between October 2021 and September 2022. These were investigated and action taken where required. All 3 incidents appeared to be low in seriousness, however the service did not grade the incidents themselves. This means there is potential for incidents which require the duty of candour to be completed being missed.

The service had not recorded any never events in the last 12 months. Managers would share learning about never events with their staff if this occurred. The last never event which was recorded was in February 2020 and was related to the wrong implant being inserted. The managers had implemented stricter measures since this to ensure this did not happen again.

Managers shared learning with their staff about never events that happened elsewhere. Managers attended meetings where they learnt about serious incidents and never events which occurred at other services. When areas for improvement were identified in relation to the incidents shared, they updated their own practices and procedures at the service, and this would be shared with staff.

Inadequate

Surgery

Staff reported serious incidents clearly and in line with local policy and Regulation 18 CQC (Registration) Regulations 2009, notification of other incidents. At the time of our inspection, managers told us of a recent incident which they were in the process of sharing with the CQC. However, there had been no serious incidents reported to CQC since the never event in February 2020.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. Staff were familiar with the duty of candour and the concept of being open and transparent when things went wrong. Staff discussed the recent incident and the actions they had taken to apologise to the patient. However, we were concerned that the formal process for duty of candour could be missed as incidents were not graded.

Staff met to discuss the feedback and look at improvements to patient care. Staff told us they would receive feedback on incidents; however, we did not receive information when requested to demonstrate this was a regular item for discussion at staff meetings.

Managers investigated incidents thoroughly. Patients and their families would be involved in the more serious incident investigations. There had not been any incidents occur where this was required.

Managers debriefed and supported staff after any significant incident. Staff discussed examples of where this had occurred.

Are Surgery effective?

Requires Improvement

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 service met cosmetic surgery standards published by the Royal College of Surgeons.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff aimed to deliver high quality care and treatment in line with, in date policies, procedures and guidelines which were based on best practice and national guidance and policies. Staff assessed patients' needs and planned and delivered care in line with National Institute for Health and Care Excellence (NICE), the Royal College of Surgeons and RSC Professional Standards for Cosmetic Surgery 2016.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients if relevant, alongside their physical needs. Psychological and emotional needs were viewed as equally important in a patients well-being to their physical needs.

Nutrition and hydration

Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.

Inadequate

Surgery

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. All patients had their nutritional requirements identified during the pre-operative assessment stage of their admission. If patients had any special requirements, staff ensured provisions were made to meet their needs. Staff told us they were able to provide meals for all patients regardless of any dietary requirements or religious and cultural requirements.

Part of the admission criteria stipulated the acceptable body mass index (BMI) of a patient for admission at this service. Those who were identified to be outside of the acceptable BMI were supported to identify an alternative location where additional support could be provided with nutrition if required.

Patients waiting to have surgery were not left nil by mouth for long periods. Staff provided patients with information about the requirements for being nil by mouth (which means nothing to eat or drink) prior to their surgery. This was in line with national guidance and was checked as part of the ward checks and perioperative checks prior to surgery. Staff also risk assessed patients for the risk of post-operative nausea and vomiting. If identified as a risk, staff ensured suitable medicine was prescribed in addition to the routine anti-emetic (anti-sickness) medicine to enable them to recover satisfactory.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools.

Staff assessed patients' pain using a recognised tool. We reviewed the records of 9 patients and found staff had regularly assessed the pain scores of patients when completing their observations. However, the service had conducted a pain management audit between January to July 2022 and found staff were not always recording a pain assessment score when back on the ward or whilst awaiting to return to the ward in the recovery department. As part of the action plan, staff were reminded on the importance of completing pain assessment scores to aid the therapeutic management of a patients pain.

Staff prescribed pain relief accurately. All patients had a pre-printed medicine charts in their records which doctors would sign on admission. An opiate based pain killer for moderate pain and a codeine-based pain killer were selected as pre-determined pain killers (analgesia). An anti-inflammatory medicine (ibuprofen) was also pre-printed on the prescription chart. However, in the 9 sets of notes we reviewed for patients who had received their surgery, we did not observe any medicine recorded as being given despite regular pain assessments being completed. Within the documents we reviewed, we observed patients had informed the staff of mild to moderate pain. Following the inspection, we requested audit information which showed similar findings to our inspection findings. All patients had analgesia prescribed, however only 1 patient out of 10 included in the audit received analgesia. The audit also reviewed patients satisfaction with pain management post operatively. No patients reported being dis-satisfied with their pain management, however only 3 reported being satisfied with the management of their pain. No additional details were provided for how the remaining 7 patients felt their pain had been managed.

Patient outcomes

We were not assured that staff monitored the effectiveness of patient care and treatment. We were not assured staff always used the findings to make improvements and achieved good outcomes for patients.

Managers told us that the service regularly submitted data to the Private Healthcare Information Network (PHIN). However, we requested information after the inspection in relation to patient outcomes and performance related metrics, but we did not receive this information. We reviewed the PHIN website and were unable to identify any data specifically relating to this hospital.

Inadequate

Surgery

Staff verbally reported that outcomes for patients were positive and met expectations. However, we reviewed minimal evidence to demonstrate this. Staff referred us to social media sites and internet review sites to demonstrate this, but when we requested information in relation to outcomes, we did not receive any data to support patients consistently had good outcomes.

Managers and staff told us they used the results to improve patients' outcomes. However, we did not receive any information when requested in relation to patient outcomes and therefore could not identify if the service were collecting data on patient outcomes and how this was used to improve those outcomes.

Managers and staff carried out a programme of audits on a 6-monthly basis. Managers used information from the audits to improve care and treatment. Audits which were conducted included infection prevention and control audits, WHO checklist audits, pain management audits and documentation audits. Actions for improvements were identified and instigated immediately and improvement was checked on a 6-monthly basis.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. We reviewed a selection of staff files and saw staff had the right skills for the roles and responsibilities they undertook.

Managers gave all new staff a full induction tailored to their role before they started work. We saw evidence of the details induction programme which new starters were required to undertake.

Managers supported staff to develop through yearly, constructive appraisals of their work. Information received after the inspection confirmed all staff had an appraisal within the last 12 months.

We were not assured that managers made sure staff attended team meetings or had access to full notes when they could not attend. Following the inspection, we requested further information around staff meetings, however this was not provided.

Managers identified and staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge during their appraisals. Staff told us they would be able to approach their managers if they wanted to develop in their roles and managers were responsive to their requests.

Managers had suitable processes to identify and promptly manage poor staff performance. Managers told us there had been no recent concerns over staff performance however, they were confident in the processes and would support staff to improve if concerns were identified.

Managers told us they employed an external human resources service which provided them with documents required when staff were employed at the service. We reviewed a selection of staff records and found that these were in line with schedule 3 of Regulation 19 (the regulation which ensures those employed are fit, proper and of good character for their employment). We saw indemnity insurance for those it was applicable for, continual professional development, appraisals, current Disclosure and Barring services (DBS) checks, health checks and thorough recruitment processes including references and a complete employment history.

Inadequate

Surgery

Multidisciplinary working

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

Staff worked with other agencies when required to care for patients. Staff told us they had a strong relationship with the local acute hospital. Managers told us they also worked with patient's GPs to ensure patients received safe and effective care. They would ensure they gained consent to communicate with the GP by the patient if they believed they required further information about the patients past medical history.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. Staff told us it was rare that they needed to arrange follow up assessments for any mental ill health concerns, however if they had concerns about a patient, they would ensure consent was gained to communicate with the patients GP and arrange follow up through them.

Seven-day services

The hospital did not provide a seven days a week service. However, the service had systems for patients to receive advice and support after their surgery.

Whilst the hospital was not open every day, it provided flexibility and performed surgery on days that were suitable for the patients. This often included operations being scheduled at the weekend if this was the patients preference.

Following a patients surgery, they were provided with details where they could ring for advice if they had concerns.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support around the hospital. We observed patient information leaflets within consulting rooms and waiting rooms advising patients on a healthy lifestyle which will improve wound healing.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff told us it was important to them to ensure all relevant patient information was provided to patients on how best they can ensure their wounds heal without any problems. This included providing specific information around diet and smoking for patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance and ensured that patients gave consent in a two-stage process with a cooling off period of at least 14 days between stages. They understood how to support patients.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records. We observed good examples of consent forms which had been completed with patients undergoing surgery, as well as staff gaining verbal consent prior to performing any procedures or initiating any therapy. The service followed national guidance and ensured they adhered to the 14 days cooling off period for patients undergoing cosmetic surgery. We saw patients were on average given double this time due to how consultations were arranged and their own preferences for surgery dates.

Inadequate

Surgery

The service audited their own consent forms to ensure they were completed in line with legislation and to ensure informed consent was given. Audit results for January to July 2022 showed the service were 100% compliant against the criteria. However, the criteria they were auditing against did not include reviewing consent forms against the recommended 14 day cooling off period for patients undergoing cosmetic surgery as a criteria element. We were therefore concerned the service were not assuring themselves that all surgeries completed were in line with recommendations.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff were aware of best decisions; however, this was rare that they would be in this position due to the strict processes for admission criteria.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff were aware of the Mental Capacity Act (2005) and the requirements of when to complete a capacity assessment on patients. However, it was rare that they would need to consider this due to the strict processes in place around the admission criteria.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff told us it was rare to have any patients where any of the aforementioned acts would be required to be acted upon. However, they still received training which included information on patients who may lack capacity, safeguarding children and best decisions and depriving patients of their liberty as this was part of their overall safeguarding training. For any situations where concerns were identified, staff would access the safeguarding lead who would assess the situation.

Are Surgery caring?

Insufficient evidence to rate

Compassionate care

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

At the time of our inspection, there were no patients attending the service for an operation, although there were a small number of patients attending for other reasons. We requested feedback from the service and also provided our details for sharing their experience. However, we did not receive sufficient evidence to rate the service for caring.

Staff told us they were discreet and responsive when caring for patients. Staff would always take time to interact with patients and those close to them in a respectful and considerate way. Staff told us they were always respectful of patients and any family or friends attending the hospital with them. This was evident in the feedback which the service received.

Patients said staff treated them well and with kindness. We observed minimal staff and patient interaction during our inspection as there was no operating list scheduled at that time. However, we received feedback from a patient who could not have praised all staff at the hospital any higher.

Staff followed policy to keep patient care and treatment confidential. Staff told us all conversations between patients and staff were conducted within rooms with doors closed, and confidentiality was always maintained. This was also confirmed in the patient satisfaction survey shared after the inspection.

Staff also understood and were respectful of the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff told us they treated all patients equally and respectful. They ensured they met the individual needs of all patients who attended the hospital. When discussing challenging issues such as mental ill health, they were professional at all times.

The service provided chaperones to patients who required one. There were numerous signs around the hospital promoting the assistance of a chaperone.

Emotional support

Staff told us they provided emotional support to patients to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. All patients were given details for concerns escalation following their operation. This was accessible to them day and night post operatively. Staff would help patients over the telephone or signpost to alternative services if required.

Staff would support patients who became distressed in an open environment and help them maintain their privacy and dignity. However, staff were not aware of any situations which occurred where this had been a problem. All patients were given privacy when discussing their intended procedures and plans.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. However, at the time of our inspection, visitors were not permitted within the ward areas. As the patients were only admitted for a short period, there had not been any concerns raised in relation to this.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff told us when they discussed the procedures or follow up care with the patient, they always pitched the information at a level the patient would understand. They would regularly give patients the opportunity to ask questions as well. This was confirmed by the patient satisfaction survey which was submitted after the inspection.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients gave positive feedback about the service. The service mainly received their feedback through forms which were completed on site. However, the service also had online feedback mechanisms which some patients preferred to use. We observed some feedback which had been collected by the service which all appeared very positive about the service. Staff told us the majority of patients who used the service were through the recommendations of patients who had undergone surgery at the service.

Inadequate

Surgery

Staff supported patients to make informed decisions about their care. Staff told us they always endeavoured to provide the patients all the information they required when making a decision about their procedure. This was through verbal information and also printed literature which they took home with them to review. Feedback indicated that patients agreed they were always given the information and time to review the information they needed to enable them to make an informed decision.

Staff had sensitive discussions with patients about the cost of the procedure at the earliest opportunity. They ensured all potential costs were covered to ensure patients had full payment details prior to deciding on whether to go ahead with surgery or not.

Are Surgery responsive?

Good

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of a target group of patients. It was also looking into potential ways of working with others in the wider system and local organisations.
Managers planned and organised services so they met the needs of a group of patients not only in the local population, but also the wider population who were looking for cosmetic surgery. The service provided a specific service for patients who required cosmetic surgery. There were specific procedures which they conducted at the service due to the consultants they had working at the service. When staff received enquiries from patients for services they did not provide they were able to signpost them to other providers.

At the time of our inspection, the service was in the initial stages of looking into offering services for patients waiting for care and treatment at the local acute. Managers told us this was in its infancy; however, they were keen to look at what support they could provide to the local acute to help with the recovery phase following the COVID-19 pandemic.

Meeting people's individual needs

The service took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. There was a system for referring patients for psychological assessment before starting treatment, if necessary.

Patient services were provided over 3 floors at the hospital, with the top floor being accessible to staff only. The hospital was accessible to all patients with ramps in place outside and lifts to all floors within the hospital. Patient bathrooms were spacious enough to meet the needs of patients with a physical disability.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff always tried to ensure all communication needs of patients who used the service were met. This was not only for patients with a disability or sensory loss, but also those whose first language was not English.

The service had information leaflets available in languages spoken by the patients and local community. Staff told us it was rare for their patients to require information leaflets in other languages; however, they were able to provide this for patients if required. Staff told us of one example where they received external assistance to translate some information for a patient in the past.

Managers made sure staff, and patients could get help from interpreters or signers when needed. Staff told us this was infrequent for patients to require interpreters, including British Sign Language (BSL) interpreters. However, they had systems to meet the needs of patients should this be required.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Any specific requirements were recorded within patient notes during the pre-operative assessment. During our inspection, we observed meals which were suitable for those with a vegan diet as well as meeting cultural needs.

Staff had access to basic communication aids to help involve patients in their care and treatment. Staff told us it was rare that any additional communication tools or aids were required to be used with the patients who attended the service.

Access and flow

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

Between October 2021 to September 2022 there had been 233 operations completed. The most common procedures performed were breast augmentation, abdominoplasty, breast re-augmentation, mastopexy and blepharoplasty.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes. Managers told us the service was focused on meeting the needs of the patient and therefore organised theatre bookings around the patient. This meant there were no patients waiting for prolonged periods for their surgery, unnecessarily. At the time of our inspection, 2 patients were waiting for a date for their operation to be agreed.

Managers and staff worked to make sure patients did not stay longer than they needed to. Staff ensured discharge arrangements was discussed during the pre-operative assessment stage. Procedures were arranged for day case however there were occasions when patients did not recover as quickly as expected and therefore stayed at the service overnight. There were 23 patients who stayed at the hospital overnight between October 2021 and September 2022.

Managers worked to keep the number of cancelled appointments and operations to a minimum. Staff told us they rarely had cancellations for appointments or operations. Between October 2021 to September 2022 there had been 5 patient operations which were cancelled. Where appropriate, patients were rescheduled for their operations at the earliest opportunity.

When patients had their appointments or operations cancelled at the last minute, managers made sure they were rearranged as soon as possible. Staff would work with patients to arrange a new date for their appointment or operation which was suitable for them. Staff discussed an example where they had recently done this for a patient and received positive feedback for this.

The service moved patients only when there was a clear medical reason or it was in their best interest. Managers told us only 2 patients had been transferred since the service opened.

Learning from complaints and concerns

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

Inadequate

Surgery

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. We observed posters displayed around the hospital which provided patients with information on how to complain.

Staff understood the policy on complaints and knew how to handle them. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff always tried to ensure any complaints could be resolved locally in the first instance prior to any escalation of formal complaints.

Managers investigated complaints and identified themes and shared feedback from complaints with staff and learning was used to improve the service. The service had 3 complaints raised between October 2021 to September 2022. All 3 complaints were unique, and no themes identified. All complaints were successfully resolved locally, and any learning identified and shared with the team.

The service had a system for referring unresolved complaints for independent review. Patient complaints which remained unresolved after review by the service were shared with an external independent service for external mediation. Patients were required to provide their consent for the service to do this on their behalf.

Are Surgery well-led?

Inadequate

Leadership

Leaders mainly had the skills and abilities to run the service and identified their priorities for the service. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills. However, they did not always have the skills to identify whether they had appropriate governance to support processes.

The managers at the service had diverse backgrounds, however both had transferable skills to enable them to manage and lead the service. The owner of the service had run the hospital for a number of years and understood what service they were aiming to deliver and the patients who were likely to use the service. However, we had concerns around some of their oversight of running a service in relation to governance and managing performance and risk.

Staff were complimentary about the leaders of the service and believed they were competent in their roles. Staff told us the leaders of the service were visible, supportive and approachable.

Vision and Strategy

The service had a vision for what it wanted to achieve, however there was no strategy for how the service planned to achieve the vision or measures to identify if the vision had been achieved.

The vision of the service had always been to provide high quality patient care to patients who undergo cosmetic surgery.

"Our goal has always been to combine the ethos of patient-centred care with the individual attention and clinical excellence of the elite healthcare field, ensuring that patients receive the highest standard of medical treatment available"

Staff were able to tell us what they believed the service was about, however they were not aware of any formal strategy for the service.

Inadequate

Surgery

Leaders were passionate about ensuring those who used the service received care and treatment which adhered to the strictest of medical ethics and was not influenced by commercial factors.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff we spoke with during the inspection were extremely complimentary about the service and the leaders stating they felt respected, supported and valued. They also extended this feeling about their peers as well. Staff told us there was a family feel to the service and everyone supported each other and valued their contributions.

Staff told us the service was patient centred and they were committed to ensuring patients had a safe and positive experience whilst admitted.

Governance

Leaders operated some governance processes; however, we found these processes were not always effective to identify and mitigate patient safety risks. Staff at all levels were clear about their roles and accountabilities.

Following the previous focused inspection, managers told us they had formalised their service level agreements (SLA) with a third party which covered services such as sterilising equipment, pathology and equipment safety testing. We found on this inspection, these agreements had not been reviewed or updated since they were formalised. This meant the agreements may no longer be adequately covering the needs of the service and the patients who were admitted for surgery. During the inspection, we found all medical equipment (apart from anaesthetic machines) appeared to be out of date for their electrical safety testing. We raised this as a serious concern after the inspection and the managers provided a letter by the third party who completed the electrical safety tests to confirm the testing could be moved from annual testing to 2 yearly testing. This had not been updated in the SLA and staff told us the testing was usually annual. This was one example where the lack of process to ensure the SLAs met the needs of the service had impacted on the delivery of safe care and treatment. We requested copies of the SLAs which were in place at the time of our inspection. We found a formalised agreement in place for sterilising services and clinical engineering. However, for pharmacy services we were provided with a copy of a letter which confirmed the service had an agreement to provide a service to the hospital. We did not receive any documentation in relation to pathology services.

During our inspection, we found the service's systems and processes did not identify when patient safety was being compromised. There were regular checks of medicines and equipment being conducted, however they failed to identify when medicines had become out of date and therefore required removing from service.

The service had a medical advisory committee (MAC) in place who met quarterly. Meetings had continued to take place via teleconference which had proved successful for ensuring full attendance. The registered manager was also the MAC chair and there was a set agenda which they followed. The role of the MAC was to advise on key governance processes which involved the medical staff at the hospital. This included granting or reviewing practicing privileges, escalation of any clinical or consultant concerns, reviewing key medical policies and performance. We reviewed minutes from the MAC meetings and found key elements were not recorded within the minutes. There was no reflection of any new members being considered and no reflection on performance within the service. MAC members had raised considerations for service improvement which we were able to follow through and identify when changes had been made.

Inadequate

Surgery

We were not assured that staff had the opportunity to meet regularly and discuss important governance issues and escalate any concerns to the managers of the hospital. We requested evidence of staff meetings after the inspection, however we did not receive any information which demonstrated these meetings occurred.

The service used an external company to manage the human resources element. When new starters commenced employment at the service, they would ensure managers requested and received the appropriate documentation to ensure staff were ready to start at the service.

Staff told us policies and procedures were reviewed through the MAC and where amendments and updates were required, these were completed before being submitted for approval to the MAC. We reviewed a selection of policies and found these were all in date and reflected current national guidance and policy. However, from the MAC minutes we reviewed, we did not identify any policies being reviewed or discussed.

Following our inspection, we were informed that the accountable officer for controlled drugs had not submitted their controlled drugs incident occurrence reports since before 2021/2022 reporting period. Despite staff indicating there had been no incidents involving controlled drugs during the inspection, the service's governance processes had not identified the requirement for this to be reported to the responsible authority.

Management of risk, issues and performance

We were not assured the service had an effective system for recording and reviewing risks within the service. Internal processes for auditing were infrequent and did not always promptly identify areas for improvement.

During this inspection, we found the service had still not implemented a risk register for the service. During our inspection, we asked the managers what their main risks were for the service. Risks were identified however, this was not formalised in a register or document which could be regularly reviewed and where possible, mitigation identified on how to address this.

When reviewing the minutes of the MAC meeting, we identified there were risks which were discussed and actions identified on how to mitigate these risks. However, these risks did not align to those identified by the managers. We were therefore concerned that the service was not assured there was an accurate oversight of risk within the service.

The service locally completed audits to monitor performance against a range of areas. Staff told us they believed audits happened on an annual basis, however managers reassured us this was on a 6-monthly basis. We raised concerns that even if this was a 6-monthly basis, this process was not robust enough and failed to identify some of the concerns in relation to documentation standards. Following our inspection, the service provided audit information on a range of key clinical aspects, which included VTE risk assessments and WHO checklists. Where areas of improvement were identified as being required, there was no additional follow up to ensure these improvements had been made. The follow up audits remained scheduled for up to 6 months after the previous audit was conducted. This therefore did not demonstrate that there was an assured process for managing performance in a timely way.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Data was consistently submitted to external organisations as required. The information systems were integrated and secure however, there was a server error at the time of our inspection.

Inadequate

Surgery

The service told us they had an effective processes for the collection and submission of data in relation to the implants that were used during surgeries as well as information to PHIN (Private Healthcare Information Network) about the outcomes of surgeons procedures. Patients were given a record of their implants to keep when they were discharged. However, we were unable to identify any data on the PHIN system in relation to this service.

At the time of our inspection, the service had identified a concern with their server. The managers were taking appropriate steps to rectify this issue and were able to provide steps they would take if the concerns they identified turned out to be as a result of an IT security breach. Managers told us that even if the server had an external breach, all data stored within this was safe due to an encryption which automatically occurred. This unfortunately meant we were limited in what we were able to review on site and also impacted the service being able to provide information for all of our data requests following the inspection.

Patient records remained paper based and were stored securely on site. Staff told us this made the records very accessible should a patient return for further procedures or should any concerns be raised where a review of the records was deemed essential.

Patients received a discharge letter with clinical information after surgery, as well as implant details if relevant to them. The letter could be shared with the GP if the patient consented to this.

Engagement

Leaders and staff engaged with patients and staff to help improve services for patients. They looked for opportunities to collaborate with other organisations to improve services for patients.

All staff encouraged patients to provide feedback on their experience at the service. This was through the various feedback options available to them. The service regularly reviewed the feedback they were given and had acted on feedback received. When positive feedback was given, the service shared this amongst the staff and celebrate this.

Managers discussed their engagement with a range of third-party providers where they looked to improve the services available for patients and to also help reduce local waiting lists. Although some of these collaborations had not gone ahead, managers were confident that there would be future collaborations which they were excited about.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services.

Managers told us they continuously looked for opportunities to improve the service. They attended meetings with other responsible officers where key clinical governance and research areas were discussed. Managers found these meetings extremely useful in the development and modification of practices and policies at the service. One example discussed was around learning from other services never events. This gave them the opportunity to reflect on their own service and review their own measures to ensure these did not occur at their service.