Harley Street Healthcare Ltd

Harley Street Healthcare - 96 Harley Street

Inspection report

96 Harley Street
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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	Inspected but not rated
Are services safe?	Inspected but not rated
Are services effective?	Inspected but not rated
Are services well-led?	Inspected but not rated

Summary of findings

Overall summary

Harley Street Healthcare - 96 Harley Street is operated by Harley Street Healthcare Ltd. The service was registered by CQC in August 2021. The service provides dermatology treatment procedures to private patients over the age of 18. The service treated dermatology conditions such as mole removal, cyst removals, and carried out dermatological investigations. All procedures are undertaken using local anaesthesia.

The service is registered to provide the following regulated activities:

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

There has been a registered manager in post since the service registered with CQC.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Outpatients	Inspected but not rated	

Summary of findings

Contents

Summary of this inspection

Background to Harley Street Healthcare - 96 Harley Street

We inspected this service using our comprehensive inspection methodology on 14 and 15 September 2021. During the inspection, we identified numerous concerns as a result of which, on 21 September 2021, we served an urgent notice under section 31 of the Health and Social Care Act 2008, resulting in suspension of the provider's registration in respect of the regulated activities carried out. We suspended the provider's registration for a period of four weeks.

We re-inspected the service on 19 October 2021 to review the improvements made by the provider in specific areas of concern identified in the notice.

As it was a follow up focused inspection, reviewing actions taken in response to previously identified specific areas of concerns, on this occasion we did not rate the service. Due to the suspension, at the time of the inspection, the service was not operational. This meant we were unable to assess the impact of the improvements made by the provider on patients and the practical service delivery.

How we carried out this inspection

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

Areas for improvement

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

Action the service SHOULD take to improve:

- The provider should assess, monitor, and mitigate the risks relating to the health, safety, and welfare of staff. They should ensure staff personal risk assessments are conducted and recorded on a regular basis.
- The service should consider reviewing consent documents to ensure full information on photographs taking, use, storage, and retention period is provided to patients.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients	Inspected but not rated	Inspected but not rated	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated
Overall	Inspected but not rated	Inspected but not rated	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated

Inspected but not rated

Outpatients

Safe	Inspected but not rated
Effective	Inspected but not rated
Well-led	Inspected but not rated

Are Outpatients safe?

Inspected but not rated

As it was a focused follow-up inspection, we did not rate this domain.

Mandatory training

During our previous inspection, in September 2021, records indicated staff mandatory training had lapsed. They did not renew their basic life support, safeguarding, information governance, and fire safety training.

At this inspection, a check of completion certificates confirmed staff compliance with mandatory training for life support, information governance, and safeguarding. For all other areas, we examined the providers training record log which showed all mandatory training was up to date for all staff.

Safeguarding

In September 2021, staff did not show an understanding of how to protect patients from abuse. The safeguarding adults' policy and procedure were generic with no local service-specific amendments. There was confusion regarding who the safeguarding lead was. The provider was unable to demonstrate staff had received appropriate levels of safeguarding training.

During this inspection, staff were clear who the safeguarding lead was. The lead had been trained to Level 3. Although the provider had not reported any safeguarding issues, the management team exhibited a good understanding of how to identify abuse and what actions they would need to take in these circumstances. We found that since the suspension all staff had been trained in safeguarding adults.

Cleanliness, infection control and hygiene

During our inspection in September 2021, we observed that staff did not adjust their practice to take account of the COVID19 pandemic, to minimise the risk of the spread of infection. The provider did not follow Public Health England's infection prevention and control guidelines. Not all staff and patients were wearing face coverings or visors. There was no requirement for staff or patients to have a negative COVID19 test before entering the premises.

After the last inspection, the provider introduced a policy that required staff to undertake two lateral flow tests per week. Since the inspection, the provider was recording both positive and negative test results. We examined records that confirmed the policy was operational.

On arrival at the service, all staff and visitors underwent a temperature check and were asked if they had exhibited any COVID19 symptoms.

Inspected but not rated

Outpatients

Since the suspension, the provider had re-written and improved their infection prevention and control (IPC) policy to ensure it was compliant with national guidance.

We saw staff wore face masks except for two staff who were exempt. Staff showed us proof of exemption from wearing a face covering. However, the provider did not undertake individual risk assessments for staff. This could create a risk that vulnerable staff, such as those with a pre-existing condition, would not be identified and appropriate mitigation would not be taken.

Since the suspension, the provider had worked with external compliance advisors to improve their systems. They had developed several IPC related audits which addressed sterilisation of instruments, general cleaning, post-procedure infection rates, and staff COVID19 testing.

Patients were screened over the telephone for COVID19 and other infectious diseases, as well as their fitness for the procedure they were visiting the service for.

We observed appropriate signage advising wearing of masks and social distancing. The provider informed us that importance of these had been reinforced with staff.

Assessing and responding to patient risk

In September 2021, we found that the deteriorating patient policy was not robust and not embedded into practice. The policy was not specific to the service and staff did not follow it. The policy did not state the frequency clinical observations should be taken and recorded. The lack of systems to identify if a patient suffered a decline in health whilst receiving treatment exposed them to the risk of harm.

In October 2021, the provider had adopted a new policy on deteriorating patients. Before treatment, patients were effectively triaged to ensure unstable patients, such as those with a pacemaker, were not treated. The new policy had fully incorporated the national early warning score system (NEWS). Vital signs were to be taken every three hours. We found that NEWS charts and guidance on how to calculate it were visible in treatment rooms.

Following treatment, patients were given a leaflet setting out what potential complications to look out for and what to do in case of an emergency. During our inspection, it was clear who the resuscitation lead was and what their responsibilities were. Records indicated all staff were up to date with the basic life support training.

During our previous inspection, there was no evidence the World Health Organisation's (WHO) safe surgery checklist was used or completed. The registered manager and clinic manager told us surgeons did not use the checklist. There were no other procedures in place for reducing unnecessary surgical harm and complications.

At this inspection, we examined patient records for procedures undertaken before the provider's suspension and found that the WHO checklist had been followed by all except for one surgeon. The surgeon, after the manager's intervention, had agreed to ensure compliance with the requirement. In addition, the patient record system was adapted to ensure the surgeon completed checks while undertaking a procedure. There was an enhanced regular audit to monitor the use of surgical safety checks.

Are Outpatients effective?

Inspected but not rated

Outpatients

Inspected but not rated

As it was a focused follow-up inspection, we did not rate this domain.

Competent staff

During our previous inspection, we were not assured staff were regularly appraised and that they had learning goals and objectives set to support their development and ensure they had skills required to carry out their duties. There was no evidence of non-clinical staff having their work evaluated.

At this inspection, we examined staff records and found that since the last inspection the provider had completed appraisals for all staff. All appraisals contained individual staff objectives.

Consent

During our previous inspection, we noted patients were not offered a suitable cooling-off period between initial consultation and the procedure being undertaken. The provider did not set a prescribed time to allow patients to change their minds about receiving treatment.

At this inspection, we examined the provider's new policy on consent. We found that the policy was compliant with the Royal College of Surgeons (RCS) Professional Standards for Cosmetic Surgery (April 2016) guidance in this area and the provider allowed for 14 days cooling-off period. This was to ensure patients had time to fully consider the risk and benefits of the treatment and to change their minds should they feel it was necessary.

In September 2021, we noted the provider did not appropriately obtain patients' consent concerning taking and storing photographs. There were no effective procedures for storing the images and staff did not know how long the images were stored. There was no policy relating to the taking and storing of images.

Since the last inspection, the provider had produced a new policy on the taking and storage of images. It prescribed those images could only be taken on business equipment and they would be taken in a way that would not allow patients' identification. The provider kept images safe and had set a clear timescale for their retention period. However, the provider still needed to review the information provided to patients and to undertake a necessity test to ensure that patients were fully informed on what they were consenting. The provider did not undertake a full impact assessment to ensure taking and storing images was necessary for the legitimate interests pursued by the provider. At the time of inspection, it was not clear if the benefits of taking patients' before and after treatment photographs outweighed any risks to patients' rights and freedoms.

Are Outpatients well-led?

Inspected but not rated

As it was a focused follow-up inspection, we did not rate this domain.

Inspected but not rated

Outpatients

Management of risk, issues and performance

During our previous inspection in September 2021, disclosure and barring system (DBS) records were missing from staff files. The clinic manager was unable to articulate or demonstrate how the service ensured staff had current and valid DBS certificates and that all staff were of good character and fit to work in health service settings.

Since the inspection, the provider had implemented a recruitment and vetting policy in line with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 19 (Fit and proper persons employed). Staff were vetted on appointment and then DBS checks were completed every three years. We examined the DBS checks for all staff and found them to be satisfactory and undertaken within the last three years. We also checked the records for all staff to ensure they had proof of identification on file and that they were eligible to work in the UK.

In September 2021, the registered manager was unable to produce a risk log and had little understanding of risks, risk mitigation, and its ownership. The service did not undertake regular reviews to assess the quality and safety of the service and to take mitigating action where service users could be exposed to the risk of harm. In general risk assessments were not robust or embedded. It was unclear who carried out risk assessments and the purpose of them. For example, there was no risk assessment for the storage of medical gases.

Since the suspension of the service, the provider had developed a risk policy and an extensive set of risk assessments. These risk assessments had been completed and the management team were able to describe how an effective risk system should work. They had developed a new risks log, which was reviewed at the quarterly risk meeting, as well as the new monthly 'CQC meetings' they held. The risk logs contained appropriate business and patient risks with suitable mitigating actions listed and evidence of them being taken. For example, it included the risk of Legionella infection, the use of adrenaline, and the storage of medical gases. We examined both provider's sites and found that there was appropriate signage where the oxygen cylinders were being stored. This meant that the risk assessment was implemented, and risk-mitigating actions put in place.

At our previous inspection, it was unclear who was responsible for investigating incidents and complaints. Although patients' complaints were responded to, the staff we spoke with were unable to demonstrate any complaint outcomes or evidence of learning from them being disseminated. Staff were unclear on how to report incidents. The incidents' log lacked detail, it did not show how incidents were investigated and it did not document any learning outcomes.

We found that since the last inspection, the complaints log had been enhanced to include the learning identified. The provider had made learning from incidents and complaints part of the standing agenda for the monthly 'CQC meetings'. The minutes of these meetings were e-mailed to staff who were unable to attend.