Prem House Clinic Ltd

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

The location of Prem House Clinic Limited (known as Prem House Clinic) is part of a larger provider known as Prem House Clinic Limited. Prem House Clinic is an independent hospital based in Liverpool, which provides surgical cosmetic services.

We undertook a focussed follow up inspection on 31 July 2017 to review action taken by the provider in response to a warning notice issued 18 August 2016.

We regulate cosmetic surgery services but we do not currently have a legal duty to **rate** them when they are provided as a single specialty service. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

The warning notice issued 18 August 2016 highlighted areas where the provider was required to make improvements. These included:

- Ensuring staff understood what constituted an incident and incidents were reviewed to ensure improvements in standards of care.
- Ensuring there were effective systems and processes in place to assess, record and mitigate risks relating to patient safety.
- Ensuring there were robust systems in place for the safe management and administration of medicines.
- Ensuring staff were up to date with annual and three yearly mandatory training, especially in basic, immediate and advanced life support training safeguarding.
- Ensuring robust systems were in place to ensure that surgeons undertaking procedures are competent and work within the scope of their qualifications, skills and experience.

During our focussed follow up inspection on 31 July 2017, we found the provider was compliant with the requirements of the warning notice.

We found the following areas of improvement:

- Staff knew how to report incidents; incidents were discussed at clinical governance meetings and feedback was provided to staff in monthly clinical staff meetings.
- There were effective systems and processes in place to assess record and mitigate risks relating to patient safety. Staff had received training in completion of the national early warning system (NEWS) and records were audited to assess compliance.
- Medicines management had significantly improved to provide safe care and treatment for patients.
- All staff were compliant with mandatory safeguarding training. Annual basic life support training (BLS) had been completed by 100% of staff and seven out of nine ward staff and three theatre staff had completed immediate life support (ILS).
- There were systems in place to ensure that surgeons undertaking procedures were competent and worked within the scope of their qualifications, skills and experience.

Ellen Armistead

Deputy Chief Inspector of Hospitals (North Region)

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Summary of this inspection

Background to Prem House Clinic Ltd

Prem House Clinic is an independent cosmetic surgery hospital based in Liverpool and is part of Prem House Clinic Limited.

The hospital is registered with the Care Quality Commission to carry out the following regulated activities:

• Treatment of disease, disorder or injury

• Surgical procedures

• Diagnostic and screening procedures

The registered manager has been in post since January 2014.

The hospital provides self-funded cosmetic surgery for patients over 18 years of age. The majority of surgical procedures are completed as day cases and include breast augmentation, blepharoplasty (correcting defects of the eyelids) and abdominoplasty (reduction and tightening of the abdomen).

We inspected this service on 15 and 18 July 2016 as part of our ongoing programme of comprehensive Independent Health Care inspections. A warning notice was issued to the provider on 18 August 2016 setting out improvements that were required.

We undertook a focussed follow up inspection on 31 July 2017 to review action taken by the provider in response to the warning notice and found them to be compliant.

During the inspection, we spoke with six staff including registered nurses, healthcare assistants, doctors and senior managers. We reviewed 10 medicine prescription records, 23 patient records and four staff records.

Our inspection team

The team that inspected the service comprised of three CQC compliance inspectors and a CQC medicines inspector. The team was overseen by Julie Hughes, Inspection Manager.

Information about Prem House Clinic Ltd

The hospital has one theatre and seven beds situated in a self-contained ground floor clinical area in addition to a reception and waiting area and four consulting rooms.

The hospital provides cosmetic surgery for self-funded patients over 18 years of age.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

- Staff knew how to report incidents; incidents were discussed at clinical governance meetings and feedback was provided to staff in monthly clinical staff meetings.
- Surgical site infections were reported as adverse incidents and discussed in both MAC and infection; prevention and control meetings to ensure investigation and learning took place.
- All incidents were reviewed to identify themes and allow appropriate action to be taken.
- Emergency resuscitation equipment was in place and in date, and records indicated this was consistently checked.
- Robust policies and procedures were in place for the safe storage and administration of medicines.
- All staff were compliant with mandatory safeguarding training. Annual basic life support training (BLS) had been completed by 100% of staff and seven out of nine ward staff and three theatre staff had completed immediate life support (ILS).
- The World Health Organization (WHO) Surgical Safety Checklist and the National Patient Safety Agency (NPSA) five steps to safer surgery (2010) were consistently used to improve patient safety and help reduce risk during surgery.
- Nationally recognised guidance from the National Institute for Health and Clinical Excellence (NICE) guidance was consistently followed as pregnancy testing was observed to be routinely carried out preoperatively.
- There were effective systems and processes in place to assess record and mitigate risks relating to patient safety. Staff had received training in completion of the national early warning system (NEWS) and records were audited to assess compliance.
- Discharge documentation within the Integrated Care Pathway (ICP) was consistently completed and staff were aware of the discharge process.
- Staff were able to access the call bell when they required assistance in the recovery area and additional support was provided by the resident medical officer.

Are services effective?

- There were systems in place to ensure that surgeons undertaking procedures were competent and worked within the scope of their qualifications, skills and experience.

Surgery

Safe	
Effective	

Are surgery services safe?

Incidents

- Since our last inspection, we observed the hospital had reviewed their adverse incident management policy. Examples of adverse outcomes and serious incidents that should be reported to the Medical Advisory Committee (MAC) included unplanned return to theatre, drug errors and postoperative infection. This ensured that staff had information regarding the process and the type of incidents they should report.
- Staff we spoke with were aware of the adverse incident management policy and how to access it. Incidents were discussed at clinical governance meetings and feedback was provided in monthly clinical staff meetings. Managers told us new policies were emailed to staff, presented at staff meetings and made available in the break room for review.
- Staff we spoke with could describe the types of incidents they would report and discussed a change in practice as a result.
- We observed the hospital had a lessons learned policy, which detailed the roles and responsibilities of staff regarding the investigation of incidents, how lessons learned should be shared and analysis of incidents to promote organisational learning.
- Managers told us all incidents were reviewed on a daily basis and any clinical incidents were reviewed at MAC meetings. All incidents were reviewed to identify themes and allow appropriate action to be taken however a statistical thematic review could not be performed due to the low number.
- Managers told us that surgical site infections were reported as adverse incidents and discussed in both MAC and infection; prevention and control meetings to ensure investigation and learning took place. Meeting minutes we observed supported this.

Environment and equipment

- At our last inspection, emergency resuscitation equipment was found to be out of date meaning there was a risk to patients receiving safe care and treatment if they deteriorated and needed emergency care. During this inspection emergency resuscitation equipment was in place and records indicated this was consistently checked.
- All items of equipment were noted to be present and in date.

Medicines

- During our inspection, we observed improvements with the handling of controlled drugs (strong medicines that are subject to specific law). Processes had been introduced to manage the usage of medicines in theatre. All controlled drugs stock was counted at the start and end of each theatre day and a process was in place to record and investigate discrepancies. We saw no discrepancies recorded which indicated that medicines were being managed safely.
- The controlled drug register demonstrated that single ampoules had been issued to individual patients and staff confirmed that the process of sharing ampoules had ceased. Quarterly audits were being undertaken by the local pharmacy as part of a service level agreement. (A service level agreement is a contract between a provider and user regarding a level of service to be provided). We looked at the last three audits, which stated there were no concerns.
- The Integrated Care Pathway (ICP) documentation had been updated since our last inspection and now included specific pages for recording medicines given in theatre, once only post-surgery and PRN (when required) on the ward. The ICP is a single record used to document all patient details, interventions and medicines from the time of admission for surgery, until discharge
- We reviewed medicine prescription records of ten patients who had recently had surgery at Prem House Clinic. A time of administration of medicines was recorded for medicines given in theatre to ensure that doses were not duplicated, along with batch numbers and expiry dates to ensure that they were suitable for use. The PRN medicines were pre-printed from an agreed and appropriate list of medicines.

- We saw records that showed doctors prescribed medicines specifically for the individual patient and medicines administered were recorded correctly. All medication given PRN and by the anaesthetist in theatre had the time and route recorded. This indicated medicines were being managed safely.
- All medicines given by staff from stock on the ward were recorded in a medicines log to track safe usage. Information recorded included date, patient's details and a stock balance check. This included medicines given on the ward and for a patient to take home.
- Regular stock checks of every medicine had been introduced and a discrepancy form completed when necessary. We saw that discrepancies were investigated and lessons learned. We checked a sample of medicines stored on the ward and found that balances were correct and stock was in date and stored safely.

Safeguarding

- Safeguarding training formed part of the hospitals mandatory training programme and since our last inspection, all staff had completed training in relation to Female Genital Mutilation (FGM) and Prevent. Prevent is a government led counter-terrorism strategy.
- Records indicated that all staff had completed children and adults safeguarding training to the appropriate level to enable them to identify safeguarding concerns and address any safeguarding issues that may arise.

Mandatory training

- The hospital required staff to undertake mandatory training and this included subjects such as manual handling, fire safety, medicines management and record keeping. Some subjects required an annual update, others were three yearly. At our last inspection, we found uptake of mandatory training levels were low. Records we reviewed at this inspection indicated this was much improved and most staff were compliant in all subjects. Plans were in place to ensure all staff met the agreed level of training.
- At our last inspection, only 9% of staff were compliant with basic life support (BLS) training and no staff were compliant with immediate life support (ILS). Mandatory training records indicated 100% of staff were now compliant with BLS and seven out of nine ward staff and three theatre staff had completed immediate life support (ILS).

Assessing and responding to patient risk (theatres, ward care and post-operative care)

- Following our last inspection, the hospital had reviewed a number of policies including the Risk Management policy, Admissions policy, Discharge policy and Complaints policy. A policy regarding Female Genital Mutilation had also been introduced. This ensured systems and processes were in place to review and mitigate risks to patients.
- The World Health Organization (WHO) Surgical Safety Checklist is a core set of safety checks for improving performance at safety critical time points within the patient's intraoperative pathway. At our last inspection we observed that this was not fully completed in records reviewed. During this inspection the WHO Surgical Safety Checklist was observed as complete in all 23 records reviewed which improved patient safety and reduced risk.
- The National Patient Safety Agency (NPSA) five steps to safer surgery (2010) provides guidance to help reduce harm during surgical care. This includes a briefing session before a surgery starts and a debriefing session afterwards. At the last inspection the briefing session was observed however, staff reported the debriefing session did not happen. During this inspection staff and managers advised both preoperative and postoperative briefing sessions took place involving both ward and theatre staff. Documentation reviewed for the period 8 May 2017 to 30 June 2017, showed that both preoperative and post operative briefings took place on all but four occasions.
- At the last inspection, nationally recognised guidance from the National Institute for Health and Clinical Excellence (NICE) guidance was not always being followed, as pregnancy testing was not routinely carried out preoperatively. At this inspection, we saw the revised Integrated Care Pathway (ICP) document included a requirement for staff to enquire about the date of a patient's last menstrual period (LMP). Staff documented if a pregnancy test was required, gained consent from the patient and recorded the outcome of the pregnancy test.
- Patients were also required to sign the ICP document if they were unsure of their LMP status and declined a pregnancy test.
- From the 23 patient records we reviewed, we saw LMP was discussed in 21 out of 22 cases where applicable.

- An audit in May 2017 to review if LMP was documented correctly and if female patients were offered a pregnancy test on admission, indicated 100% compliance with the policy. A further audit was planned for November 2017.
- A national early warning score system (NEWS) was used at the hospital to alert staff if a patient's condition was deteriorating. The NEWS system uses observations such as respiratory rate, temperature, blood pressure and pain score, to alert staff to any changes in a patient's condition. At our last inspection ten out of 12 records reviewed had not been completed accurately, NEWS audits were not being carried out and staff competency in calculating NEWS scores was not checked. During this inspection, all 23 records reviewed had NEWS scores completed and calculated correctly. NEWS compliance audits were completed and findings were presented monthly at clinical governance and clinical staff meetings.
- Managers told us that an audit in February 2017 had highlighted issues with the calculation of NEWS scores. Further audits in April and June 2017 had showed significant improvement and a further audit was planned for August 2017. The audit in June 2017 indicated that NEWS scores had been calculated correctly in 17 out of 20 records reviewed. Staff had also completed online training in the completion of the NEWS system and could describe how they would escalate any concerns. Staff were required to repeat training in completion of the NEWS system annually.
- Other systems and processes in place to assess, record and mitigate risks relating to patient safety included a Malnutrition Universal Screening Tool (MUST), assessment of risk of pressure ulcers (Waterlow risk assessment) and anaesthetic assessments. Of the 23 records we reviewed, all had MUST and Waterlow assessments completed as part of the ICP documentation, and 21 out of 22 had anaesthetic assessments completed where applicable.
- Audit for the completion of the (MUST) had been undertaken in May 2017. This involved a review of a random selection of 30 patient records following admission between March and May 2017. The audit indicated all patients had a full and accurate assessment on admission and if any concern had been identified, appropriate action had been taken in line with the policy. Results were shared with staff at the clinical staff meeting and reviewed at the MAC and clinical governance meetings. A further audit was scheduled for November 2017 to ensure continued compliance.
- Minutes of the clinical governance board meeting in June 2017 also included an invitation to staff to submit suggestions for any future audits.
- At our last inspection we were not assured staff were able to access the call bell when they required assistance in the recovery area. During this inspection, we observed staff demonstrating its use and found they could use it if they needed to summon assistance.
- Following our last inspection RMO duties had also been amended to include the RMO remaining in the theatre recovery area while patients were present. Staff and managers told us this remained current practice and the RMO was observed in recovery during our inspection.
- At our last inspection, a review of records indicated a patient had been discharged within two hours of having surgery despite records showing that they were feeling unwell. Since our last inspection, the discharge policy had been reviewed and staff described the discharge process, which included provision of post-operative instructions and a 24 hour emergency telephone number. Of the 23 records we reviewed 22 had the ICP discharge documentation completed.

Are surgery services effective?

Competent staff

- At our last inspection, we observed the hospital had a system in place to check a surgeon's competencies on commencing employment with the hospital. However, apart from annual appraisal, there was no review system in place to ensure that surgeons and anaesthetists were still competent to undertake procedures.
- The hospital was authorised as a Designated Body with the General Medical Council (GMC). A Responsible Officer was in post to provide support to ensure compliance with GMC regulations. Effective mechanisms were in place to share intelligence with NHS trusts and other healthcare providers where surgeons may work, should any concerns be raised regarding competencies or practise.
- Managers told us monthly monitoring of procedures completed by each surgeon was performed by the Medical Advisory Committee (MAC) to monitor the

individual surgeon's performance. This included number of patients who returned to theatre, infection and revision rates and complaints. Revision of surgery is usually undertaken when there have been complications or if the surgery was not in line with the patient's expectations.

- From reviewing staff records, we observed all four surgeons at the hospital had received a biennial review of their practising privileges.
- Two surgeons had completed an annual appraisal within the last year. However, two were overdue, which was not in line with the hospital's medical appraisal and revalidation policy. We discussed this with the registered manager who confirmed the two outstanding appraisals were scheduled for August 2017.