

Facemed Limited

FACEmed Cosmetic Medical & Dental Centre

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

Good



Are services safe?

Good



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

Overall summary

This was the first time we inspected and rated this service. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned from them.
- Staff provided good care and treatment, gave patients pain relief when they needed it. The registered manager monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients and supported them to make decisions about their care and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their treatment.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Managers ran the service well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities.

However:

- Meeting minutes were not detailed and tended to list bullet points or brief notes of discussions.

Summary of findings

Our judgements about each of the main services

Service

Surgery

Rating

Good



Summary of each main service

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- Staff provided good care and treatment, gave patients pain relief when they needed it. The registered manager monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients and supported them to make decisions about their care and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their treatment.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Managers ran the service well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities.

However:

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Summary of findings

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Summary of this inspection

Background to FACEmed Cosmetic Medical & Dental Centre

FACEmed Cosmetic Medical & Dental Centre is operated by FACEmed Limited. The clinic opened in 2017. It is a private clinic located in Billericay, Essex, in a purpose-built facility which has been designed to provide aesthetic medicine for adults and day surgery procedures under local anaesthesia and sedation for adults. It also provides dentistry services for adults and children.

Between April 2021 and April 2022, the service provided 203 surgical procedures. Of these, 179 were performed under local anaesthetic and 24 were under local anaesthetic with sedation. Surgical procedures included eyelid surgery, liposuction, removal of skin lesions, moles and skin tags and podiatric surgery. The service also provided dentistry for Adults and Children.

The clinic offered cosmetic procedures such as dermal fillers, rejuvenation treatments and other cosmetic treatments which are not regulated activities. Therefore, we did not inspect these procedures.

The clinic has a spacious reception area, a range of offices, consultation and treatment rooms, an operating theatre and a recovery area, set out over two floors. The service has two dental treatment suites and a dedicated dental radiography area. The clinic has no inpatient beds.

The service has had a registered manager in post since 2020 and is registered to provide the following regulated activities:

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

The service has not been previously inspected.

How we carried out this inspection

The team inspecting the service comprised a CQC lead inspector, a CQC oral health team inspector, and a specialist advisor with expertise in dentistry. The inspection was overseen by Zoe Robinson, Head of Hospital Inspection.

During the inspection, we visited all areas of the clinic, including consultation and treatment rooms and the operating theatres. We spoke with 13 staff members including a surgeon, surgical nursing staff, dental staff, the registered manager, and the company director who is also the nominated individual for the CQC. We observed clinical practice, spoke with three patients and reviewed eight sets of patients' records. We also reviewed information relating to service activities, company policies, performance, and patient feedback, both during and following the inspection.

As the main service provided is surgery, the oral health findings have been reported within the report.

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>.

Summary of this inspection

Outstanding practice

We found the following outstanding practice:

There was a wide-ranging use of innovative technology which facilitated efficient service delivery. For example, environmental impact and awareness was integral to the service's current and future plans for expansion. They also introduced new equipment to provide safe and effective care to patients.

Areas for improvement

Action the service **SHOULD** take to improve:

- The service should ensure they improve protocols and procedures for the use of dental X-ray equipment in compliance with The Ionising Radiations Regulations 2017 and Ionising Radiation (Medical Exposure) Regulations 2017 and taking into account the guidance for Dental Practitioners on the Safe Use of X-ray Equipment and taking into account HPA-CRCE-010 Guidance on the Safe Use of Dental Cone Beam (Computed Tomography).
- The service should ensure that antimicrobial prescribing audits are completed in order to monitor and provide feedback on antimicrobial prescribing practice.






Our findings

Overview of ratings

Our ratings for this location are:

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

Surgery

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

Are Surgery safe?

Good 

Mandatory training

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

Staff received and kept up-to-date with their mandatory training. At the time of our inspection all staff had received mandatory training in safety systems, processes and practices.

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory and statutory training was provided by a combination of e-learning and face-to-face training sessions, including adult basic life support, infection prevention and control, fire safety, manual handling, health and safety, equality and diversity, and safeguarding for both children and vulnerable adults.

Managers monitored mandatory training and alerted staff when they needed to update their training. Training was completed at the same time each year to ensure full compliance. Training was booked by the manager in advance of expiration to ensure staff were available.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Safeguarding children and vulnerable adults formed part of the mandatory training programme. All staff completed level 2 training for both children and adults safeguarding. This was in line with the recommendations from the Intercollegiate Document adult safeguarding: roles and competencies for health care staff (August 2018) and the Intercollegiate Document safeguarding children and young people: roles and competencies for healthcare staff (January 2019).

The service had a named safeguarding lead who was trained to level three safeguarding adults and children. All staff we spoke with knew who the safeguarding lead was and how to contact them.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. We were told how staff would escalate any concerns to the clinical lead and local authority if necessary.

Surgery

Staff knew how to make a safeguarding referral and who to inform if they had concerns. There was a safeguarding flowchart that staff used for easy reference on how to follow the safeguarding process. Staff had not had the need to raise concerns so could not give us any examples where they had done so.

Staff followed safe procedures for children visiting the service. The cosmetic surgery part of the service did not provide care or treatment for children or young adults under 18 years old. The only care provided for this age group was dentistry. Staff confirmed that whenever children or young adults attended, they were always accompanied by a parent.

The service had a safeguarding children and vulnerable adult's policy including guidance on female genital mutilation (FGM). The safeguarding policy contained definitions of abuse, signs of potential abuse and the definition of FGM. The policy contained up to date contact details for the local authority and clear guidance on the process staff should follow if they suspected abuse or harm. Staff had access to the safeguarding policy.

Safety was promoted through recruitment procedures and employment checks. Staff had Disclosure and Barring Service (DBS) checks undertaken at the level appropriate to their role. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. The service used an external cleaning company to clean all non-clinical areas. All clinical areas were cleaned by the clinical staff, before and after any treatments.

The service generally performed well for cleanliness. Managers monitored the cleaning schedules and daily checks. The annual infection prevention and control external audit dated May 2021 showed 100% compliance with all cleaning, this included all equipment. Audit findings were shared with the team.

Staff hand hygiene audits were completed as part of the annual infection prevention and control external audit and there was also a six-monthly internal audit. Results showed full compliance with hand washing, sanitising and the use of gloves where appropriate.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff wore PPE in line with national guidance. Patients were asked to wear face masks and sanitise hands where appropriate throughout their appointments. The provider informed patients of COVID-19 arrangements on the service website before the patient attended the clinic. This included the completion of a COVID-19 declaration which was completed before arrival and a temperature check before entering the clinic. All surgical patients would also complete a lateral flow COVID-19 test on the day of surgery.

Staff cleaned equipment after patient contact and recorded this on a cleaning schedule. Sterile equipment was sent to an external company to be decontaminated before being returned to the service for the next use.

Staff worked effectively to prevent, identify and treat surgical site infections. Patients were provided with written information about pre-operative skin preparation before their treatment as well as post treatment care requirements to

Surgery

promote healing. Patients were followed up to review their treatment and assessed for any signs of infection. If any surgical site infection was identified this would be recoded on the patient's notes. Where appropriate preventative antibiotics were prescribed. The service reported no surgical site infections in the twelve months preceding the inspection (April 2021 to April 2022).

The service had two infection prevention and control (IPC) leads, one for the surgical department and a separate lead for the dental department. We saw that both IPC leads had attended IPC link practitioner course to help them gain greater understanding for IPC requirements and support staff to implement and embed the process.

The dental staff followed guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices, (HTM 01-05), published by the Department of Health and Social Care. Staff completed infection prevention and control training and received updates as required.

The dental service had arrangements for transporting, cleaning, checking, sterilising and storing dental instruments in line with HTM 01-05. The records showed equipment used by staff for cleaning and sterilising instruments was validated, maintained and used in line with the manufacturers' guidance. The provider had suitable numbers of dental instruments available for the clinical staff and measures were in place to ensure they were decontaminated and sterilised appropriately.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The design of the environment followed national guidance. The treatment room, operating theatres and the recovery room, followed national guidance and all areas were well maintained.

The clinic rooms and theatres were arranged over two floors; the first floor was mostly used for office and staff area, with consultation rooms for the aesthetic part of the service which is not regulated. There was a stairlift to access the first floor for those unable to use the stairs.

Theatre room, recovery and dental treatment rooms were situated on the ground floor.

Staff carried out daily safety checks of specialist equipment. Staff told us they received training in the use and management of equipment directly from the manufacturers. We saw annual safety checks of equipment showing all equipment was safe to use.

The service had enough suitable equipment to help them to safely care for patients. Each clinical treatment room contained suitable equipment for the procedures completed in that area. Each room had a supply of sterile and single use equipment such as needles, syringes and dressings. We saw that sterile items were stored in easily accessible trolleys and all items were checked for expiry regularly.

There was a fully equipped adult resuscitation trolley in theatre. This included medications for anaphylaxis, automated external defibrillator, airways and oxygen. Staff carried out daily safety checks of the specialist equipment including the resuscitation trolley.

Staff had access to emergency grab bags and automated external defibrillators, one located on the ground floor outside the dental treatment room and the other on the first floor by the aesthetic department.

Surgery

Access to clinical areas was via staff security pass, which restricted unauthorised access.

Staff disposed of clinical waste safely. Sharps bins were labelled and used appropriately with no overfilled sharps' bins seen in the clinic. There was a service level agreement in place with an external company for a weekly collection of clinical waste. In the interim, waste was stored in a secure area external to the clinic.

The service employed an external contractor to carry out air quality testing, electrical systems maintenance, fire safety assessments, water checks and portable appliance testing.

Fire safety equipment was fit for purpose and in date. This included fire extinguishers, alarm system and emergency lighting. Practice fire drills were carried out regularly. A fire risk assessment was also carried out by an independent fire safety advisor. The service was fully compliant in line with current fire safety guidelines.

The service had procedures to reduce the risk of Legionella or other bacteria developing in water systems, in line with a risk assessment.

The service had risk assessments to minimise the risk that could be caused from substances that are hazardous to health.

The practice had arrangements to ensure the safety of the X-ray equipment and we saw most of the required radiation protection information was available. However, the three yearly performance check for the intra oral dental X-ray unit was out of date. This was raised with the dental manager on the day of inspection. Following the inspection, the registered manager submitted evidence of the three yearly performance checks which was performed by the third party contractor in November 2020.

We saw evidence the dentist justified, graded and reported on the radiographs they took. The dentist carried out radiography audits although not six monthly as recommended in current guidance and legislation.

The practice had a cone beam computed tomography X-ray machine. Staff had received training in the use of it although this was not seen on the day, and appropriate safeguards were in place for patients and staff.

We observed that the dental service used a hand-held X-ray machine. We were told that this machine was stored in a locked treatment room when not in use and the battery was removed. Staff had received training in the use of it and appropriate safeguards were in place for patients and staff.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. The service made sure patients knew who to contact to discuss complications or concerns.

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident. Pre-operative consultations were carried out in line with national guidance. Risk assessments included the patient's suitability for the procedure, which included, medical history, general health, age, existing health concerns, medications and other procedures. Psychologically vulnerable patients were identified and referred for appropriate psychological assessment in line with the Royal College of Surgeons Professional Standards for Cosmetic Surgery (2016). We reviewed eight patient records and saw that risk assessments were completed for all patients with evidence that information recorded was reviewed by the doctor.

Surgery

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. For example, the National Early Warning Score system (NEWS) was used to monitor patients' clinical observations during treatments. This involved monitoring of clinical observations including heart rate, respiratory rate, blood pressure, oxygen saturations and temperature. Any concerns identified were immediately escalated to the surgeon for review. Staff completed clinical observations on patients during and following surgery.

The service used conscious sedation and staff completed patient clinical observations regularly throughout sedated procedures and monitored their conscious level to ensure patients were not too heavily sedated. Staff were aware of what actions to take if a patient became too heavily sedated, and reversal medicines were available.

In the event of an emergency, staff would call emergency ambulance services to transfer the patient to an NHS hospital. A consultant anaesthetist with advanced life support training was always present when sedation was being used. All nursing staff were trained in immediate life support (ILS).

In addition, a service level agreement (SLA) was in place with a private ambulance provider to transfer patients if a patient required admission to a hospital for acute care and was deemed non urgent .

Staff knew about and dealt with any specific risk issues. Managers told us patients who attended the clinic were generally very low risk, and they were careful about their selection of patients for surgical procedures; inclusion and exclusion criteria were based on the American Society of Anaesthesiologists' (ASA) classification of physical health and only those classified ASA one (completely healthy) or ASA two (with a history of mild disease) were accepted.

Staff knew about and dealt with any specific risk issues including sepsis and venous thromboembolism (VTE). All patients undergoing surgery were assessed for VTE risks before admission for treatment and were given prophylactic as necessary. We saw that risks associated with treatments were discussed as part of the patient's initial consultation. Staff were aware of the signs and symptoms of sepsis. If they suspected a patient had sepsis, they would arrange for immediate transfer to the local acute NHS trust. There was no evidence of any patients being transferred for sepsis since the service opened.

Staff completed the World Health Organisation (WHO) five steps to safer surgery checklist for all patients undergoing invasive clinical procedures. This process ensured that all staff were aware of the patients planned procedure before commencement, and ensured safety following the procedure with a debrief. Staff safety briefs and debriefs were held regularly before and after each surgical procedure. Surgical clinical meetings were held regularly to discuss upcoming and previous surgeries, processes and improvements.

Patients were discharged once they had recovered fully from their procedure and anaesthesia; staff ensured their clinical observations were within normal parameters, they had eaten and drunk, they had passed urine, and there were no adverse symptoms. Comprehensive post-operative advice was given, along with any necessary medicines or equipment, and a follow-up appointment.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. The service used a cosmetic procedure pre-operative screening tool to identify any psychological issues which may affect a patient's decision to have surgery. Patients were asked to complete a questionnaire which was designed to enable the identification of patients who may require additional psychological support or at a higher risk of being manipulated into cosmetic procedures. All patients had a consultation with the doctor before acceptance for treatments, and the team confirmed that if there were any concerns as to the rationale for procedures, the case was rejected. Managers told us they would refer any patients they were concerned about for a more in-depth psychological assessment.

Surgery

Staff shared key information to keep patients safe when handing over their care to others. The team did not routinely share care with other providers, although would refer to specialist support from the local acute hospital or patient's GP if necessary. For example, there may be a suspicious growth for removal, and the team would refer the patient to an alternative service.

Handovers included all necessary key information to keep patients safe. The small theatre team enabled information to be shared about planned and expected procedures. The same staff would be present throughout the treatment procedure which prevented risks associated with handing over care.

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.

The service had enough medical, nursing and support staff to keep patients safe. The service consisted of five consultant surgeons and two consultant anaesthetists who worked under practising privileges, a surgical service coordinator and two operating department practitioners. There was also a scrub nurse who worked as part of a bank service.

The dental team consisted of one dentist, a dental manager and four dental nurses. Dental staff were qualified, registered with the General Dental Council and had professional indemnity cover. Dental staff had the skills, knowledge and experience to carry out their roles.

Managers accurately calculated and reviewed the number and grade of staff needed for each shift in accordance with national guidance. Staff were available according to the procedures planned. There was always a staff member assigned to the recovery room, who was a qualified operating department practitioner or registered nurse, with a second qualified person available in theatre.

All patients seen at the service had consultant-led care and a consultant surgeon was always present during a surgical patient's admission.

The manager could adjust staffing levels daily according to the needs of patients. The bank nurse was called in for all treatments where a nurse was required and worked consistently for the service enabling familiarity.

The number of staff matched the planned numbers.

The service had no staff vacancies at the time of our inspection.

Managers limited their use of bank and agency staff and requested staff familiar with the service. We saw that the same bank nurse worked regularly. Managers made sure bank staff had a full induction and understood the service. Agency or locum staff were not used in the last three years.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Surgery

Patient notes were comprehensive, and all staff could access them easily. The surgical services used paper patient records, which were then scanned into electronic patient records once treatment was completed. Follow up clinic appointments were recorded electronically.

Preadmission records included, a copy of the patient's initial assessment, demographics, including allergies and next of kin contact details, planned treatment and completed risks assessments (including venous thromboembolism (VTE)), blood and swab test (methicillin-resistant *Staphylococcus aureus* (MRSA) and Covid-19). Consent was clearly recorded within the record and signed by the patient and the doctor.

Following admission, the records included details of the procedure, clinical observations, medicines administered and also the recovery observations, and follow up appointments and/or treatment.

Patients were given a discharge summary letter and details of the procedure completed, with the appropriate post treatment advice, with contact numbers and any follow up appointments.

Staff reported that any notifiable implants were recorded in line with guidance.

The dentist made detailed dental care records containing information about the patients' current dental needs, past treatment and medical histories.

Records were stored securely, in locked filing cabinets within the administration office. Paper records were scanned to form the electronic patient record. Staff had individual usernames and passwords to access the records securely.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. We reviewed the service's policy for the management of medicines and saw it was version controlled and had been modified in June 2021. The policy was comprehensive and gave information regarding: the prescribing, storage, and dispensing of medicines; controlled drugs (CDs); antibiotics; record keeping; adverse drug reactions; and audits.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Patient records showed details of medicines being taken in advance of an appointment and the discussion completed during consultation regarding whether medicines should continue on the day of planned treatment.

Staff completed medicines records accurately and kept them up-to-date. We reviewed eight patients' records which detailed the dose of medicines, route and time of administration.

Staff stored and managed all medicines and prescribing documents safely. Medicines were stored in the operating theatre in locked cupboards in line with national guidance. Medicines which are temperature sensitive were kept in medicine fridges. Staff checked the ambient and fridge temperatures daily to ensure medicines were stored in line with guidance.

The service kept controlled drugs (CDs) at the premises and these were stored in the operating theatre in line with national legislation. There was an appointed controlled drug accountable officer (CDAO) responsible for the management of CDs. We reviewed the CD register during our inspection and saw all entries and checks had been completed appropriately and in line with guidance. We checked a range of medicines and all were in-date.

Surgery

The service used conscious sedation for some procedures, and we saw that this was clearly recorded in patients' notes. Staff had access to anaphylaxis kits to be used in the event of an adverse reaction to medicines used.

The staff were aware of current guidance with regards to prescribing medicines. However, antimicrobial prescribing audits were not carried out.

Staff learned from safety alerts and incidents to improve practice. We saw that any safety alerts were shared by the service manager with the wider team.

Incidents

The service had processes in place to manage patient safety incidents. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the team.

Staff knew what incidents to report and how to report them. They raised concerns and reported incidents and near misses in line with the service's policy.

The service had reported one incident in the 12 months prior to our inspection (April 2021 to January 2022). We saw that this incident was investigated appropriately and feedback from the incident shared with staff to facilitate improvement and learning.

The service had no never events or serious incidents from April 2021 to April 2022. Never Events are serious, largely preventable patient safety incidents that should not happen if all available preventative measures have been used.

Staff understood the duty of candour. They knew how to be open and transparent, and how to give patients and families a full explanation if and when things went wrong. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were no incidents reported to meet the threshold for the duty of candour.

Are Surgery effective?

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. This included guidance from the Royal College of Surgeons (RCS) Professional Standards for Cosmetic Surgery (2016), RCS Good Surgical Practice (2014), the Association of Anaesthetists of Great Britain and Ireland (AAGBI) and the National Institute for Health and Care Excellence (NICE). There was a process in place for policies to be reviewed regularly to ensure they were updated in line with national guidance.

Surgery

We reviewed a selection of policies including the sepsis management, sedation, emergency care, medicines management, management of deteriorating patient, and management of histology specimens and saw that they were clear and accessible to all staff.

Staff assessed people's suitability for proposed treatments. During consultations, surgeons reviewed and assessed each patient's medical history, general health, mental health and any previous cosmetic surgery. Expected outcomes and potential risks were discussed openly and honestly, in line with national guidance and professional standards.

The service had an audit programme which reviewed staff compliance with policy, this included infection prevention and control audits, medicines management and pharmacy annual audit, perioperative annual audit and patient documentation audits. If non-compliance or the need for additional training was identified by the audit, this was addressed by managers and action was taken to ensure compliance or for staff to complete additional training.

The dentist assessed patients' treatment needs in line with recognised guidance.

The dental service had quality assurance processes to encourage learning and continuous improvement. Staff kept records of the results of these audits, the resulting action plans and improvements. However, monthly quality assurance tests were not carried out on the cone beam computed tomography X-ray machine.

Nutrition and hydration

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

Patients were informed of any dietary requirements before attending the service for a procedure. Patients requiring conscious sedation were informed of the need to fast in advance of attending the clinic for surgery.

All patients who received conscious sedation were required to eat and drink before leaving the clinic.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. The patients we spoke with told us their pain had been managed very well during and after the procedure, and they had been provided with appropriate pain relief on discharge. We saw, during a procedure, the team checked with the patient to ensure that pain was well controlled and the correct level of analgesia was used.

Patients received pain relief soon after requesting it. Pain relief was provided in advance of treatments and as part of the aftercare. Patients were prescribed pain relief medicines to take home and advised on how often to take them.

Staff prescribed, administered and recorded pain relief accurately. We saw patients' records relating to the prescription and administration of pain relief was completed and signed appropriately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Surgery

The service participated in relevant national clinical audits. The service submitted data to the Private Healthcare Information Network (PHIN). PHIN publishes data for 11 performance measures at both service and consultant level. These measures included the volume of procedures undertaken, infection rates, readmission rates and revision surgery rates. We saw that the service did collect data on the PHIN performance measures applicable to them, such as the number of procedures undertaken, infection, readmission and revision rates.

Outcomes for patients were positive, consistent and met expectations, such as national standards. We saw that patient satisfaction with outcomes was recorded as part of follow up visits. In addition, the service completed online feedback surveys and data for April 2021 to March 2022, showed that patients that responded rated it five stars.

Managers and staff used the results to improve patients' outcomes. The service continually looked at how they could improve treatments and outcomes for patients, with plans to implement new and improved treatments following research. We were given examples of how the team had taken on improved treatments to ensure better patient outcomes and measured satisfaction from patients treated. The service routinely audited patient outcomes and ensured that staff understood information from the audits. All patient outcomes were discussed with staff as part of team meetings, enabling them to understand overall satisfaction with the service.

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. At the time of our inspection there were five consultant surgeons on practising privileges, three of whom were plastic surgeons and the other two were podiatric surgeons on the specialist register. The service also had two consultant anaesthetists with practising privileges.

There was an up-to-date policy in place for the granting and reviewing of practising privileges. The documents required before practising privileges were granted included evidence of current medical indemnity insurance in line with General Medical Council (GMC) guidance, immunisation status, appraisal records, Disclosure and Barring Service (DBS) check, and references

Staff received role specific training to ensure that they were able to complete their roles. Any follow up competency assessments were completed either in house or by external training providers.

The surgeons had the skills, competence and experience to perform the treatments and procedures they provided. They each performed specialist surgical procedures at independent or NHS hospitals, in addition to their work at the clinic, and participated in training demonstrations and teaching.

Consultants were trained in advanced life support (ALS) and the nursing staff were trained in immediate life support (ILS). All other staff received basic life support (BLS) training.

Training compliance and competencies of all the consultants was checked by the registered manager at the time of application for practising privileges and reviewed annually; we saw documented evidence of this in the staff records.

Managers gave all new staff a full induction tailored to their role before they started work. A local induction was completed for all staff, this included protected time to shadow staff and complete training sessions.

Surgery

Managers supported staff to develop through yearly, constructive appraisals of their work. All appraisals were in date. We were told that this included a review of training completed, feedback from learning and a 360-degree review from peers.

Clinical staff completed continuing professional development in respect of dental radiography.

As part of the annual practising privileges review, the registered manager received the consultant surgeons and anaesthetists' annual appraisal from their substantive NHS role.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. We saw completed notes from meetings, which were shared with the team electronically.

Managers made sure staff received any specialist training for their role. Team members received training from source, for example, all equipment training was provided by the manufacturer and updated regularly.

Dental staff had the skills, knowledge and experience to carry out their roles. Newly appointed staff had a structured induction and dental clinical staff completed continuing professional development required for their registration with the General Dental Council.

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 held regular and effective multidisciplinary meetings to discuss patients and improve their care. We saw the team worked very well together and delivered care and treatment in a co-ordinated way. There were positive working relationships between all staff, and they told us they were all focused on providing the best care possible to patients. As the service was small, we were told the team communicated effectively. Theatre safety briefings and debriefs took place before and after surgical procedures, attended by all staff, and we saw there was inclusive and supportive discussion. Briefings included an overview of the planned procedure, medication likely to be needed, potential risks and plans for discharge.

Multidisciplinary working was also evident across departments including the dental and the aesthetics departments. We saw staff working together to ensure consistent care and service for patients.

Staff worked across health care disciplines and with other agencies when required to care for patients. Treatment provided was consultant-led. All team members knew who had overall responsibility for each patient's care. When or where necessary the team would consult other specialities, for example for ongoing review or treatments.

Seven-day services

Patients could contact the service seven days a week for advice and support after their surgery.

The clinic was open from 8am to 6pm Monday to Friday and from 8am to 3pm on Saturdays. Surgical lists were planned in advance, with consultations and procedures requiring local and general anaesthetic taking place on set days.

Staff informed patients of any post treatment care and how to escalate any concerns in and out of hours before discharge. Patients were given the consultant's phone number to call if they had any problems or concerns.

Surgery

The dental department provides an emergency out of hours dental service. This service was provided through a contract with a third party provider, and covers nights, weekends and bank holidays.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards/units.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

The dental service provided preventive care and supported patients to ensure better oral health. The dentist where applicable, discussed smoking, alcohol consumption and diet with patients during appointments. The practice had a selection of dental products for sale and provided leaflets to help patients with their oral health.

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 to gain patients' consent . They understood how to support patients.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff told us they had not had any patients at the clinic who lacked capacity, request their services. If they had any concerns about a patient's capacity to consent, they would not perform treatments or surgery without involvement from the patient's GP and a psychologist.

Staff made sure patients consented to treatment based on all the information available. Staff understood their responsibilities regarding consent. Consultants had consultations with the patients before they carried out any treatments and explained the expected outcomes and ensured the patient understood these and any potential risks before agreeing to go ahead with procedures or surgery. We saw detailed preoperative information given to patients, which included managing expectations, risks and potential complications.

Staff clearly recorded consent in the patients' records. Patients who were booked for cosmetic surgery were given a two-week cooling off period before undergoing the procedure, in case they wanted to change their mind. This was in line with national guidance.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. There was an up-to-date consent policy for staff to follow. Staff could tell us how they would access relevant policies, and who they would contact for further advice or support.

The dentist obtained patients' consent to care and treatment in line with legislation and guidance. The dentist used a dental intraoral camera to demonstrate to patients what treatment was needed to help them to make an informed decision.

Surgery

Are Surgery caring?

Good 

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed interactions between staff and patients and saw that they were respectful friendly and considerate. Care was taken to ensure privacy during consultations.

Patients said staff treated them well and with kindness. We spoke with three patients and saw over 20 reviews which were all positive about the service, all confirmed that they had been treated well and that staff were professional and understanding. The service subscribed to an independent feedback service and we reviewed comments posted on its website. Feedback was consistently positive, where patients said staff were 'friendly', 'professional', 'caring' and 'polite'.

Staff followed policy to keep patient care and treatment confidential. Patients told us and we saw that their privacy and dignity were protected at all times. All patients were escorted into consultation rooms to discuss treatments which prevented discussions in communal areas.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Patients told us they felt their assessments had been well planned and they were not rushed or pressurised into choosing particular treatments or procedures; surgeons took time to explore the most appropriate individual options, offer alternatives, and were honest about expectations and outcomes.

We observed a surgical procedure during our inspection and saw all staff worked hard to ensure the patient's experience was comfortable and positive. Staff provided reassurance, information and support throughout their episode of care; they actively encouraged patients to ask questions throughout their procedure.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients told us that staff listened to their concerns and responded to their needs. Patients said they were made to feel safe and comfortable during the procedure.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. All staff we spoke with had a clear focus on patient care and aimed to provide the highest standard of care possible to all patients at the clinic.

Staff demonstrated empathy when having difficult conversations. Staff spoke to patients with compassion and empathy when discussing the treatments or expected outcomes.

Surgery

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. We saw patients were supported at all times from the very first stage of consultation, and the support given to each patient was timely and tailored to their individual needs. The support continued after discharge as all patients were given a 24 hour telephone number they could contact if they had any queries or concerns. The team had links with a psychologist who they could refer patients to, if they had any concerns about their emotional wellbeing.

Understanding and involvement of patients and those close to them

Staff 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. Patients told us they had time to consider their treatment and that the risks and benefits were clearly explained. All those we spoke with said communication and documentation from the clinic had been excellent.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. We saw procedures were clearly explained to patients and those accompanying them, with diagrams used where appropriate.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Questionnaires were automatically sent to patients following treatment and they contained free-text boxes along with questions, enabling patients to provide comments if they wished. The clinic subscribed to an independent feedback service which we saw was well utilised by patients who had attended, and managers responded to all comments received.

Staff supported patients to make informed decisions about their care.

Patients gave positive feedback about the service. We saw comments such as "Excellent service very clean and highly recommended", "Everyone is professional, helpful and knowledgeable. Everything is explained thoroughly to us and we are able to make informed choices."

Dental staff described to us the methods they used to help patients who were particularly anxious about having dental treatment in particular, very young children and patients who had additional needs. This included having longer appointments and creating a calm environment. We spoke with one dental patient during the inspection and the feedback was wholly positive.

Are Surgery responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. The service provided a wide range of treatments for patients to access that were not all within the scope of CQC registration and inspection methodology.

Surgery

The service has been working with the local NHS trust and provides a consultant led podiatry surgery to help support the local trust reduce their waiting times. The registered manager told us that they were in discussion with the NHS trust to expand the provision of the podiatry surgery service.

Facilities and premises were appropriate for the services being delivered.

Meeting people's individual needs

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

All treatments were personalised, and staff took time to ensure that the patients' thoughts, considerations and wishes were taken into account. Staff completed personalised communications which were always written detailing the individual's options.

The service was flexible, provided informed choice and ensured continuity of care. Managers and staff planned and delivered care in a way that reflected people's needs, and patients told us they had been given choices of appointment times and consultation methods to suit them.

We saw detailed discussions took place between surgeons and patients prior to them making any decisions; this included information about how the procedure would be performed, cost, and any potential risks or complications. We saw surgeons would also explore the possibility of non-surgical options or not performing a procedure at all, if they felt this was more appropriate for the patient. All patients said they had been fully informed and supported at all stages of treatment.

Facilities and premises were innovative and met the needs of a range of people who used the service. There was ample car parking available for patients. The service was accessible to patients who used mobility aids, with accessible bathroom and treatment room facilities.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters when needed and the clinic had access to an online translation service.

Staff had access to communication aids to help patients become partners in their care and treatment. We saw procedures were clearly explained to patients, with diagrams used where appropriate.

Access and flow

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

The service provided cosmetic surgery and dental treatments for self-funded patients. It also had a contract with a local NHS trust to provide podiatric surgery to help with the NHS waiting times.

Self-funding patients made contact with the clinic by referring themselves through an email, phone call or through the clinics online form. Each patient was sent a personalised email from the service manager within 24 hours of receipt of the contact, detailing information about the services available. NHS patient referral was handled through the NHS trust and all initial and follow up consultation was completed through the trust. FACEmed only provided the surgical patient pathway.

Surgery

The consultants completed the initial consultation, collecting past medical history, medications, and expectation of the treatment. If the patient went ahead with treatment a patient file and patient number was created on the patient record system. Patients could then book an appointment for the treatment. Patients would choose a time and date that suited them.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Once patients had been accepted for treatment, they were able to book themselves into the clinic. The manager tracked consultations and appointments to ensure that treatments were completed in a timely manner, and enabled cooling off periods.

Managers and staff worked to make sure patients did not stay longer than they needed to. All procedures were completed as day cases. Staff told patients the time they should expect to be at the clinic in advance of the procedures.

Managers and staff started planning each patient's discharge as early as possible. Patients were informed of any requirement for discharge in advance of treatments. For example, patients requiring sedation were told they needed an escort for discharge home and that they could not drive. Staff told us they did not let patients who had sedation for treatments leave the clinic unaccompanied.

There were processes in place to manage repeat attenders, and the team would not accept patients for repeated treatments within specific time frames for each procedure. When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. Staff told us appointments were rarely cancelled, however, if they were next available slots would be offered.

Dental patients were sent email or text reminders for their appointment. Emergency slots were available for patients who needed emergency dental treatment. New patients were being accepted.

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.

Patients knew how to complain or raise concerns. There were clear processes in place for feeding back to the clinic. Staff prompted patients to complete satisfaction surveys post procedure. There were feedback forms available within the clinic and the service used an online feedback forum. All feedback was monitored by the manager, and responses made. We saw that the online reviews were positive, and all had a response from the clinic.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. The complaints' lead was the clinic manager and they were aware of their roles and responsibilities in relation to this. Patients could complain verbally or in writing; verbal complaints received were often dealt with quickly and informally. Written complaints received a response in writing, with an acknowledgment sent within two working days of receipt and a full written response within 20 working days wherever possible. Patients would be offered a meeting to discuss any potential solutions and would be kept informed of the progress of the investigation.

Surgery

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. The clinic received very few complaints and managers told us those received were dealt with quickly and to the patient's satisfaction. In the last 12 months prior to our inspection, the service received two formal complaint. We saw these had been dealt with appropriately.

Managers shared feedback from complaints with staff and learning was used to improve the service. Lessons learnt would be discussed at team and clinical governance meetings. Staff we spoke with confirmed this.

Are Surgery well-led?

Good 

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The service was led by the company director, who was the clinical lead and aesthetic registered nurse, and they were supported by the business development manager who was the CQC registered manager. All had significant previous experience in their respective areas and understood the priorities of the service and any issues which may affect it. There was a clear organisational structure with defined lines of responsibility. All staff we spoke with were clear about their roles and accountabilities.

During our inspection, we saw the management team were visible, supportive and had good working relationships with staff. They told us they encouraged an open culture and actively sought staff feedback and opinion. Managers held regular staff meetings in order to communicate and engage with staff regularly.

All staff spoke very highly of the management team and felt they were always approachable and actively involved in all aspects of the service. Staff told us they were encouraged to develop their knowledge and skills and were supported to attend training courses.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services.

The service had a vision for what it wanted to achieve which was based on “providing the highest standards of care in a safe and modern environment that continues to evolve and adapt to modern healthcare innovations and approaches to treatment. The service aims to offer a personal and bespoke approach to patients alongside a multidisciplinary team approach to treatment, ensuring that all patients needs are catered for.”

Staff were aware of the vision and worked to meet the requirements of the service.

To help with the waiting list of the local NHS trust, the service was increasing the provision of podiatry surgery. We saw that the service was taking on board additional podiatric surgeons to facilitate the increase.

Surgery

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients and staff could raise concerns without fear.

All staff we spoke with told us they felt respected, supported and valued. Managers told us they operated an 'open door' policy and were always happy for staff to discuss, challenge and raise ideas. Staff corroborated this and said they always felt comfortable discussing ideas and raising concerns; they felt confident any issues would be responded to positively and dealt with appropriately.

The service considered and promoted the safety and wellbeing of staff. Access to the building was controlled remotely by reception staff and clinical areas were secured with keypads. There was a lone worker policy in place and managers told us they would complete regular welfare checks should a colleague be working out of hours at the clinic.

Managers told us they took time to recruit staff who they felt would be the 'right fit' and shared the ethos of the service to provide a high standard of patient care; clinic values were shared during staff induction.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was a defined governance structure within the service and staff at all levels were clear about their roles, responsibilities and accountabilities.

Staff had regular meetings. We saw that meeting minutes followed a set agenda which included details of performance, updates on risks, training and any feedback from patients or audit outcomes. However, minutes were not detailed and tended to list bullet points or brief notes of discussions. The whole team could access minutes which were stored in a shared electronic file.

The service held quarterly medical advisory committee (MAC) meetings, where clinical governance was discussed. We reviewed minutes and saw they were well attended. There was discussion of relevant topics, such as best practice, practising privileges, risks and complications, infection control, audits and sharing of lessons learned. Although the meeting had a set agenda and attendees took actions from the meeting to address any issues identified, minutes were not detailed and tended to list bullet points or brief notes of discussions.

Performance was monitored through an audit programme which included non-clinical and clinical areas such as infection control and prevention audits. These were completed for inhouse staff as well as external advisors and shared with the team. Any non-compliance was addressed by managers and we were told that staff were responsive to any concerns raised.

Management of risk, issues and performance

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

Surgery

The service had a risk register which detailed risks associated with the clinic and business continuity. Risks, actions, mitigations and designated responsibilities of staff were recorded clearly. We saw that the risks identified were reviewed regularly and any mitigations recorded. All risks were rated according to likelihood and impact, and actions to reduce risks were documented; these involved liaison with external services where appropriate.

Risks and performance were discussed regularly at MAC and team meetings and took into account issues highlighted by incidents, complaints and other occurrences. All staff were involved, could contribute, and were aware of actions.

The service had a business continuity plan in place. Managers told us they had become much more focused on the need to plan effectively for unexpected events, due to the impact of the COVID-19 pandemic on service provision.

The service had a planned programme of clinical and internal audit. Although some audits were yet to be completed and were awaiting further data collection, we saw the programme was detailed and would enable managers to effectively monitor and review the quality of care and clinical processes, and to identify where improvements were needed. Managers had clear oversight of audit processes and progression.

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. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff had access to the organisation's computer systems and could access latest guidance and communication about changes for the service.

Information Governance and confidentiality were included as part of the staff induction training programme, which ensured that staff were aware of the requirements of managing patient's information and that information was managed in line with the General Data Protection Regulations (GDPR).

Computer terminals were locked during the inspection or manned to prevent unauthorised access to patient information.

Managers told us that data relating to patient outcomes was routinely monitored. The results from patient surveys were reviewed and used to improve the service.

The service had a website and contracted a marketing and design company who was responsible for ensuring all information was kept up to date. Information on the website relating to the clinic, its staff and treatments offered to enable patients to complete their research about the service.

Engagement

Leaders and staff actively and openly engaged with patients and staff to plan and manage services.

Staff were fully engaged with the service and staff continually looked at how they could improve treatments and experiences for patients.

Patient's feedback was collected and used to shape and improve the service. Patients told us that they were fully involved in decisions about their care and were given time to ask questions and their concerns were listened to by staff.

Surgery

Staff completed a 360-degree feedback as part of the staff appraisal process. Communications between the whole team were open and positive, with all staff feeling engaged and valued. All team members were actively involved in meetings and briefings.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation.

Staff of all levels were supported to learn and develop, and managers encouraged them to suggest further training they wished to pursue.

Innovation is one of the values of the service. Managers told us that environmental impact and awareness was integral to the service's current and future plans for expansion. The service had a purpose-built facility with an A-rated energy efficiency running system to reduce excessive energy consumption.

The service was keen to provide treatments which were proven to have higher success rates and consequently pioneered new treatments. For example, in March 2021 the service purchased a new machine which was a safe, gentle and effective minimally invasive procedure for body contouring procedures which used radiofrequency

The surgical department used an imaging system in podiatric surgery which allowed the podiatric surgeons to safely perform foot and ankle surgery which routinely used metalwork under guided imagery. This in turn reduced the risk of 'missing' metalwork and misplaced metalwork (such as screws) which reduced the overall risk of post-operative complications in foot and ankle surgery. The imagery equipment also allowed surgeons to operate on patients who had metalwork that had 'migrated' within the foot after many years in situ.

In February 2022 the service introduced ultrasound guided injections within podiatric surgery. With the use of a handheld device the surgeons could deliver precise and efficient block anaesthetic injections to the foot whilst minimising any risk of injection related oedema or injection site difficulties.

The dental department had invested in a dental camera. This assisted them to deliver a complete and time efficient oral examination showing the patient in real time on the screen their current dental health. The camera also enabled the dental team to identify gingival inflammation, show plaque levels and cavities in different colours on the image.

The dental department also used technology to assist in pain free dental injections, whereby the flow of anaesthetic was delivered using a computer-controlled hardware. This minimised the possibility of the injection being delivered too fast.

The service used a scanning machine to scan a patient's mouth and send digital impressions directly from the machine to the laboratory for all laboratory related work such as crown and bridge work or implant case study models.