Harley Street Skin (Hannah House)

Quality Report

3rd Floor, Hannah House,
11-16 Manchester Street,
London,
W1U 4DJ
Tel:0207436 4441
Website: www.harleystreetskinclinic.com

Date of inspection visit: Announced inspection 18 January 2017. Unannounced inspection 27 January 2017
Date of publication: 13/06/2017

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

Harley Street Skin – Hannah House is operated by Skin@harleystreet LLP. The service provides cosmetic surgery and other cosmetic treatments to people over the age of 18 years. The clinic does not have in-patient beds. Facilities include two operating theatres, six consultation rooms and a three chaired pre assessment/recovery room. The outpatient consultation prior to the procedure itself is provided at the provider's main Harley Street Skin Clinic at Harley Street and was not inspected as part of this process.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 18 January 2017, along with an unannounced visit on 27 January 2017.

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

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

Services we do not rate

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

We found the following issues that the service provider needs to improve:

- There was no system for checking the expiry date of medicines.
- There was no system for checking the expiry date of single-use items.
- Though there was a system for checking the resuscitation trolley, we found expired single-use items upon checking the trolley.
- There were no records of safety checks on portable equipment or evidence of equipment maintenance.
- The clinic did not use the World Health Organisation (WHO) safety checklist for day surgery cases and the '5 steps to safer surgery' were not used. Although the sign-in part of the checklist was incorporated within the operative notes, these were not audited and there was no evidence of compliance with this measure. Other main elements of the WHO checklist, such as face-to-face briefing and debriefing of all staff, were not implemented.
- All policies were updated in December 2016. Previous versions of policies were updated to reflect changes in national guidance, however, compliance with these policies was not audited.
- There were very limited competency records held for nursing and theatre staff members.
- There was no evidence to show that staff had up to date safeguarding training.
- There were no formal meetings, including medical advisory committees (MACs) and governance meetings. There was no formal governance structure in place. However, the provider showed us documentation of the terms of reference of the MAC and governance committee, which they planned to introduce within the next few weeks.
- Although senior clinical staff were able to tell us their vision for the service, there was no coherent vision or strategy for the clinic. Junior staff were not aware of the vision or strategy.
- The Disclosure and Barring Service (DBS) records of some of the clinical staff were not up to date.

Summary of findings

- There was no clinical audit plan in place. Although consultants reviewed their own cases on a regular basis, there was no formal documentation audit or consent audit.
- There was no documented admission policy.

However, we found the following areas of good practice:

- All clinic staff we observed treated patients with respect and dignity, throughout all interactions at the clinic. Feedback from patients was very positive about the caring nature of the staff looking after them.
- The clinic was responsive to feedback and complaints raised by patients, though the numbers were very small.
- The clinic followed best practice guidelines and was determined to set realistic expectations for patients' outcomes after surgery. This resulted in a low number of complaints about the procedures offered.
- Clear information was provided to patients about the cost of their treatment or procedure.
- Patients and relatives felt involved in their care and treatment and detailed information was given to them prior to the procedure.
- There was effective system in place for postoperative patients to contact the consultant directly outside of normal working hours.

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

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery		Surgery was the only activity of the clinic. We regulate cosmetic surgery services but we do not currently have a legal duty to rate them. Overall surgical services at the clinic did not keep people safe from avoidable harm and there were many areas we identified for improvement. Surgical services were not effective, as they did not monitor patient outcomes and there were no clinical audit plans in place. Patients were satisfied with the care and treatment they received. Treatment was individualised around patient expectation and patient convenience. However, there was no admission policy in place at the time of inspection. Leaders were visible but there were no governance systems in place.

Summary of findings

Contents

Harley Street Skin (Hannah House)

Services we looked at
Surgery

Summary of this inspection

Background to Harley Street Skin (Hannah House)

Harley Street Skin – Hannah House (HSS) is operated by Skin@harleystreet LLP. The clinic opened in 2010. It is a private cosmetic skin clinic in Harley Street, London. The clinic accepts referrals from local independent GPs, and self-referrals from patients living in London and internationally.

All invasive surgical services take place at Hannah House in Manchester Street. However, their main outpatient clinic is based in Harley Street, at the Harley Street Skin Clinic. This includes the administrative team. The main Harley Street Skin Clinic is registered separately and was not inspected this time.

The registered manager for the clinic is Dr Michael Tee, who is been the registered manager and the nominated individual for this location since March 2014.

The clinic also offers cosmetic skin procedures such as dermal fillers and Botox. We do not regulate these services so we did not inspect that part of the service.

Our inspection team

The team that inspected the service comprised a CQC lead inspector,one other CQC inspector and a specialist consultant advisor with expertise in plastic surgery.

Information about Harley Street Skin (Hannah House)

The clinic provides day surgery and is registered to provide the following regulated activities:

- diagnostic and screening procedures,
- surgical procedures and
- treatment of disease, disorder or injury.

During the inspection, we visited the whole clinic. We spoke with eight staff including; registered nurse, health care assistant, general physicians, consultant anaesthetist, operating department practitioner, general manager and non-clinical director of the service. We spoke with three patients and their relative. During our inspection we reviewed six sets of patient records.

On 10 February 2017 we sent a letter for requirement to provide the Care Quality Commission with specified information and documentation under Section 64 of the Health and Social Care Act 2008, asking the provider to submit information as we had difficulty in getting all information from them and not all evidence was submitted after the inspection.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected once before under a different provider name in 2013, which found that the clinic was meeting all standards of quality and safety it was inspected against.

Activity (January 2015 – December 2016):

In the reporting period January 2015 – December 2016 there were173 day case episodes of care recorded at the clinic; Out of these 69 were invasive procedures, including bodytite, fat transfer, micro suction, blepharoplasty and otoplasty. All of the procedures were carried out under local anaesthetic or conscious sedation. All patients were self-pay.

Two general physicians (GPs), one consultant surgeon and two visiting anaesthetists worked at the clinic under practising privileges. The Harley Street clinic employed one theatre manager, one health care assistant and two regular bank registered nurses. The management included non- clinical director and general manger with support from reception and administration staff.

Summary of this inspection

The clinic hired the Hannah House premises from another provider for two days per week. The lease covered the provision of access to the premises, cleaning staff and maintenance of the premises and the lifts.

Track record on safety

Between January 2015 and December 2016 there were:

- No never events.
- Two clinical incidents, resulting in no harm.
- No serious injuries.
- No surgical site infections.
- Three complaints.

Services provided at the clinic under service level agreement:

- Cleaning services.
- Sterilisation services.
- Laundry.

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?

We do not currently have a legal duty to rate cosmetic surgery services.

We found the following issues that the service provider needs to improve:

- There was no system for checking the expiry date of medicines.
- There was no system for checking the expiry date of single-use items.
- Though there was a system for checking the resuscitation trolley, we found expired single-use items upon checking the trolley.
- There were no records of safety checks on portable equipment or evidence of equipment maintenance.
- There was no evidence to show that staff had up to date mandatory training including safeguarding training.
- The clinic did not use the World Health Organisation (WHO) safety checklist for day surgery cases and the '5 steps to safer surgery' were not used. Although the sign-in part of the checklist was incorporated within the operative notes, these were not audited and there was no evidence of compliance with this measure. Other main elements of the WHO checklist, such as face-to-face briefing and debriefing of all staff, were not implemented.
- Staff had not attended any fire evacuation drill.

Are services effective?

We do not currently have a legal duty to rate cosmetic surgery services.

We found the following issues that the service provider needs to improve:

- There was no clinical audit plan in place. Although consultants reviewed their own cases on a regular basis, there was no formal documentation audit or consent audit.
- All policies were updated in December 2016. Previous versions of policies were updated to reflect changes in national guidance. However, compliance with these policies was not audited.
- The provider was not submitting data to the private health information network.
- There were very limited competency records held for nursing and theatre staff members.

Summary of this inspection

Are services caring?

Are services caring?

We do not currently have a legal duty to rate cosmetic surgery services.

We found the following areas of good practice:

- All clinic staff we observed treated patients with respect and dignity throughout all interactions at the clinic. Feedback from patients was overwhelmingly positive about the caring nature of the staff looking after them.
- Clear information was provided about costs of treatment and procedures.
- Patients and relatives felt involved in their care and treatment and detailed information was given to them prior to the procedure.
- There was effective system in place for post-operative patients to contact the consultant directly outside of normal working hours.

Are services responsive?

We do not currently have a legal duty to rate cosmetic surgery services.

We found the following issues that the service provider needs to improve:

- There was no admission policy.
- There was no system to follow up patients within 24 hours post-operatively.

We also found the following areas of good practice:

- The clinic was responsive to feedback and complaints raised by patients and had made improvements to their services as a result.
- There was clear discharge information given to patients, with multiple numbers for them to call in the event of a problem following discharge. This included the direct number for the consultant outside of normal working hours.

Are services well-led?

We do not currently have a legal duty to rate cosmetic surgery services.

We found the following issues that the service provider needs to improve:

Summary of this inspection

- There were no formal meetings, including medical advisory committees (MACs) and governance meetings.There was no formal governance structure in place. However, the provider showed us documentation of the terms of reference of the MAC and governance committee, which they planned to introduce within the next few weeks.
- Although senior clinical staff were able to tell us their vision for the service, there was no coherent vision or strategy for the clinic. Junior staff were not aware of the vision or strategy.
- The Disclosure and Barring Service (DBS) records of some of the clinical staff were not up to date. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children. It replaces the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA).

We also found the following areas of good practice:

- Staff were positive about the team work and their interactions with colleagues and consultants.

Surgery

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are surgery services safe?

The main service provided by Harley street skin clinic at Hannah house (HSS) was surgery.

Incidents

- Between January 2015 and December 2016 there were two incidents (one clinical and one non-clinical) reported by Harley Street Skin (HSS). Both incidents occurred at the main clinic location and not at Hannah House. Both incidents were related to slips, trips and falls, and resulted in no serious harm.
- There had been no never events at the clinic between January 2015 and December 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death, but neither need have happened for an incident to be a never event.
- Although the number of incidents reported was low, there was varying degree of understating among staff of what type of incidents could be reported. This indicates that staff may not have not been reporting all incidents that occurred.
- All staff we spoke with were aware of how they would report incidents. A paper log book was kept at the main clinic, where details would be completed and sent to the general manager. However, their incident log forms lacked any grading of these incidents. There were no investigations, including root cause analysis (RCA) into the incidents reported. Learning from incidents was not routinely discussed in team meetings and some staff we spoke with were unaware of incidents that had taken place within the clinic.
- The risk management policy for the clinic was updated in December 2016. However, this did not include details of how to grade incidents according to severity. In addition, the policy did not clarify what training would be provided to staff in relation to incident management and reporting.
- As the clinic undertook only minor surgical procedures, it was reasonable not to expect deaths within the service; consequently mortality and morbidity reviews were not held.
- The duty of candour (DoC) 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. This means providers must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. There were no incidents during reporting time period that met the threshold for DoC. Not all staff were aware of their responsibilities under this regulatory duty, with only senior staff able to explain the principles.

Safety thermometer or equivalent (how does the service monitor safety and use results)

- The clinic, unlike NHS trusts, was not required to use the national safety thermometer to monitor areas such as venous thromboembolism (VTE). However, services are required to have equivalent systems in place. The clinic did not use any clinical quality dashboards to monitor safety.

Cleanliness, infection control and hygiene

- All areas that we inspected were visibly clean, including equipment. Staff told us that portable equipment was

cleaned after every use. However, there was no mechanism to ensure this occurred and no record kept of when the equipment was last cleaned. The pieces of portable equipment e.g. diathermy machine and suction machines stored in the rooms were not covered while not in use during the week.

- An infection control audit was conducted in May 2016, by the premises provider. Recommendations from the audit included; all staff to have an up to date infection prevention and control (IPC) training and evidence based IPC audits undertaken regularly. However, we were not assured that the audit action plan was used by Harley Street Skin (HSS) to identify learning points and improve their own practice.
- Between January and December 2016, there had been no surgical site infections (SSIs) identified by the provider. The clinic was compliant with National Institute for Health and Care Excellence (NICE), Clinical Guideline 74 Surgical site infections: prevention and treatment. For example, all staff and visitors to theatre were required to change into surgical scrubs and theatre caps. When a procedure had commenced, movement in and out of theatres was restricted. This minimised the infection risk.
- The clinic did not screen patients routinely for MRSA as they had no inpatients, and it did not apply to the setting and types of procedures undertaken. The clinic would screen patients for MRSA only if there were any concerns. However, there was no MRSA screening policy.
- A service-level agreement (SLA) was in place with a private company for the sterilisation of surgical instruments. The instruments were removed and new equipment was delivered every week. Theatre manager told us that this worked smoothly and the clinic staff never had any problems. A logged record of this sterilisation was kept by the theatre manager, which we found to be in order.
- Clinical waste disposal was provided through an SLA with an external provider. Waste was kept outside the clinic in a locked outbuilding and collected weekly for disposal. However, the clinical waste from theatre room 5 (which was the main theatre used by HSS staff) was taken in individual sealed bags into the dirty room before disposal. There was limited space in that room. During the unannounced inspection, we saw clinical waste bags stored there whilst clinical staff were also using the room to do their pre and post-operative paperwork. There was also a centrifuge machine in the room which should not be used there.
- There were dispensers with hand sanitising gel situated in appropriate places around the unit, including the main entrance to the unit and inside rooms. The seven-step guidance for effective hand washing was displayed above hand washbasins. Hand washbasins were equipped with soap and disposable towels.
- Adequate supplies of personal protective equipment (PPE) including gloves and aprons, were available and we observed adherence to 'bare below elbows' (BBE) and theatre dress codes throughout the inspection.
- Staff hand hygiene was not audited by the provider.

Environment and equipment

- All services, including reception, waiting area, theatres and recovery were located on the fourth floor of Hannah House. There was step-free access to the service via two lifts, including one for disabled access.
- There were two operating theatres. Both theatres were used for surgical procedures under local anaesthetic and had ventilation systems that ensured 15 air changes per hour, in accordance with current guidelines.
- There was also a pre assessment/waiting/recovery lounge with three reclining chairs. Patients recovering from a local anaesthetic procedure sat in this lounge. There was a TV and magazines were available for all patients. The room was carpeted and there were stains on the carpet. Staff from the provider of the premises informed us that the carpet was cleaned twice annually by an external provider as part of the SLA. One of the actions of the infection control audit of May 2016 was the removal of this carpet, which was to be acted at next refurbishment phase by the premises provider. However, HSS staff were not aware that this was an area of concern. There were also dried-on stains on one of the chair's foot rests, which looked like coffee or tea had been spilled.
- There was a large theatre light stored in the recovery lounge. This cluttered the room and could potentially be a hazard and fall on a patient.
- There was lift access to the theatre floor; however it was too small to fit a bed or stretcher in the event of an

emergency transfer. We were told by the premises provider staff that bed-bound patients could be moved out of the department via a back exit over the roof to the adjoining building. This route entailed taking several narrow steps to the lift of another building.

- The clinic had a contract with an external company for maintenance and servicing of all equipment. None of the electrical equipment had any stickers on it showing the last date it had been safety tested. The non-clinical director informed us that all maintenance records were kept at the main office. Evidence was submitted to us later, which showed that equipment including suction machine, microdermabrasion, infiltration pump and bodytite machine were serviced within the last 12 months. However, there was no record of maintenance of medicine fridge, fluid warming machine and portable vital sign monitoring machine. We were informed that "we had previously used our service agreements as suitability of electrical compliance but have a PAT testing date scheduled in March".
- A resuscitation equipment trolley (containing equipment for both adults and children) was available outside the theatre. There was a checklist confirming that the full contents were checked twice a week, or at every theatre list. However, we found several single-use items that were out of date, or had no expiry date including: one single-use tracheostomy tube with no expiry date, two tracheal tubes that expired in December 2016, a nebuliser aero mist that expired in November 2014 and an oxygen mask that was not in packaging. We also found that there was no service tag on the defibrillator and no safety checks were done. We removed these out-of-date items from the trolley and highlighted it immediately to the registered manager and non- clinical director. They assured us that these would be replaced and an incident form would be completed, with appropriate actions would be taken. We saw evidence of this being logged as serious event. However, the log did not include any actions to identify training requirements for the staff responsible for these checks.
- A fluid warming machine was available within the clean room. However, there was no record of checks to confirm the temperature of the fluid.
- There was a small staff kitchen adjacent to theatre dirty room. The floor under the sink cabinet was filled with dirt and grime and there were mousetraps placed under the sink cabinet. We saw evidence of pest control inspection certificate (November 2016) which confirmed that there were no visual signs of mouse activity and that mouse traps were removed from treatment rooms to discreet areas of clinic.

Medicines

- There was a medicine optimisation policy (December 2016) in place.
- The clinic did not had a service level agreement with any pharmacy. Senior staff informed us that they would contact a local pharmacy or an accountable officer at the local NHS primary care trust for any guidance or further advice regarding medicines management or controlled drugs.
- Medicines were stored in a secure room, although this room was not locked, it was only accessible through the theatre. However, there was no monitoring of the room temperature to ensure the environment was optimal for the drugs stored in the cupboard.
- A temperature checking system was in place for refrigerated medicines that complied with the Royal Pharmaceutical Society of Great Britain (2005) guidance. Staff were aware of what actions to take if the fridge temperature was out of range. We saw evidence of those checks and all records were within the range of 2 to 8°C.
- All medicines including controlled drugs (CDs) were stored in a locked cupboard, which the doctor on duty held keys for and was compliant with legislation for safe storage of CDs. The lead physician, along with theatre manager, checked CDs at each theatre list. Senior staff informed us that there were two occasions, one in February 2016 and in November 2016, when an error in recording was identified and was corrected at the time. We saw evidence of those corrections in the CD log book but staff told us that these were not reported as incidents.
- However, we found several medicines in the medicine fridge and in medicine cupboard that were out of date, or not stored correctly. In the medicine fridge: there were empty/half empty ampoules (three kehalog bottles –empty, two dermaheal bottles – half full, one anticoagulant bottle –empty, one clinicare ECF bottle – half full) in a plastic tray stored in the fridge. There were

also one lidocaine + tetracaine cream which expired in July 2014, 19 x atropine sulphate injections which expired in December 2016, and six lacrilube 5g which expired in November 2016. In the medicine cupboard there were: 10 Ciprofloxacin (antibiotic) tablets out of the packet and loose, with no expiry date on the strips, one bottle of solution pour instillation nasal which expired in July 2016, six flumazenil 0.5 mg tablets which expired in September 2016, three azithromycin 250 mg tablets which were loose with no expiry date, and one anaesthetic cream 15g which expired in July 2014. The lead physician and the theatre manager were not clear why empty ampoules were stored in the medicine fridge and said that they would throw them away. They told us that this would be reported as an incident. We saw evidence of these incidents being logged. Practice was changed, with more stringent checks by the lead physician put in place. However, there were no actions related to staff training or audit of medication on a regular basis.

- A blue filing box containing drugs required in the event of emergency or anaphylaxis (severe allergy) was also available. This box was kept sealed with a masking tape in an area that was accessible to patients and visitors. We saw evidence that these were checked regularly. However, we highlighted the unsafe storage of these emergency drugs to the registered manager and non-clinical director. They assured us that an incident form would be completed and appropriate actions would be taken. We saw evidence of this being logged as serious event and a new box with breakable seal was put in place. However, no actions were taken to identify training requirements for the staff responsible for these checks.
- There was no record that a medicines management audit had been completed by the clinic since its inception.
- There were two waste bins used for the disposal of unwanted or expired medicines. These were shared with the premises provider. One waste bin (yellow) was labelled for 'drugs use only' and to be destroyed by incinerator. The pharmaceutical yellow waste bin was dated 14 June 2013 when brought into use. Though the bin was not full, it should had been replaced more frequently. The second (blue) bin had no label to indicate that it was for drugs only and we found a scalpel and surgical tape in there, along with out of date medicines (for example, epipen boxes and a gaviscon bottle). These bins were not compliant with HSS policy, which stated that 'the pharmaceutical waste bin will be of a type, which prevents the physical retrieval and re-use of the unwanted or expired medicine', as the medicines could be retrieved from those boxes.
- There was no Disposal of Old Pharmaceuticals (D.O.O.P) waste receptacle available. The clinic were not compliant with their policy, which stated that any controlled drugs within the Harley Street Skin (Hannah House) which are no longer required, will be rendered irretrievable prior to being disposed.
- We found several out of date single use items in the storage cupboard, including : BD vacutainers (four boxes of 100) which expired in July 2015, April 2015, March 2015 and February 2015, three continuous plasma kits which expired in December 2015, three autologous platelet preparation kits which expired in October 2015,two boxes of BD spinal needles which expired in September 2014 and August2016, one box of carbon steel surgical blades which expired in September 2014, one clear 2-0 sutures (single item) which expired in December 2015, one vicryl rapid suture 3-0 (single item) which expired in December 2016, and seven single-use ligatures which expired in November 2016. Staff told us that they did not use these anymore and were not clear why these had not been discarded.
- Consultants had their own printed prescription pads for prescriptions for patients receiving day surgery. Consultants told us that these were kept locked at the main clinic securely.
- There was no antibiotic policy in place. NICE guidance CG 74 states that antibiotic should be prescribed where surgical site infections are suspected, with consideration of local resistance patterns and the results of microbiological tests when choosing an antibiotic. We reviewed six records of patients and all patients were given broad-spectrum antibiotic cover after surgery. During the unannounced inspection, in five out of seven procedures, broad-spectrum antibiotics were prescribed. For example, co-amoxiclav 375mg x 20 tablets and ciprofloxacin 500 mg x 10 tablets.

We were informed after the inspection that consultants used the NICE clinical guidance 74: for prescribing guidance at present, and they were reviewing and developing a standalone policy.

Records

- Patient records were all paper based. The records were kept in a secure office at the main clinic and staff would bring the records on the day of surgery. We looked at six patient records and found them to be comprehensive with forms, such as the pre-assessment medical questionnaire, operative notes and detailed consultation letters.
- All patients having day surgery at the clinic were required to complete a pre assessment medical questionnaire. This included questions about any recent surgery, medications, any treatment for any medical conditions, allergies, and if female patient could be pregnant or breast-feeding. We saw these completed in all six records we reviewed. Patients requiring conscious sedation would complete an additional pre assessment questionnaire. This was completed in all relevant records. However, the anaesthetic pre assessment questionnaire did not ask about sickle cell disease or anticoagulation drugs, which would be an important considerations for certain patient groups.
- An operative notes audit covering March 2016 to September 2016 was undertaken in December 2016, to look at completion rates of pre and post-operative assessment. Pre-operative assessment was filled in 100% of cases, whilst 96% of post-operative assessments were fully complete. The audit found three missing entries for the date range, instrument log and one column missing from post-operative monitoring. The lead physician told us that the relevant doctor was reminded of the guidance for monitoring, and that there were plans to re-audit in March 2017. However, we did not see any formal plan for this re-audit.
- At HSS, each consultant kept their own individual theatre register so there was no information to identify which theatre a procedure was carried out in. The registered manager informed us that almost all procedures were carried out in theatre five. A theatre register for each theatre should be kept, with details of all surgical procedure carried out in a theatre. This allows patients to be traced in the event of an infectious outbreak. During the unannounced inspection, one consultant's theatre register was not available and was with the consultant who was outside the country at that time. There was no copy kept by the office and this information was provided to us at a later date. There were no theatre records audits to review the accuracy of the theatre register against the patients' notes. In one theatre register, we found two entries written in pencil.

Safeguarding

- The clinic had a policy for safeguarding adults. They did not treat children, but the policy included aspects of children's safeguarding, as well as good practice points. For example, what to do if a patient had a child with them during their appointment or if staff had concerns about child welfare and safeguarding. Despite the fact that the policy was reviewed in December 2016, it did not reference three key documents published prior to this revision. One was the intercollegiate document 'Safeguarding children and young people: roles and competences for healthcare staff' that was published by the Royal College of Paediatrics and Child Health in 2014. The second was 'Working together to safeguard Children,' updated in March 2015. In addition, the policy did not reference the Care Act 2014, which included key changes to information relating to adult safeguarding. The safeguarding policy also did not include information on female genital mutilation (FGM).
- There was no nominated safeguarding lead for adults.
- We were informed that all safeguarding training was conducted in house with the doctors, in line with the local policy. However, except one clinical staff member who joined recently and completed the online training externally, there were no records of safeguarding training for any other staff. Government guidance states that all staff working in healthcare settings should receive a minimum of level one training. Staff we spoke with were not aware of their level of training received in the past. We were not assured that staff had safeguarding training relevant to their role.

Mandatory training

- Mandatory training included: fire safety, health and safety, infection control, basic life support, adult and child safeguarding, resuscitation, fire safety and manual handling. However, HSS did not monitor mandatory

training rates and senior staff informed us that "a formal record is not kept of this but each staff member signs our folder with a copy of all our policies that are updated annually". One consultant file showed that policies were last read in 2011. We were not assured that effective monitoring systems were in place.

- We reviewed eight staff members' files and only one staff member (HCA) who recently joined the clinic had in date mandatory training record in the file. All other staff records were inconsistent. We were not assured that staff had up-to-date mandatory training.
- Not all staff had up to date BLS or ALS (basic and advanced life support) training. The lead physician last attended a course in 2011. We were informed that his renewal date was scheduled for September this year, after his February course conflicted with his appraisal. The health care assistant had no BLS training. The theatre manager's last certificate expired in January 2015. We were informed that next training date was April 2017 for these staff members. However, no evidence of this was provided.
- The clinic did not provide information governance training. This means that the clinic did not follow the requirements of the information governance toolkit for qualified providers. The HSS information governance policy stated the essential elements of data protection, and non-clinical director told us that this had been circulated to staff members. However, the clinic did not had a method of ensuring that this policy had been read and understood by staff.

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

- There was no admission policy in place. The lead physician explained to us that there were strict exclusion criteria and they did not accept patients for surgery unless they were medically fit. An exclusion policy was submitted to us after the inspection, which listed absolute exclusion criteria (for example, patients under the age of 18 years, patients with significant psychological or psychiatric disorder and patient with limited mental capacity), red flag patients (for example, perfectionists, litigious patients, serial complainers and indecisive patient) and psychological red flag patients (for example, patient with unrealistic expectations)
- All patients were asked to complete a medical questionnaire prior to surgery to assess their suitability for surgery.
- The clinic asked every patient for their consent to share post-operative information with their GP. Senior clinical staff informed us that majority of the patients would not want their GP to be informed about their treatment. However, they did not routinely ask for further information about a patient's medical history from their GP or conduct a pre-assessment clinic. This could mean that there was a risk that a complete medical history was not received prior to surgery. Senior clinical staff informed us they were encouraging patient to share information with their GP. Senior staff informed us that copies of the discharge letter were sent to the patient's GP, unless patient did not give permission. In all six records we reviewed, patients did not want to share the information with their GP.
- Clinic staff told us they asked the patient if there was any chance that they may be pregnant prior to surgery, but did not routinely carry out pregnancy tests. National Institute for Clinical Excellence (NICE) guidance states that all pregnancy testing discussions, including risk of anaesthesia and the procedure to a foetus, should be documented. We checked the records and this was the first question on the medical history proforma.
- Though the nature of the procedures undertaken at the clinic did not require the use of early warning score (EWS) to identify any 'at risk' patients following a procedure. There was no guidance or scoring system for escalation of deteriorating patient.
- There was no formal psychological assessment of the patient, but the lead physician told us he included this in his overall assessment at the pre-surgery consultation. It is a requirement of the Royal College of Surgeons that this key aspect of consultation identifies any patients who are psychologically vulnerable and they are appropriately referred for assessment. We saw in two patients' records that this was discussed with patient. However, one assessment did not detail whether any questions had been asked about a patient's mental health or whether they were taking any anti-depressants.
- The Senior clinical staff informed us that they did not use the World Health Organisation (WHO) safety

checklist for day surgery cases. The checklist is a process recommended by the National Patient Safety Agency for every patient undergoing a surgical procedure. The process involves a number of safety checks before, during and after surgery to avoid errors. The lead physician informed us they had incorporated some aspects of this in their operative proforma. However, other main elements of the WHO checklist, such as face-to-face briefing and debriefing of all staff, were not implemented. We saw a patient record who had a procedure in January 2017, where a separate WHO checklist was completed. However, of the six care records we reviewed, this was the only case where it was used.

- There was no emergency button available in recovery lounge and the clinic did not have a dedicated team of people that would respond in the event of an emergency. If there was a medical emergency at the clinic either during, or after, surgery which required emergency care, the clinic used the 999 service to transfer the patient to the local emergency department. The clinic had a medical or clinical emergency policy.

Nursing and support staffing

- There was one whole time equivalent (WTE) theatre manager and one health care assistant.
- The clinic did not use an acuity tool to plan their theatre staffing. The theatre had two regular bank registered nurses/operating department practitioners (ODPs). There were no additional support staff within theatres (such as porters), so nurses and HCAs carried out additional general tasks, such as restocking equipment.
- Between six and eight shifts each month were filled by bank staff. We were informed that the clinic never used agency nurses. Data submitted to us showed that no shifts were filled by agency staff in the last 12 months. However, during our unannounced inspection, there was an agency ODP who was working their first shift at the clinic. The agency staff member told us that she was given a comprehensive orientation of the building and emergency equipment, but there was no documented record of this.
- The theatre followed Association for Preoperative Practice (AFPP) guidelines for staffing levels for day surgery cases.
- There was no specific recovery nurse, as majority of the patients would not require close monitoring. All conscious sedation patients were recovered within the theatre. The Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines and the AFPP guidelines state that patients must be observed on a one-to-one basis by an anaesthetist until they are awake and stable. During our unannounced inspection, we observed that the conscious sedation patient was indeed recovered within theatre and the anaesthetist was present during that time. Patient who had surgery under local anaesthetic would wait in the recovery room or in one of consulting rooms to recover for half an hour to one hour depending on the type of surgery. However, there was no policy for patients recovering from surgery.
- All staff we spoke with in the theatre environment felt that there were adequate staffing levels to provide safe and effective care for patients.

Medical staffing

- At the time of our inspection, there were three consultants, including two general physicians and one plastic surgeon. We saw evidence that practicing privileges were granted by the lead physician who was also the co-founder of the clinic; however, there was no formal process in place to review these practicing privileges. None of consultants had their practicing privileges reviewed since those were first granted.
- Consultants were clinically responsible for the patients under their care, and were required to review their patients following the operation. We were told that consultants would remain at the clinic until the patient had left. Both consultants we spoke with said they would remain on the premises until the patient was ready to go home. The amount of follow-up consultation would depend on the procedure.

Emergency awareness and training

- The fire and evacuation training was provided by the premises provider. However, none of the HSS staff were able to tell us when they last had taken part in any fire drill. We requested to see records of attendance and were informed that: “no list of attendance is currently held. We have advised the premises provider to ensure we are added to their training next time they hold a fire evacuation session, though the fire evacuation checklist has been given to our theatre team.”

Surgery

- All fire extinguishers at the building were within their service dates. We saw the certificate of conformity and these were maintained by the premises provider.
- The clinic did not have an emergency generator and had no isolated power supply. Staff were not aware of emergency arrangements in case of a power failure. However, the anaesthetist on the day told us that this would not be a concern as they had portable monitors.

Are surgery services effective?

Evidence-based care and treatment

- Staff told us that they followed NICE guidelines for antibiotic use and were considering developing a stand-alone policy for the clinic.
- Policies and procedures were available in a folder at the main clinical location. Clinical policies and procedures we reviewed all referenced relevant NICE and Royal College guidelines. We were informed that all policies were reviewed and updated on 1 Dec 2016. However, there was no audit to assess compliance with previous versions of the policies.
- There was no clinical audit plan. The HSS conducted only two audits; surgical site infection and operative notes audit during last 12 months. Both of these audits showed positive outcomes, but there was no methodology or conclusion to support the validity of these audits. Consultants told us that they reviewed their own patients' records to assess that documentation was in line with good practice. However, there was no formal method of data collection, or review of this, across the board. The service did not conduct audits in areas such as consent or medication.
- The HSS had not audited their compliance with the Royal College of Surgeon's professional standards for cosmetic surgery. We were informed that, "all doctors were aware of this. We have not carried out a specific audit in relation to this particular guidance but we will now action this as a priority to be carried within the next three months". The clinic was unable to provide assurance of compliance with their compliance with the Royal College of Surgeon's professional standards for cosmetic surgery.
- The clinic had no formal admission policy. Consultants told us that they had set exclusion criteria, although these were not written down. Exclusion criteria included: patients under 16 years of age or older than 75 years, pregnant women or patients with any other complex medical conditions. A list of exclusion and 'red flag' criteria was submitted to us after the inspection, but we did not see any evidence that they were not adhering to these criteria. A standard policy document would ensure consistency.
- There was no policy for patients requiring psychiatric assessment.

Pain relief

- There was no pain management policy. Senior staff informed us that they would action this immediately.
- There were no formal pain assessment tools used by the clinic.
- All patients were prescribed paracetamol or co-dydramol for pain control.
- A discharge form, completed for each patient, included guidance on pain relief that should be taken once at home.

Nutrition and hydration

- Staff followed The Association of Anaesthetists of Great Britain and Ireland AAGBI best practice guidance on fasting prior to surgery. For healthy patients who required a conscious sedation, this allowed them to eat up to six hours prior to surgery and to drink water up to two hours before.
- Pre-admission information for patients gave them clear instructions on fasting times for food and drink prior to surgery. Records showed checks were made to ensure patients had adhered to fasting times before surgery went ahead.
- All patients were provided with a cup of water or tea after surgery. As the post-operative recovery period was short (a maximum of one or two hours), patients were able to go home soon after surgery, and so would not be offered any food. However, this meant there was no provision for patients if the list was running late, meaning they had to wait longer.

Patient outcomes

Surgery

- There was no system in place to review patient outcomes on regular basis.
- There was no data available on number of revisions carried out in last 12 months.
- The clinic reported no cases of unplanned transfer of a patient to another hospital. There were no unplanned readmissions within 28 days of discharge between January 2016 and December 2016. However, the clinic did not capture the data of any patient who might have self-reported to local NHS emergency department post operatively.
- The clinic did not collect Quality Patient Reported Outcome Measures (Q PROMS). Q Proms are recommended by the Royal Collegeof Surgeons and involve the patient completing a pre and post-operative satisfaction survey based on the outcome of the cosmetic surgery. Q PROMS are recommended for blepharoplasty procedure which was carried out at the clinic.
- The clinic had not been submitting data to the Private Health Information Network (PHIN) in accordance with legal requirements regulated by the Competition and Marketing Authority. The PHIN data is a defined set of performance measures and clinical quality indicators that should be collected from January 2016, submitted from September 2016 for publication April 2017.

Competent Staff

- The clinic granted practising privileges where necessary for doctors, once they had completed their induction and submitted relevant paperwork. However, there were no arrangements in place to review these practicing privileges annually. We were informed that, "no renewal date was allotted but post inspection we are renewing all doctors practising privileges annually. A policy for this is currently being set up"
- The HSS staff recruitment policy stated that no staff would be allowed to provide any healthcare services to patients before an enhanced disclosure and barring service (DBS) check had been completed. However, the staff files we checked were inconsistent. We reviewed eight staff records, most staff files had Disclosure and Barring Service (DBS) certificates held within their files. However, there was no DBS record in the files of one anaesthetist and another consultant's file contained only an outdated criminal records bureau (CRB) form from 2008, stating the name of another provider. We were not assured that there were effective systems in place to check DBS of staff.
- There was no Medical Advisory Committee (MAC). Practising privileges were granted by the lead physician but these were not renewed on annual basis. There were no suspensions of the practising privileges of any consultant in the 12 months prior to inspection.
- We saw documentation detailing whether staff had received an appraisal. Data showed that staff that been in post for over six months had completed an appraisal but there were no performance targets set.
- Consultants with practising privileges had their appraisals and revalidation undertaken by an independent body if they did not work at an NHS trust. We saw evidence of these.
- There was no record available of scrub competencies for nurses (including bank staff), the theatre manager and the HCA.

Multidisciplinary working

- We observed good working relationships between all grades of staff and all professional disciplines, including the visiting anaesthetist.
- All patients were asked for their consent to send communication to their GP and if they agreed a discharge letter was generated and sent to the patient's GP, or given to the patient to take with them if they preferred. This was to ensure the GP was aware of the procedure and post-operative treatment recommended. The discharge letters also included contact details for the clinic, should another health professional require further advice about patients' care or treatment post-discharge.
- The clinic had no service level agreements (SLAs) for emergency or non-emergency transfers with a local or independent acute hospital. The lead physician told us there had been no cases that required transfer in the 12 months prior to inspection.

Seven-day services

- The clinic was open two days a week and all surgeries were planned procedures.

- There was effective system in place for post-operative patients to contact the consultant directly outside of normal working hours.

Access to information

- Patient records were all paper-based and were stored securely. Staff would bring patients' records over from main location at Harley Street to Hannah House on the day of the surgery.
- Access to pathology and histopathology was provided by external laboratories. The laboratory responded directly to the doctor, taking between three hours and three days depending on the test. The results were fed back directly to the patient, face-to-face. An electronic copy was sent directly to the clinic, as well as a paper copy. The results were signed off by the doctor and added to the patient's notes.
- Staff did not have access to any computers and were not able to access any local guidelines electronically. However, paper copies were kept centrally. Staff were able to access national guidelines on their mobile phones.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consultants were able to provide a comprehensive explanation of the consent procedures. After the two week cooling off period, (time given to the patient to consider whether they wanted to proceed with the surgery) the patient would complete a consent form along with the medical questionnaire. A further reconfirmation and sign-in consultation would happen on the day of surgery, which was good practice.
- There was a consent policy in place December 2016, which was in line with current guidelines.
- Although consultants reviewed their own practices against compliance with consent, no consent audits had been carried out.
- We looked at six sets of patient records and found clear documentation of consent, including signed consent forms, in all patient notes. All records that we reviewed had a clear gap of two weeks from final consultation to the surgery procedure.
- Consultants informed us that any patient who changed their mind during this two week cooling off period would be fully reimbursed.
- Consultants we spoke with were aware of the Mental Capacity Act 2005 and Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) orders. The clinic only accepted low risk, medically fit patients for surgical procedures so patients lacking capacity or with DNACPR orders were not treated at the clinic. The consultants told us that they would not take on any patients for procedures who lacked capacity.
- A mental capacity policy was in place at the time of the inspection, and made reference to carrying out mental capacity assessments where necessary and included a mental capacity assessment form and best interest form.

Are surgery services caring?

Compassionate care

- Nurses and doctors introduced themselves to patients. Interactions between staff and patients were observed to be positive across the unit.
- Staff had a caring, compassionate and sensitive manner. We observed staff reassuring patients and answering questions about their care. They made sure that patients and their relatives were informed about their care plan.
- We saw a caring and respectful interaction between staff and one patient during a procedure. A member of nursing staff held the patient's hand for reassurance and the doctor was talking to the patient to calm them.
- We spoke with two patients, who told us they were treated with dignity and respect whilst at the clinic. They told us staff spent sufficient time with them and put them at ease. They told us that staff were "friendly and professional".
- The separate waiting area/recovery lounge was used for taking consent on the day of procedure and marking the patient for location of the surgery. The use of this room meant that patient's privacy and dignity was maintained. Patients were provided with scrubs, instead of gowns, which meant that they were able to move easily from the waiting area to theatres.

Surgery

- The clinic had a chaperone policy and consultants told us how they always had a chaperone with them when conducting any intimate examination of the patient. Patients told us that they were always asked if they required a chaperone.

Understanding and involvement of patients and those close to them

- The clinic produced a detailed brochure on skin treatments that provided costs of some treatments for patients. The website also provided clear information about the cost of procedures, identifying that this was variable but would be confirmed by the consultant prior to having the procedure.
- Doctors we spoke with were able to tell us about the importance of managing patient expectations prior to surgery. This ensured patients were realistic about the final outcomes of surgery. We saw evidence of this within patient notes. Two patients told us that the clinician had discussed the surgery outcome at length and they had realistic expectations.
- We saw a detailed information leaflet for patients and relatives explaining what to expect on the day of the procedure. Patients told us that they were well informed and prepared for the day.
- One relative told us that they were given lots of information regarding the procedure. They felt involved throughout the process.

Emotional support

- We observed a procedure being conducted under local anaesthetic and saw that the doctor and the nurse reassured the patient throughout the procedure.
- Patients were positive about the emotional support they received from staff, especially around the choice of treatment options available to them.
- One patient, who was there for a second procedure, told us that on a pervious occasion the nurse held her hand during the procedure to calm her.

Are surgery services responsive?

Service planning and delivery to meet the needs of local people

- The clinic hired the premises two days per week. All theatre lists ran on Tuesdays and Fridays. Senior staff told us that they had previously tried to run additional theatre lists on Wednesdays and Thursdays, but there was not enough demand and Fridays were popular with patients. One patient told us that she preferred going to the Friday clinic as this would give her the weekend to recover.

Access and flow

- Patients could contact the clinic directly through the website, or via email or telephone. There was a team of patient-booking staff based at the main HSS location, who responded to enquiries made via the clinic's website or by patients who called the clinic directly. Patients considering surgical procedures would have a face-to-face consultation with the relevant physician or consultant. Following this appointment, subsequent consultations could be offered or the surgery could be booked.
- Patients we spoke with told us they were offered a choice of appointment times according to their need and availability. One patient told us that she had to cancel the procedure a few times but the clinic was accommodating in rearranging it.
- During the unannounced inspection, there were three patients who were waiting for longer than two hours as the theatre list was running late. However, we were told that patients were always informed of any delays. We observed this during our visit and patients were satisfied with the explanations for lateness given to them. The clinic did not monitor average wait times for theatre, so it was not clear if patients would normally have to wait for long in the waiting area before their procedures.
- Patients were provided with a general discharge information sheet, which included phone numbers that they could use to contact the clinic after their operation. All patients having specific procedures were also provided with an advice sheet with more specific aftercare advice. We saw an example of this for fat transfer and bodytite procedures, which was comprehensive. In addition, all patients had a 24-hour contact number of the surgeon that carried out their operation.

Surgery

- Consultants told us that there was no standard follow-up process. This would depend on type of procedure, with patients booking follow-up appointments to be reviewed at four weeks, three months and six months. The surgical information sheet we saw, showed that post-operative appointments were booked at six weeks, and three months, after the procedure. These dates were given to patients, along with other aftercare information, before leaving the clinic.
- There was no system to follow up patients within 24 hours post-operatively. One patient we spoke with told us that they would have found such a telephone call useful.
- The clinic did not carry out any unplanned surgery. If patients had an issue following surgery, they would be provided with a phone number to contact their consultant. In an emergency, the patient was directed to an acute hospital accident and emergency department. For non-emergency issues, the patient would be reviewed by their consultant. Any revisions to their surgical outcomes could be arranged as planned episodes of surgery.
- Staff informed us that in the past, they sometimes cancelled the theatre lists as there were not enough patients booked on that day. Though they were able to monitor the number of these cancellations via their electronic system, this was not something the clinic kept a record of.

Meeting people's individual needs

- Staff we spoke with told us that the clinic used two independent interpreters, one for Arabic and one for Mandarin. However, staff also told us that on rare occasions, they would use family members as well, which is not best practice.
- Due to the nature of the surgeries, the majority of patients would only wait an hour or two after their procedure. As a result, they were not offered any food and there were no provisions of this kind for patients. There were however, tea and coffee making facilities available. During the unannounced inspection, when the theatre list ran late, patients were able to go to the nearby shops or cafes and come back to the clinic later.
- The clinic's waiting area was a row of chairs opposite the reception. There were hot drinks, magazines and newspapers available for those waiting. Staff also told us that patients could choose to wait in the consultation rooms, depending of the rooms' availability. During our unannounced inspection, we observed this practice. Each patient was waiting in a separate consultation room, which allowed them complete privacy while they were waiting.
- The clinic had comprehensive information leaflets available for each type of procedure and for postoperative care management. We reviewed a range of information leaflets including pre and post-operative information leaflets for fat transfer and bodytite. There was patient friendly information leaflet for sedation advice. However, these were only available in English.

Learning from complaints and concerns

- The provider received 14 complaints between January and December 2016. Out of these, three were related to the Hannah House location. These were related to outcomes following surgery. In all cases, the concerns were resolved either by a refund or repeat procedure.
- We were informed that staff aimed to resolve concerns immediately if possible, and inform the manager or consultant of the concerns raised. A complaints leaflet was available for patients, which described the process to be followed, should a patient want to raise a concern. There was also the ability for people to provide feedback directly on the clinic's website. Patients we spoke with were aware of the complaints process and told us that staff were always there to resolve any concerns.
- Though there was no formal forum in which complaints were discussed and learning shared, some staff could tell us about changes that had been made as a result of complaints. For example, the clinic have changed the greeting process when a patient arrives in the unit. In the past, the patient was greeted by the reception staff who were not part of the HSS team. The clinic now had a buzzer at the reception for staff to alert HSS clinical staff to greet the patient at the reception.

Surgery

Are surgery services well-led?

Leadership / culture of service related to this core service

- The leadership included three company directors, one of which was the registered manager. There was one general manger to support the administration team. The theatre manager and the healthcare assistant (HCA) also reported to the general manager.
- All staff we spoke with reported that they enjoyed working at the clinic as they got on with their colleagues well. They said there were good team working relationships amongst colleagues.
- Junior staff told us that they feel confident to raise any concerns with the manager or the consultants.
- Staff felt supported in their development. However, staff informed us that developmental opportunities for non-clinical staff were not a priority.

Vision and strategy for this core service

- The vision of the service was to develop an integrated cosmetic and anti-ageing clinic. Senior staff told us that this vision was shared with staff. However, not all staff were able to tell us this vision. There was no specific documented strategy for implementation of this vision.

Governance, risk management and quality measurement (and service overall if this is the main service provided)

- There was no formal governance structure in place, with no MAC or governance committee. The lead physician and director told us that there were plans to start both committees by February 2017 and then quarterly thereafter. We saw the terms of reference of these committees.
- There was no formal structure or meeting in place where complaints, incidents, infection control, mandatory training, clinical audit or patient outcomes, patient feedback or practising privileges were reviewed. Consultants informed us that they did meet with the director to discuss any issues or concerns. However, these meetings were not minuted so there was no documented evidence of these discussions.
- Senior clinical staff told us that each consultant would review their own surgery outcomes on an on-going basis. There was no formal forum to discuss any performance issues.
- There were no safety theatre huddles at the start of the theatre list. Staff we spoke with did not demonstrate any awareness of the benefit of these briefings.
- There was no risk register but a risk assessment (as part of the risk management policy) was completed by the theatre manager for the first time on 1 December 2016. It included five risks including: slips and trips, needle stick injury, control of substances hazardous to health (COSHH), medicines and controlled drugs, and emergency care. However, there was no grading of severity of risks and no evidence of how this risk assessment was incorporated with the overall risk register of the provider. There was one risk relating to disposal of hazardous substances, which was the responsibility of premises provider. However, it was not clear as how they monitored the mitigation of this risk. Not all the risks we identified during inspection were present on this risk assessment. For example, there was no mention of mandatory training, safeguarding training, systems for checking out of date medicines and lack of governance structure.
- The non-clinical director was the health and safety lead. The clinic did not meet the requirements of the Health and Safety Executive and did not carry out regular risk assessments.

Public and staff engagement

- Staff told us that there were some staff meetings for administrative staff at the main clinic. However, these were informal and no minutes were recorded. The theatre staff members did not have separate team meetings.
- The clinic did not carry out any staff surveys as it was a relatively small team. From speaking with staff, we found that staff at all levels were able to provide feedback and input into the running of the service, but there was no formal meeting where feedback was discussed.
- All staff told us they felt valued for the work they did and it was “like a second family”.

Surgery

- Patients and relatives were asked to complete a provider feedback questionnaire about their experience. Patients were also able to provide feedback via the clinic website and email. However, there was no separate feedback questionnaire for patients visiting Hannah house for surgery. Relatives and patients we spoke with told us that they felt involved in care and treatment decisions and that the level of information given to them was appropriate and very clear. However, one patient waiting for her procedure was not aware of the feedback questionnaire. We saw evidence of completed questionnaires and staff informed us that they reviewed each form as received and would act on any concerns. We requested for collated results of these. Senior staff told us though the feedback was generally positive, the clinic did not quantify information or look at any trends or themes.
- During our unannounced inspection, we noted that the CQC comment cards we provided for distribution to people using the service were not given out to patients. CQC comment boxes were not on display. No completed feedback cards were returned to us.
- There was no staff room on the floor that housed the clinic. Due to structure of the building and limited space available, staff used the same toilets and changing rooms as the patients.

Innovation, improvement and sustainability

- The clinic used Total intravenous anaesthesia (TIVA), a technique of anaesthesia which involved the use of intravenous drugs to anaesthetize the patient without the use of inhalational agents. This benefited patients as it decreased the length of their recovery.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all policies, including the risk management policy and safeguarding policy, are updated to include best practice guidelines.
- The provider must ensure there is a programme in place for staff to be prepared in emergency situations by attending regular resuscitation and fire evacuation drills.
- Ensure there is effective system and policy in place for antibiotic usage and pain management.
- The provider must ensure that infection prevention control measures are followed at all times, including in the recovery room. Waste must be properly stored before disposal and separation of clean and dirty areas must be kept at all times.
- The provider must keep a record of the cleaning of the environment and equipment, ensuring that all staff are aware of the escalation process should any infection control issues are identified.
- The provider must implement an effective system for checking the expiry date of medicines and single-use items, including those that are part of the resuscitation trolley. Staff responsible for these checks must be properly trained and given full instruction.
- The provider must provide a method of safe disposal of expired or unwanted medications including control drugs.
- The provider must ensure that all portable equipment is regularly checked and maintained, and that a record is kept of this as evidence. This includes records of fluid temperature in the fluid warming machine.
- The provider must ensure that all staff have appropriate, up-to-date mandatory training including safeguarding, duty of candour, emergency evacuation and life support training and keep up-to-date competency records for all staff, including evidence of the provision of resuscitation scenarios and theatre staff scrub competency and clinical supervision.
- The provider must ensure that the Disclosure and Barring Service (DBS) records of all staff are up to date.
- The provider must ensure that there is an effective system in place to review the practising privileges of consultants. A record must be kept of practising privileges documentation.
- The provider must ensure that all potential risks are recorded and regularly reviewed in an integrated system. The provider must ensure that all staff are aware of what constitutes an incident and how to report this.
- The provider must ensure that the World Health Organisation (WHO) safety checklist for day surgery cases and the '5 steps to safer surgery' are used.
- The provider must begin a clinical audit programme to ensure that evidence based practice and patient outcomes are regularly reviewed. Learning and action points from all audits, incidents and complaints should be shared with staff.
- The provider must ensure a clear clinical governance and medical advisory committee structure is in place, with evidence of team meetings and committees in the form of minutes.
- The provider must have effective systems in place regarding transfer of a deteriorating patient requiring overnight stay.
- The provider must audit its compliance with Royal College of Surgeon's standards for cosmetic surgery.

Action the provider SHOULD take to improve

- There provider should draft and implement an admission policy, monitoring patient in recovery and MRSA screening policy.

Outstanding practice and areas for improvement

- The provider should develop and implement guidance or scoring system for early identification of patient at risk of deterioration.
- The provider should ensure that their pre-assessment questionnaires are fully comprehensive and that all aspects of a patient's history are covered during the pre-assessment process, including psychological assessment and mental capacity.
- The provider should ensure they comply with the data collection and submission criteria for the Private health Information Network.
- The provider must keep an accurate theatre log of all procedures carried out in each theatre on the premises.
- The provider should have effective process in place to follow up patients within 24 hours post-operatively.
- The provider should have systems in place to review patient outcomes on regular basis.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider failed to comply with Regulation 12 (1) and (2), Safe care and treatment, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** 1. Care and treatment was provided in a safe way for service users. 2. without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include– (a) assessing the risks to the health and safety of service users of receiving the care or treatment(c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely; (e) ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and used in a safe way; (g) the proper and safe management of medicines; (h) assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

The provider failed to comply with Regulation 17, 1 and 2, Good governance, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

1. Systems and processes must be established and operated effectively to ensure compliance with the requirements in this part.

2. Without limiting to paragraph (1), such systems or processes must enable the registered person, in particular, to—

(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services;

(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The provider failed to comply with Regulation 19, 19 (1) a, Fit and proper persons employed, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** 1. Persons employed for the purposes of carrying on a regulated activity must— (a) be of good character.