Alexandra Private Hospital

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

The Alexandra Private Hospital is an independent cosmetic hospital, based in Chesterfield and is part of Alexandra Health Care Limited.

The Alexandra Private Hospital is registered to provide the following Regulated Activities:

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

The hospital's senior management team consists of the owner who is also the registered provider and a theatre manager.

Our inspection was part of our ongoing programme of comprehensive Independent Health Care inspections. We inspected the hospital on 14 June 2016 on an announced visit. During this visit, there were no patients and no surgery planned for the day. On 16 June 2016, we carried out an unannounced inspection of the hospital, when there were patients undergoing surgical procedures.

We inspected the core service of surgery, at the Alexandra Private Hospital, which also incorporated the consultations patients had with their surgeon prior to and after their operations.

Are services safe at this hospital/service

Systems in place were not consistently reliable in protecting people from the risk of healthcare associated infections. We found some out of date consumable items on the resuscitation trolley and within theatres. The arrangement for managing medicines was not robust. Some medicines were out of date and some medicines were left unattended. There was no process in place for monitoring the use of prescriptions and no protocols for antibiotics prescribing. Temperatures of the medicine fridge were above the recommended range. Records were not kept securely. The safeguarding policy lacked detail, did not reflect current best practice and the service was unsure as to what level of safeguarding training staff received. There were no robust processes in place to respond to and reduce patients' risk. The use of an early warning score (EWS) to identify a deteriorating patient was inconsistent; however patients did receive regular monitoring following surgery. Although there was a procedure in place for a patient to be transferred to the local acute NHS hospital if their condition deteriorated there was no formal written agreement between the local NHS acute trust to admit patients as required by the Independent Healthcare Advisory Services (2015). There were no clear processes for assessing patients' risk of developing venous thromboembolism (VTE), for identifying those patients who should be screened for MRSA, or for assessing the psychological well-being of patients prior to theatre.

However, all staff had attended mandatory training. Staffing levels, including resident medical officer cover (RMO) were planned, implemented and reviewed to ensure there were sufficient staff to provide safe care. There was clear patient exclusion criteria to identify those patients who would not be suitable for surgery, which meant patients who were potentially high risk were not admitted. The service reported no never events, no wound infections and no VTE incidents**.** During our inspection we observed an anaesthetist respond appropriately and efficiently to a potential risk to a patient.

Are services effective at this hospital/service

Policies referred to out of date material, or did not reflect current best practice. The service had not started to collect data for the submission to the Private Healthcare Information Network (PHIN); PHIN requires every private healthcare facility to collect a defined set of performance measures and to supply that data to PHIN. The service did not collect and report Q-PROMs from patients. Q-PROMS are patient report outcome measures, which describe the level of patient satisfaction with certain operations and is a recommendation from the Royal College of Surgeons (RCS). The service did

not keep electronically the details of implants used. This is required to ensure information is easily accessible in the case of a product recall. However, the service did use a paper-based system that recorded details of all the equipment used during a patient's operation. There was no robust system in place to ensure information was communicated with the patient's GP.

However, patient pain was managed effectively. Staff worked well together with effective communication and partnership working between the different professional groups. There was a robust procedure in place to ensure patients were able to give an informed consent. The service had an audit programme in place.

Are services caring at this hospital/service

Without exception, patients told us they were treated with kindness and compassion by all staff. Patients spoke positively about the service and the care they had received. Patients were fully involved in their care and staff explained procedures to them, and provided emotional support.

Are services responsive at this hospital/service

The service arranged appointments and surgery times to meet the needs of individual patients. Patients were able to self-refer to the hospital or were referred from other independent cosmetic surgery services. There was a clear complaints policy, although patient information displayed regarding this was inaccurate. Written information for patients was out-of-date.

Are services well led at this hospital/service

There was no documented vision or strategy for the hospital, which had been shared with staff. Governance arrangements were not robust. Quality assurance systems and audits completed had not identified the issues found on our inspection. Whilst the service reported no incidents, we could not be assured whether this was because there were no incidents or there was a failure to report. Many policies and risk assessments did not reflect up-to-date practice or current guidance. Disclosure and barring service (DBS) checks had not been completed for one staff member and one doctor did not have evidence of indemnity insurance in their file. The hospital had not made arrangements to ensure they were meeting the recommendations from the Review of Regulation of Cosmetic Interventions (2013).

However, staff spoke very positively about the leadership of the service; staff felt engaged and enjoyed working at the hospital. The service sought feedback from all patients regarding the care they had received.

Our key findings were as follows:

- Systems in place were not consistently reliable in protecting people from healthcare associated infections. We saw dust on equipment such as fans and dust in the corners of patients' rooms. We saw debris had collected in the light fitting of theatre. There was inappropriate storage of items such as mop heads and linen. Decontamination procedures for equipment were ineffective and staff did not always adhere to recognised good practice procedures, such as using aseptic non-touch technique (ANTT), which is a standardised approach to performing procedures in order to reduce the risk of a healthcare acquired infection (HCAI).
- Whilst the service reported no incidents, we could not be assured whether this was because there were no incidents or there was a failure to report.
- The policy for reporting notifiable incidents to the CQC, referred to out of date legal regulations.
- We found some out of date consumable items, some of these were on the resuscitation trolley.
- The arrangement for managing medicines was not robust; some medicines were out of date and some medicines were left unattended. There was no process in place for monitoring the use of prescriptions and no protocols for antibiotics prescribing. Temperatures of the medicine fridge were above the recommended range.
- Records were not kept securely and poor quality photocopied documentation was used.
- The safeguarding policy lacked detail, did not reflect current best practice and the service was unsure as to what level of mandatory safeguarding training was provided.

Summary of findings

- There were no robust processes in place to respond to and reduce patients' risk. The use of an early warning score (EWS) to identify a deteriorating patient was inconsistent, although patients were monitored regularly following surgery.
- Although there was as procedure in place for a patient to be transferred to the local acute NHS hospital if their condition deteriorated there was no formal written agreement between the local NHS acute trust to admit patients, as required by the Independent Healthcare Advisory Services (2015).
- Documentation that reflected The World Health Organisation (WHO) Surgical Safety checklist (2008) was under development, but this had not yet been implemented.
- There was no clear guidance as to which risk assessments and screening were required preoperatively for patients. There was no clear guidance for assessing patients for their risk of developing venous thromboembolism (VTE), or identifying those patients who required screening for MRSA. There was no consistent assessment of the psychological well-being of patients prior to theatre.
- There was no robust system in place to ensure information was communicated with the patient's GP.
- The service had not started to collect data for the submission to the Private Healthcare Information Network (PHIN), nor did it collect and report on Q-PROMs for all patients. Q-PROMS are patient report outcome measures, which describe the level of patient satisfaction with certain operations and is a recommendation from the Royal College of Surgeons (RCS)
- The hospital had not made any arrangements to ensure that surgical cosmetic procedures were coded in accordance with SNOMED_CT. SNOMED_CT uses standardised codes to describe cosmetic surgical procedures, which can be used across electronic patient record systems.
- There was no system to electronically record details of implants, which could be easily accessible in the case of a product recall.
- Many policies and risk assessments did not reflect up-to-date practice or current guidance.
- Disclosure and barring service (DBS) checks had not been completed for one staff member and one doctor did not have evidence of indemnity insurance in their file.
- Written information for patients relating to having an anaesthetic was not current.
- All staff had attended mandatory training.
- Staffing levels and skill mix were planned, implemented and reviewed to ensure there were sufficient numbers of staff.
- Staff spoke very positively about the leadership of the service; staff felt engaged and enjoyed working at the hospital.
- We saw effective communication and partnership working between the different professional groups.
- There was a clear patient exclusion criteria to identify those patients who would not be suitable for surgery.
- The service reported no never events, no incidents, no wound infections and no VTE incidents.
- We observed an operation, where the anaesthetist responded appropriately and efficiently to a potential risk
- Without exception, patients told us they were treated with kindness and compassion by all staff. Patients spoke positively about the service and the care they had received. Patients were fully involved in their care and staff explained procedures to them.
- Patient's pain was managed effectively and staff provided emotional support.
- Patients were able to self-refer to the hospital and the service arranged appointment and surgery times to meet the needs of the individual patient.
- There was a robust procedure in place to ensure patients were able to give a fully informed consent.
- The service had a clear complaints policy, and the service continually sought feedback from all patients regarding the care they had received.

There were areas where the provider needs to make improvements.

Importantly, the provider must:

- Ensure systems and processes are in place to ensure people are protected from healthcare associated infections.

Summary of findings

- Ensure policy for reporting notifiable incidents in line with the CQC (Registration) Regulations 2009.
- Ensure systems and processes are in place so that all incidents are reported and investigated.
- Ensure learning from incidents is used to evaluate and improve practice.
- Ensure processes are in place to guarantee that consumables are in date.
- Ensure there is a safe process for the management of medicines.
- Ensure safe storage of patients' records.
- Ensure that safeguarding policy is in line with current legislation and that staff receive mandatory safeguarding training at the correct level.
- Finalise and implement new documentation that reflects the World Health Organisation (WHO) Surgical Safety Checklist.
- Ensure there is a formal written agreement with the local NHS acute trust for the transfer of a deteriorating patient.
- Improve compliance with the use of the early warning system (EWS).
- Ensure there is clear guidance for which risk assessments and screening are required preoperatively for patients.
- Ensure all policies reflect up-to-date guidance and that care provided reflects best practice.
- Ensure the recommendations from the Review of the Regulation of Cosmetic Interventions (2013) are being met.
- Ensure there are robust governance arrangements in place that include ensuring risk assessments reflect best practice and that there is a robust system for staff checks.
- Ensure patient information is up-to-date and patients are signposted to information resources to help make an informed decision about their procedure as recommended by the Royal College of Surgeons Standards (2016).

In addition the provider should:

- Consider providing clear guidance describing which operations need to be performed in the theatre with specialist ventilation.
- Consider improving the quality of the documents used for patients' records.
- Consider the procedure for the nurse lead pre-operative clinic.
- Consider developing a training needs analysis for all staff.
- Consider how they meet the requirements of the Duty of Candour regulation.

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		Systems in place were not consistently reliable in protecting people from healthcare associated infections. We saw dust on equipment such as fans and dust in the corners of patients' rooms. We saw debris had collected in the light fitting of theatre. There was inappropriate storage of items such as mop heads and linen. Decontamination procedures for equipment were ineffective and staff did not always adhere to recognised good practice procedures, such as using aseptic non-touch technique (ANTT). We found some out of date consumable items, some of these were on the resuscitation trolley. The arrangement for managing medicines was not robust; some medicines were out of date and some medicines left unattended. There was no process in place for monitoring the use of prescriptions and no protocols for antibiotics prescribing were in place. Temperatures of the medicine fridge were above the recommended range. Records were not kept securely and poor quality photocopied documentation was used. The safeguarding policy lacked detail, did not reflect current best practice and the service was unsure as to what level of mandatory safeguarding training was provided. There were no robust processes in place to respond to and reduce patients' risk. The use of an early warning score (EWS) to identify a deteriorating patient was inconsistent, although patients were monitored regularly following surgery. Although there was as procedure in place for a patient to be transferred to the local acute NHS hospital if their condition deteriorated there was no formal written agreement between the local NHS acute trust to admit patients, as required by the Independent Healthcare Advisory Services (2015). There were no clear guidance for assessing patients for their risk of developing venous thromboembolism (VTE), or identifying those patients who required screening for MRSA, or for assessing the psychological well-being of patients prior to theatre. There was no robust system in place to ensure information was communicated with the patient's GP.

Summary of findings

Governance arrangements were not robust. Quality assurance systems and audits completed had not identified the issues found on our inspection. Many policies and risk assessments did not reflect best current best practice or update guidance. Disclosure and barring service (DBS) checks had not been completed for one staff member and one doctor did not have evidence of indemnity insurance in their file. Information for patients was out of date. The policy for reporting notifiable incidents, to the CQC, referred to out of date legal regulations. Whilst the service reported no incidents, we could not be assured whether this was because there were no incidents or there was a failure to report.

The service had not started to collect data for the submission to Private Healthcare Information Network (PHIN), nor did it collect and report on Q-PROMs for all patients. The hospital had not made any arrangements to ensure that surgical cosmetic procedures were coded in accordance with SNOMED_CT. There was no system to electronically record details of implants that could be easily accessible in the case of a product recall.

All staff had attended mandatory training. Staffing levels and skill mix were planned, implemented and reviewed to ensure there was sufficient numbers of staff. Staff spoke very positively about the leadership of the service; staff felt engaged and enjoyed working at the hospital. We saw effective communication and partnership working between the different professional groups.

There was clear patient exclusion criteria to identify those patients who would not be suitable for surgery. The service reported no never event, no wound infections and no VTE incidents. We observed an operation, where the anaesthetist responded appropriately and efficiently to a potential risk.

Without exception, patients told us they were treated with kindness and compassion by all staff. Patients spoke positively about the service and the care they had received. Patients were fully involved in their car and staff explained procedures to them. Patients' pain was managed effectively and staff provided emotional support.

Patients were able to self-refer to the hospital with the service arranged appointment and surgery times to meet the needs of the individual patient. There was a

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robust procedure in place to ensure patients gave a fully informed consent. The service had a clear complaints policy, and the service continually sought feedback from all patients regarding the care they had received.

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Cosmetic Surgery

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Background to Alexandra Private Hospital

The Alexandra Private Hospital is an independent cosmetic hospital, based in Chesterfield and is part of Alexandra Health Care Limited.

The hospital was built in 1908 and was originally part of the local acute hospital. The property was purchased by the registered provider, and has been running as a private hospital since 1987. The hospital's owner has been the registered provider since 1 October 2010.

The hospital provides cosmetic surgery for self-funded patients. The hospital facilities include 21 individual rooms located over two floors and two operating theatres. The hospital does not perform surgery every day; on average there are four to five days per month when surgery takes place.

We inspected surgery at the Alexandra Private Hospital, as part of our ongoing programme of comprehensive Independent Health Care inspections.

The hospital also offers cosmetic procedures such as dermal fillers and laser hair removal, ophthalmic treatments and cosmetic dentistry. We did not inspect these services.

Our inspection team

Our inspection team was led by:

Inspection Lead: Tracey Warren, Inspector, Care Quality Commission.

The team included CQC inspectors and a plastic surgeon specialist advisor.

How we carried out this inspection

We carried out an announced visit on 14 June 2016, during this visit were no patients and no surgery planned. On 16 June 2016, we carried out an unannounced inspection of the hospital, when there were patients undergoing surgical procedures.

We spoke with 12 staff including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with six patients and one relative. We also received six 'tell us about your care' comment cards which patients had completed prior to our inspection. During our inspection we reviewed 12 sets of patient records.

Information about Alexandra Private Hospital

From January 2015 to September 2015 there were 340 surgical procedures performed. Of these, 122 were overnight cases and 218 were day cases. The five most common operations performed at the Alexandra Private Hospital were breast augmentation, rhinoplasty (plastic surgery to the nose), liposuction (surgery for removing excess fat from under the skin), mastopexy (breast uplift) and abdominoplasty (removal of excess flesh from the abdomen).

Between, January 2015 to December 2015, 448 outpatients were seen. Of these, 259 were for a first visit and 229 were seen for a follow-up visit.

The hospital employed two surgeons regularly, two anaesthetists regularly and one regular resident medical officer (RMO) under practising privileges. It employed three registered nurses, two care assistants and one

Summary of this inspection

receptionist, as well as having its own bank staff that included operating department practitioners (ODPs). There was an accountable officer for controlled drugs (CDs) in place.

Surgery

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

The Alexandra Private Hospital provides cosmetic surgery for self-funding patients. Patients either self-refer to the hospital or are referred to by one of four other independent cosmetic clinics. On average, four or five theatres lists run a month. In the reporting period January 2015 to December 2015 there were 340 surgical procedures performed. Of these, 122 were overnight cases and 218 were day cases.

There were 21 individual patient rooms over two floors. The first floor had 10 rooms, one of which was used as a treatment room. The second floor had 11 rooms; however, these were not in use at the time of inspection. The hospital had two operating theatres.

Service level agreements were in place with the neighbouring acute NHS trust to provide sterile services, pathology and pharmacy services.

During our inspection, we visited the ward and operating theatres. We observed the care of patients on the ward and recovery area and during operative procedures in theatre. We spoke with 12 staff including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with six patients and one relative. We also received six 'tell us about your care' comment cards, which patients had completed prior to our inspection. During our inspection we reviewed 12 sets of patient notes.

Summary of findings

Systems in place were not consistently reliable in protecting people from healthcare associated infections. We saw dust on equipment such as fans and dust in the corners of patients' rooms. We saw debris had collected in the light fitting of theatre. There was inappropriate storage of items such as mop heads and linen. Decontamination procedures for equipment were ineffective and staff did not always adhere to recognised good practice procedures, such as using aseptic non-touch technique (ANTT).

We found some out of date consumable items, some of these were on the resuscitation trolley.

The arrangement for managing medicines was not robust, some medicines were out of date and medicines left unattended. There was no process in place for monitoring the use of prescriptions and no protocols for antibiotics prescribing were in place. Temperatures of the medicine fridge were above the recommended range.

Records were not kept securely and poor quality photocopied documentation was used.

The safeguarding policy lacked detail, did not reflect current best practice and the service was unsure as to what level of mandatory safeguarding training was provided.

There were no robust processes in place to respond to and reduce patients' risk. The use of an early warning score (EWS) to identify a deteriorating patient was inconsistent, although patients were monitored regularly following surgery. Although there was as procedure in place for a patient to be transferred to the local acute NHS hospital if their condition deteriorated

Surgery

there was no formal written agreement between the local NHS acute trust to admit patients, as required by the Independent Healthcare Advisory Services (2015). There was no clear guidance for assessing patients for their risk of developing venous thromboembolism (VTE), or identifying those patients who required screening for MRSA, or for assessing the psychological well-being of patients prior to theatre. There was no robust system in place to ensure information was communicated with the patient's GP.

Governance arrangements were not robust. Quality assurance systems and audits completed had not identified the issues found on our inspection. Many policies and risk assessments did not reflect up-to-date practice or current guidance. Disclosure and barring service (DBS) checks had not been completed for one staff member and one doctor did not have evidence of indemnity insurance in their file. Information for patients was out of date. The policy for reporting notifiable incidents, to the CQC, referred to out of date legal regulations. Whilst the service reported no incidents, we could not be assured whether this was because there were no incidents or there was a failure to report.

The service had not started to collect data for the submission to Private Healthcare Information Network (PHIN), nor did it collect and report on Q-PROMs for all patients. The hospital had not made any arrangements to ensure that surgical cosmetic procedures were coded in accordance with SNOMED_CT.

There was no system to electronically record details of implants that could be easily accessible in the case of a product recall.

All staff had attended mandatory training. Staffing levels and skill mix were planned, implemented and reviewed to ensure there was sufficient numbers of staff. Staff spoke very positively about the leadership of the service; staff felt engaged and enjoyed working at the hospital. We saw effective communication and partnership working between the different professional groups.

There was clear patient exclusion criteria to identify those patients who would not be suitable for surgery.

The service reported no never events, no wound infections and no VTE incidents. We observed an operation, where the anaesthetist responded appropriately and efficiently to a potential risk.

Without exception, patients told us they were treated with kindness and compassion by all staff. Patients spoke positively about the service and the care they had received. Patients were fully involved in their care and staff explained procedures to them. Patient's pain was managed effectively and staff provided emotional support.

Patients were able to self-refer to the hospital with the provider arranged appointments and surgery times to meet the needs of the individual patient. There was a robust procedure in place to ensure patients gave a fully informed consent. The provider had a clear complaints policy, and the provider continually sought feedback from all patients regarding the care they had received.

Surgery

Are surgery services safe?

- Whilst there was a system in place for reporting incidents we were not assured that staff consistently did so where necessary.
- Systems in place were not consistently reliable in protecting people from healthcare associated infections. We saw dust on equipment such as fans and dust in the corners of patients' rooms. We saw debris had collected in the light fitting of theatre. There was inappropriate storage of items such as mop heads and linen. Decontamination procedures for equipment were ineffective and staff did not always adhere to recognised good practice procedures, such as using aseptic non-touch technique (ANTT).
- There were some out of date consumable items on the resuscitation trolley and within theatres.
- The arrangement for managing medicines was not robust; some medicines were out of date and some medicines were left unattended. There was no process in place for monitoring the use of prescriptions and no protocols for antibiotics prescribing. Temperatures of the medicine fridge were outside the recommended range.
- Records were not kept securely and poor quality photocopied documentation was used.
- The safeguarding policy lacked detail, did not reflect current best practice and the service was unsure as to what level of mandatory safeguarding training was provided.
- There were no robust processes in place to respond to and reduce patients' risk. The use of an early warning score (EWS) to identify a deteriorating patient was inconsistent although patients were monitored regularly following surgery. Although there was as procedure in place for a patient to be transferred to the local acute NHS hospital if their condition deteriorated there was no formal written agreement between the local NHS acute trust.
- There were no clear processes for assessing patients' risk of developing venous thromboembolism (VTE), for identifying those patients who should be screened for MRSA, or for assessing the psychological well-being of patients prior to theatre.

However,

- Staffing levels and skill mix were planned, implemented and reviewed to ensure there was sufficient numbers of staff to provide safe care.
- The service reported no never event, no wound infections and no VTE incidents
- All staff had attended mandatory training.
- There was clear patient exclusion criteria to identify those patients who would not be suitable for surgery. We observed an operation, where the anaesthetist responded appropriately and efficiently to a potential risk.

Incidents

- Between January and December 2015, there were no never events reported for this service.
- We saw, in the information provided by the service prior to inspection there had been no incidents reported between January and December 2015. The service also reported at the time of inspection there had been no further incidents between January 2016 and the date of inspection.
- The service had an untoward incident reporting policy and procedure, and staff would report incidents on a paper-based incident reporting form. Staff we spoke with were aware of this process and confirmed they had not needed to report any incidents recently. Staff could give examples of when they would report, for example if a patient needed to return to theatre or needed transferring to NHS care. Staff reported that feedback would be provided to them at staff meetings, if any incidents were to occur.
- However, we saw evidence on the theatre list, which was confirmed by staff, that a patient had returned to theatre, but this had not been recorded as an incident. We could not therefore be assured that untoward incidents would consistently be reported.
- The service's untoward incident reporting policy and procedure did not reflect the duty of candour requirements, which came in force in April 2015. 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. However, the registered provider reported it has always been their culture to be honest and open with patients.

- Certain incidents, events and changes that affect a service or the people using it need to be reported to the Care Quality Commission (CQC) in line with the CQC (Registration) Regulations 2009. The service had a policy for reporting such notifiable incidents. However, this policy contained information that was out of date. The policy referred to legal regulations, which were superseded in November 2014 and stated that such notifications needed to be reported to the Healthcare Commission, which was replaced by the CQC in 2008.
- The service had not reported any notifiable incidents to the CQC January and December 2015. We could not be assured whether this was because there were no incidents or there was a failure to report.

Safety Performance

- The service reported there were no venous thromboembolism (VTE) (a blood clot in a vein), which could lead to a pulmonary embolism (blood clot in the lung) incidents between January and December 2015, and confirmed at the time of inspection there had been no further VTE incidents between January 2016 and the date of inspection.
- The service monitored surgical site infection rates, through performing a wound infection audit every three months. No infections had been identified between January 2015 and May 2016.

Cleanliness, infection control and hygiene

- The hospital performed an infection prevention and control audit every three months, looking at cleanliness of equipment and the environment and hand hygiene. We saw evidence that actions were taken as a result of these. For example, it had been identified in the September 2015 report that plaster on the wall in theatres had needed repairing, and it was noted in the December 2015 report that this work had been completed. We saw the audit report for December 2015 and March 2016, which indicated that the overall score for the infection control audit was 100%.
- Duties under the Health and Safety at Work Act (1974) and the Health and Social Care Act (2008) require that healthcare providers assess for their risk of Legionella and take necessary precautions to reduce these risks. At the time of inspection, the service could not provide us with a risk assessment or evidence that staff were reducing the risks of Legionella by regularly flushing the water outlets. Following inspection, the service did provide us with a risk assessment for the risk of potential scalding from the hot water system, which also incorporated an assessment of the risk of Legionella. Subsequently, the Health and Safety Executive (HSE) have inspected the location and identified that whilst the documentation of control measure could be improved, control measures were suitable and sufficient to protect against the risk of Legionella.
- Department of Health (DH) guidance states that healthcare providers should be providing focused screening to patients that are deemed high risk or have a previous history of MRSA infection or colonisation, and encourages providers to identify their own categories of high-risk patients who would require screening. It was unclear how the service determined which patients were screened for MRSA, prior to surgery. The MRSA policy stated all patients who worked in a healthcare setting assessed as high risk would be screened for MRSA. The MRSA procedure stated that high-risk patients would be screened for MRSA; however, this procedure did not indicate which patients or procedures were high-risk. The patient exclusion criteria clearly stated those patients with a known MRSA history would not be accepted for surgery. We reviewed ten sets of patient's records for patients who were direct admissions to the hospital and saw that no MRSA screening had occurred. We reviewed a further two sets of patient's records for those patients who had had their initial consultant and preoperative assessment at a different provider, both of these had had screening for MRSA and results had been filed in their notes.
- During our inspection, we saw the door to the main theatre was propped open halfway through the patient's procedure. This could have potentially increased the infection risk for this patient.
- Generally the hospital was tidy and was visibly clean, however we did notice some collection of dust in the corners of some of rooms and on the blades of portable fans.
- Staff told us they used hand wash detergent and water to decontaminate beds and equipment. This method of cleaning does not assure decontamination of equipment and these products are only licensed for hand hygiene procedures. We saw staff use this method of decontamination of the theatre trolley between patient use. However, decontamination of all equipment was not consistently performed. We saw

equipment to record blood pressure being moved from one patient to another, without decontamination. We saw that used ear probe covers from the thermometer had been left on the blood pressure recording machine.
- A reusable limb rest in the theatre and a theatre trolley mattress were damaged and had been repaired with tape. Correct decontamination of these items could not be assured.
- Aseptic non-touch technique (ANTT) is a standardised approach to performing procedures in order to reduce the risk of a healthcare acquired infection (HCAI). Staff we spoke with were not aware of ANTT, nor had they received training on ANTT. We saw medicines that were drawn up directly from the ampoule, rather than using a drawing up needle, and once drawn up, syringes with medicines in were left with their tips exposed. This does not reflect ANTT principles and meant that the medicines could become contaminated.
- We saw a member of staff insert a needle into a patient's vein without the use of personal protective equipment (PPE) or a tourniquet. This meant staff were not adhering to best practice and could have been exposed to blood by not wearing PPE. The lack of tourniquet could lead to a failure in the procedure resulting in further attempts being made.
- During our inspection, we saw evidence of needles being re-sheathed after use. This practice should be prevented according to the Health and Safety Sharp Instruments in Healthcare Regulations (2013) due to the increased risk in causing injury to the healthcare worker.
- We found used mop heads being stored in the cleaner's room in the theatres department. This is against guidance from the National Patient Safety Agency (2009) which states all used mop heads should be taken away for immediate decontamination after use or disposed of if they are single use.
- The linen cupboard contained items other than clean linen. This means there was potential for the clean linen to become contaminated. Only clean linen should be stored in the clean linen cupboard.

Environment and equipment

- There were 21 individual patient rooms over two floors. The first floor had 10 rooms, one of which was used as a treatment room. The second floor had 11 rooms; however, these were not in use at the time of inspection. Most of these rooms were being used to store historical patient records, one contained new furniture and one of these rooms was being refurbished. Following our inspection the provider confirmed in writing a voluntary restriction in the use of the rooms on the top floor until we had conducted a further inspection to confirm their suitability for patient use.
- All equipment had been appropriately maintained and serviced. We checked five pieces of equipment including for example, electronic blood pressure machines; all had been serviced within the past year and where necessary had received safety testing.
- Each of the two theatres had its own anaesthetic equipment, which matched those used by the consultant anaesthetists who attended from local acute NHS trust; this improved the familiarity of equipment and promoted safety.
- The service had a service level agreement with a local acute NHS trust for the sterilisation of reusable sterile items. Used items were placed securely into a black container to be taken to the acute NHS hospital. Once sterilised they were returned in a red container to show they had been correctly processed.
- Resuscitation equipment was available and the service's policy stated this equipment must be checked daily and recorded that it was in working order. However, staff we spoke with said that it was only checked on theatre days, which was not in line with the service's policy. During May 2016, there were four theatre days and we saw documented evidence that staff had recorded checks on all four of these days. However, during our inspection, we saw seven consumable items had expired in April 2011, which meant staff were not thoroughly checking the expiry dates of consumables during the checking process.
- Equipment was available in theatre to manage a difficult airway. Located alongside this trolley was guidance from the Difficult Airway Society.
- One of the two theatres did not have specialist ventilation, which is required under the Health Technical Memorandum 03-01 specialist ventilation for healthcare premises. The registered provider told us that only operations that did not need specialist ventilation were performed in this theatre; however, there was no written guidance to identify which procedures should be performed in which theatre.
- We found some out of date consumable items, such as wound swabs and needles in the theatre environment, which meant items might not have been as effective.

Surgery

Medicines

- The service had a service level agreement with a local acute NHS trust to supply stock medicines. If patients were prescribed a non-stock item, this was ordered and collected from the pharmacy department at the local acute NHS trust. Medicines for patients to take home were obtained from a local pharmacy.
- The service had a medicine storage and administration policy; however, this did not reflect current best practice. For example, the policy made reference to legal regulations, which were superseded in November 2014 and did not reflect current guidance such as the Nursing and Midwifery Council (NMC) standards for medicine management (2007).
- The service's policy stated that daily stock checks of medicines should be performed to ensure sufficient quantities but gave no specific guidance regarding the checking on controlled drugs (CDs). CDs are medicines that need extra secure storage and recording. Staff told us they checked CDs on the days when they had patients admitted for procedures.
- During our inspection, we found one packet of CDs, which had expired in 2015. We were not assured that patients had not received this out of date medicine. This indicated staff may not be checking the expiry date of medicine when checking stock levels or before administering the medicine to patients.
- The service used pre-printed pieces of paper as prescriptions in order to obtain medicines from the local pharmacy to give to the patients on discharge. Staff told us these were stored securely when not in use; however, during our inspection we saw the folder containing these prescriptions was left unattended in the nurses office, which meant the prescription sheets could have been accessed by unauthorised personal. It is also good practice to record the use of prescription sheets, however this was not done.
- Medicines for patients to take home were obtained from the local pharmacy. Hospital staff collected the medicines, which were in sealed bags. On discharge, the unopened bag was given to the patient without further checks. This meant that staff were not assured the correct medicines were handed over.
- NICE quality statement 61 states that patients are prescribed antibiotics in accordance with local antibiotic protocols in order to reduce the risk of unnecessary prescribing that could increase the resistance of bacteria. The service did not have any local protocols for the prescribing and administration of antibiotics; prescribing of antibiotics was left to each individual consultant's discretion, which does not conform with antimicrobial stewardship.
- We saw anaesthetic medicines including controlled drugs, which had been prepared in advance of treatment. These medicines had been left unlabelled and unattended on a worktop. This is not safe practice and increases the risk of a medicine error.
- We also saw a bag of intravenous fluid stored without its outer packaging, which meant there was potential for contamination or tampering to happen.
- We checked the temperature of the medicine fridge during our inspection and noted it to be above the recommended range. We saw that staff checked and recorded the temperature of the medicine fridge, and we saw from these records that the temperature had exceeded the maximum on the 30 and 31 March 2016. The service was unable to provide evidence that any actions had been taken to rectify this. This meant that medicines were not stored in appropriate conditions and could potentially be less effective.
- Symbols rather than a number were used to indicate the number of tablets to be given. It is good practice to write the prescribed quantity in full in order to prevent a medicine error.
- On all of the medicine charts we reviewed, patient allergies were appropriately recorded.

Records

- Patient records were stored in the ward office; there were times when the office was left open and unattended which meant that records could have been accessed by unauthorised personal.
- A large number of patient records were stored in rooms on the top floor. These rooms were unlocked and easily accessible. The patients' records were stored haphazardly, in some cases in cardboard boxes on the floor and in no order, making it difficult if they needed to be retrieved. These records were not stored securely.
- Patient information was recorded on pre-printed sheets. These were produced from photocopies, which at times were poor quality. We reviewed one record where a patient had completed a pre-printed health questionnaire, which due to the poor quality of the photocopying was missing some of the information.

- All information was recorded in a single patient record; this was accessible by all staff and aided communication between the different professions.
- We reviewed 14 patient records and saw that information recorded was legible, accurate and up-to-date. Information documented included a record of the pre-anaesthetic assessment by the anaesthetist as well as the operation, anaesthetic and recovery records.
- The hospital completed an audit of 10% of patient's records every month. We reviewed the results for these and saw that for the period between July to September 2015, 96% of records were completed accurately and for October to December 2015, 97% were completed accurately. We saw documented evidence on the quality report that omissions in recording were a result of a member of staff who was unfamiliar with the theatre recovery documentation and that the member of staff had received further training.

Safeguarding

- The service had a safeguarding people who use services from abuse policy and procedure. However, these did not reflect current legislation stated in the Care Act 2014, or provide details as to the level and type of training required for staff.
- Safeguarding training was mandatory for all staff; this was provided by an external company. However, the service was unaware what level this training was.
- The service told us that only patients over the age of 18 were admitted, however during our inspection we saw the records of one patient who was 17 years of age. The service told us this was an exceptional case. Following our inspection we asked the provider to update their Statement of Purpose to explicitly confirm they would not carry out surgery on patients under the age of 18. Staff asked the patients their date of birth at various points throughout their stay, and would ask for proof of age if they were concerned a patient was under the age of 18 years. Staff did not receive safeguarding children's training.
- Staff told us they had not needed to raise any safeguarding concerns.
- The registered provider was the safeguarding lead; however, staff we spoke with were unaware of this and thought it was the theatre manager.
- Staff had no awareness or training in relation to female genital mutilation (FGM). Since October 2015, it is mandatory for regulated health and social care professionals to report known cases of FGM, in persons under the age of 18, to the police. Whilst the service did not provide care to those patients under the age of 18, healthcare staff had a professional duty to report any concerns where a parent has had FGM and may have female children.

Mandatory training

- All staff were required to undertake mandatory training, which included health and safety, moving and handling, infection prevention and control, basic life support and food safety. This training was provided by an external company and all staff had attended within the previous 12 months.

Assessing and responding to patient risk

- The hospital had clear patient exclusion criteria, which set out which patient groups would not be accepted for surgery, which meant that patients who were at potentially high risk were not admitted.
- The National Institute of Health and Care Excellence (NICE) QS3 requires that all patients receive an assessment of their risk of developing venous thromboembolism (VTE). The assessment should use defined clinical risk criteria. Information sent to us prior to inspection stated that 100% of patients had a VTE screening for the period between January and December 2015. However, we reviewed the records of 12 patients, and saw that no formal risk assessment for VTE had been performed. Despite the lack of formal risk assessment staff were caring appropriately for patients to minimise this risk.
- The Royal College of Surgeons (RCS) professional standards for cosmetic surgery (2016) state the surgeon should make an attempt to identify the psychologically vulnerable patients and to consider psychological referral if a patient has co-existing psychological disturbances. In the 12 sets of records we reviewed, there was no documented evidence that a patient's psychological well-being had been considered. In one of these records, it was noted the patient had received medicine for an anxiety and depression condition for eight years; however, no further psychological health assessment had been considered.
- Staff routinely assessed patients for their risk of pressure ulcers; we saw assessments had been documented in all the patient's records we reviewed.

Surgery

- The service told us a registered nurse undertook a pre-operative anaesthetic screen with each patient, where any additional tests, examinations, appointments with the consultant anaesthetist if required were arranged. The service told us the nurses who performed this had not had any specific training. We reviewed 14 records for patients who were admitted directly to the hospital we saw that the pre-operative anaesthetic screen consisted of a healthcare questionnaire that was completed by the patient. There was no screening documented by a nurse. For those patients who were referred from other cosmetic clinics, we saw evidence that a health screen had been performed that included, for example, the recording of the patient's blood pressure and had been signed by a health care professional. However, all patients were seen and assessed by the anaesthetist on the day of operation.
- The World Health Organisation (WHO) Surgical Safety Checklist was introduced in 2008. This is a core set of safety checks, identified for improving performance at safety critical time points within the patient's intraoperative care pathway. The hospital did not use this. However, we saw evidence that the hospital was in the process of reviewing and redesigning their current theatre documentation to incorporate the principles of the surgical safety checklist.
- The hospital used an early warning score (EWS) to identify a deteriorating patient. Early warning scores have been developed to enable early recognition of a patient's worsening condition by prompting nursing staff to get a medical review at specific trigger points. Staff told us they were unsure what score would trigger further assessment by a doctor, but would automatically ask a doctor to review a patient if they were concerned. We reviewed the EWS on two patients who had undergone surgery during the unannounced inspection, and saw that one of the patients had a completed EWS. The EWS was not printed on the observation form, which made it difficult for staff to refer to it when performing the patient's observations. Despite this, we found patients were monitored closely and all of the records we looked at showed the patient had their observations recorded appropriately following surgery.
- There was a procedure in place for a patient to be transferred to the local acute NHS hospital if their condition deteriorated. The local acute trust confirmed arrangements were in place for this; however, there was no formal written transfer agreement, as required by the Independent Healthcare Advisory Services (2015). Staff told us they had a number to contact the local trust if they required a transfer for a patient, however if the patient was deteriorating fast they would call for an emergency ambulance to transfer. The service told us that this had never happened.
- The theatre team remained on call for the rest of the day so would be available if patients were required to return to theatre.
- Staff told us they would be aware if patients were admitted into their local hospitals for complications following their surgery, as they would receive notification by the hospital. They stated they would document this information in the patient notes; however, they would not raise an incident in relation to this. Staff were unable to tell us about any times where this had happened.
- Within the patient's rooms there was a nurse call bell system. There was no separate emergency call bell to alert staff to an emergency situation. Staff told us if an emergency situation were to happen they would call for help. The emergency call system in the theatres department required a member of staff to hold a button until help arrived. There was no additional light system to indicate which room the emergency had occurred in and again would rely on the member of staff calling to indicate where the emergency was.
- We observed an operation, where the device to support the patient's breathing had become slightly dislodged. The anaesthetist responded appropriately to this potential risk, dealing with it quickly, efficiently and in a calm manner.
- Following discharge, patients could call the hospital for advice or reassurance. Out of hours, this call was transferred to a mobile phone, which would be answered by the theatre manager or a member of nursing staff from the ward.

Nursing staffing

- The hospital employed three registered nurses, and two care assistants. Staff were contracted set hours per week, but worked flexibly depending on the needs of the organisation. Staff we spoke with were happy with this arrangement.
- Within the ward area, there was one registered nurse and two care assistants on during the day, who on

average provided care for five or six patients. On nights when the ward remained opened, there would typically be two or three patients who would be cared for by one registered nurse and one care assistant.
- Within theatres, there were three registered practitioners, either nurses or operating department practitioners (OPD), and one care assistant.
- One member of staff told us although they did not work on the ward or in theatre; they did sometimes help on the ward on busy days, for example by providing food and drinks for the patients.
- In addition to the contracted staff, other staff were employed via the hospital's bank process, this ensured continuity of regular staff attending.
- On some occasions, the hospital used staff from an external agency. There had been no agency used since November 2015.

Surgical staffing

- On days of surgery, a resident medical officer (RMO) was on duty and would stay overnight on the hospital premises on nights when the ward remained opened. There was one main RMO, who covered the hospital, and a further two regular RMOs who provided cover.
- The surgeon who performed the operation stayed overnight nearby or on the hospital premises in case there were any complications or patients needed to return to theatre.
- The hospital generally used one of two anaesthetists, which ensured continuity of regular staff attending the hospital. These members of staff could be contacted 24 hours a day and could return to the hospital within 30 minutes.

Major incident awareness and training

- The service had back up emergency generators in place and we saw evidence that these were tested on a weekly basis.
- Twice a year staff participated in scenario based drills for emergencies. We saw records that indicated that these had been completed in March and November 2015.

Are surgery services effective?

- The service's policies referred to out of date material, or did not reflect current best practice. Care did not always reflect best practice.
- The service had not started to collect data for the submission to Private Healthcare Information Network (PHIN), nor did they collect and report on Q-PROMs for all patients.
- The service did not keep electronic details of implants used, which could be easily accessible in the case of a product recall.
- There was no robust system in place to ensure information was communicated with the patient's GP.

However

- Patient pain was managed effectively.
- Staff worked well together with effective communication and partnership working between the different professional groups
- The was a robust procedure in place to ensure patients were able to give an informed consent.
- The service had a local audit programme in place but did not contribute to national audits.

Evidence-based care and treatment

- The hospital policies made reference to out of date material, or did not reflect current best practice. For example, the infection control policy did not reference the Health and Social Care Act (2008) the code of practice on the prevention and control of infections and related guidance. The medicine storage and administration policy, did not reference to the Nursing and Midwifery Council (NMC) standards for medicine management (2007). The notification of notable incidences policy referred to the Healthcare Commission, rather than the CQC and referred to out of date legislation. The safeguarding people who use services from abuse policy did not reference the Care Act 2014.
- Best practice guidance on fasting prior to surgery states that patients who require a general anaesthetic are allowed to eat up to six hours prior to surgery and to drink water up to two hours before. However all patients were starved from 12 midnight for an operation in the morning and from 12 midday for an afternoon operation.
- Staff told us they were aware of NICE guidance and evidence based best practice, however were unable to provide examples of where they followed best practice.
- Regulations stated in the Department of Health Review of the Regulation of Cosmetic Interventions (2013)

require that hospitals keep electronic details of implants used, which should be easily accessible in the case of a product recall. The hospital used a paper-based system to record all implants used, however the book used for this also contained details of all the sterile pieces of equipment that had been used during the procedure. This meant information regarding implants would not be easily accessible.

- We saw evidence of staff not following best practice in regards to the prevention of surgical site infection (NICE QS 49). Staff did not minimise the amount of unnecessary movement in and out of the theatre and propped open the main theatre door that led to the main corridor during a procedure. The service did not have a local antimicrobial policy.
- The service did not participate in any national audit; however, they did have an audit programme that included audits relating to post-operative nausea and vomiting (PONV) and pain management, for example.
- Twice a year a quality and clinical audit was produced, and an action plan developed as required. We reviewed these reports from July and December 2015, and saw no issues had been identified and no actions were required.

Pain relief

- Staff administered simple oral pain relief for patients on the wards. If the patient required stronger pain relief this would be administered intravenously by the anaesthetist or the RMO. We observed a nurse contacting the anaesthetist and the anaesthetist responding, in a timely manner to administer stronger pain relief.
- We observed staff regularly reviewing patient's pain following surgery. If a patient had pain, they administered pain relief and checked this had the desired effect.
- Records demonstrated that nurses regularly assessed a patient's pain post operatively using the pain scale of zero to three.
- We saw staff providing ice packs to patients to help relieve pain, in addition to providing pain relief medicines.
- Patients told us staff were quick to respond to pain and they would be given pain relief immediately if this was asked for.
- The service's pain audit reviewed the care that 10% of the patients received between January and March 2016. The results indicated that all patients received pain relief during the operation and were prescribed pain relief postoperatively. The audit results also showed patients only needed oral medicine following their surgery to relieve their pain and no patients had to wait for more than five minutes for pain relief.

Nutrition and hydration

- Pre admission information for patients gave clear instructions on fasting times for food and drink prior to surgery. Records showed that checks were made to ensure patients had adhered to fasting times before surgery went ahead. However, patients were fasting for longer than is considered necessary.
- Following their procedure, patients were provided initially with drinking water, and when they were fully recovered, staff provided snacks such as toast, sandwiches, soup or microwave meals.
- Any special dietary requirements, intolerances or allergies were identified on the patient's record, and if required the staff would provide an appropriate meal.
- Staff were aware of the importance of ensuring patients received medicine to prevent post-operative nausea and vomiting (PONV) and the importance of monitoring the nutrition and hydration given to the patients post-operatively.

Patient outcomes

- The service had a three monthly audit programme that included some audits on patient outcomes. These included for example PONV, pain management and patient satisfaction.
- We reviewed the PONV audit for 10% of patients who received care between January and March 2016. The report showed all patients received medicines to prevent nausea and vomiting during their operation and were also prescribed these post operatively as well. None of the patients in the audit experienced PONV.
- The service also undertook a clinical audit every six months, which listed the number of operations performed by the surgeons including the number of revisions of surgery. This monitored the number of operations rather than patient outcomes.
- The Private Healthcare Market Investigation Order (2014) requires every private healthcare facility to collect a defined set of performance measures and to supply that

data to the Private Healthcare Information Network (PHIN). Hospitals needed to collect this data from January 2016, ready for submission in September 2016. The service had no process in place to record this information and was unaware of the requirement.
- The Royal College of Surgeons (RCS) recommends that providers routinely collect and report on Q-PROMs for all patients receiving procedures such as breast augmentation (enlargement) and blepharoplasty (cosmetic surgery to the eyelids). Q-PROMS are patient report outcome measures, which describe the level of patient satisfaction with certain operations. The service did not collect any Q-PROMS information from patients.

Competent staff

- Doctors working at the hospital did so under practicing privileges. Practicing privileges refer to medical practitioners, not directly employed by the hospital, who have permission to practice there.
- The service had a policy for granting and reviewing practising privileges. The service was unable to tell us how many doctors had practising privileges, but told us that all doctors who were performing surgery had had their practising privileges checked within the preceding 12 months.
- The practicing privileges policy required all doctors to demonstrate their competence and experience in the relevant area. Doctors were also required to provide evidence of their disclosure and barring service (DBS) checks and indemnity insurance, for example. Practicing privileges were granted by the hospital's medical advisory committee (MAC). We reviewed the personal files of doctors working at the hospital and evidence that practicing privileges arrangements had been recorded.
- All staff told us they had received their appraisal. We reviewed the appraisal documents for three permanent staff members and all three were completed. One bank staff member had not had an appraisal since July 2014. We reviewed the records for four doctors with practising privileges and saw there were appraisal documents for three of these.
- From April 2016, all registered nurses are required to revalidate with the Nursing and Midwifery Council (NMC) in order to continue practising. One registered nurse had successfully completed this process and would in future act as a resource for others.
- There was no robust system for identifying training needs of staff, or recording attendance at training courses or study days. However, staff told us they felt supported to complete further training if they wanted to. One staff member provided an example of where they had been encouraged to complete further training; another reported that they kept up-to-dateby reading online material.

Multidisciplinary working

- We observed all staff working well together with effective communication and partnership working between the different professional groups.
- There was a service level agreement (SLA) in place with the local acute NHS hospital for sterile services, pharmacy and pathology services. Staff told us these agreements worked well and they had not experienced any difficulties with any of these services.
- The service did not directly communicate with the patients' GPs. Patients were given a discharge letter which detailed the operation performed and the medicine the patient had been sent home with. Patients could choose to pass this letter on to their GPs if they wished. No copy of this letter was kept in to the patients' record. This practice is not in line with the recommendation made in the Review of the Regulation of Cosmetic Interventions (2013) which stated that details of the surgery and any implant used must be sent the patient's GP.

Seven-day services

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

Access to information

- All information was recorded in a single paper based patient record; this was accessible by all staff and aided communication between the different professions.
- The hospital provided surgery for patients who had been referred from four other cosmetic clinics. Preoperative assessment and follow up care were all provided by the referring clinics. Information from the clinics was supplied in advance to the service. Following surgery, the service would email information to the referring clinic; this ensured that the referring clinic had

immediate access to patients' information. The registered provider told us that this information was sent through secure email, with passwords required to access the email, being provided separately by telephone, to ensure confidentiality.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital had a process of assuring that patients were giving their informed consent. Patients were given an informed consent document, which detailed the risks and complications of each procedure. Patients were sent this prior to their consultation so they had time to read the information contained within it and were required to sign each page to demonstrate they had read and understood it.
- In addition to this, patients also signed a consent form. We reviewed 12 consent forms all of which had been completed satisfactorily. We saw patients had their consent forms checked at many stages prior to their procedure.
- All patients were given a two week cooling off period between initial consultation and the procedure. This is in line with the RCS professional standards for cosmetic surgery (2016)
- Staff had not received training on Mental Capacity Act and Deprivation of Liberty Safeguards, however due to the nature of the patient group, this was not a priority for the service.

Are surgery services caring?

- Without exception, patients told us they were treated with kindness and compassion by all staff.
- Patients spoke positively about the service and the care they had received.
- Staff treated patients with dignity and respect, and provided reassurance and emotional support throughout their stay.
- Patients were kept informed of the care and treatment and staff explained procedures to them.
- Patients and their families were fully involved in their care.

Compassionate care

- Without exception, patients told us staff were kind, caring and professional.
- Feedback from patients was constantly positive about the care and treatment they had received and they would recommend the hospital to their friends and family.
- One patient told us they appreciated the registered provider visiting them prior to their operation to check on their well-being. Another described how they had been treated with kindness by staff who had promptly given them medicine for their pain following surgery.
- Patients told us they were treated in a dignified and respectful manner. All members of staff introduced themselves to the patients and we saw that staff respected a patient's privacy by always knocking on doors before entering. However, we saw that the theatre doors were left open during a patient's operation, which compromised their dignity.
- We saw staff regularly going into all of the patient's rooms to check on how they were recovering, and ask if there was anything they needed.

Understanding and involvement of patients and those close to them

- Patients told us all staff explained what they were doing in a way that they understood. If they did have any questions, they felt comfortable to ask. Patients said they were provided with a lot of information and staff explained this thoroughly.
- One patient told us following their consultation they had numerous questions and had contacted the hospital on many occasions. They told us they were always greeted in a friendly manner and never felt awkward asking questions. Staff were happy to supply the information and they had all their questions fully answered.
- One patient told us how staff listened and involved them in their care when discussing the type of anaesthetic that would be used, and they were able to influence the type of anaesthetic they received.
- Another patient praised the theatre manager, saying how thorough they had been providing information before their surgery.
- Discussions around the cost of procedures were always approached with sensitivity.
- We saw family members were encouraged to stay with patients throughout their stay and were included in conversations when appropriate.

Emotional support

Surgery

- Staff provided ongoing support to patients when they were discharged from the hospital. If there were any issues which the patients were concerned about, they had the option to contact the staff and arrange for an appointment at the hospital if required.
- One patient told us that they were distressed due to a previous experience, and the staff were very understanding about their concerns and provided them with a lot of support.
- We observed ward staff accompanying patients to the anaesthetic room and remaining with the patient until they had been fully anaesthetised. During this time, they provided emotional support and comfort to the patient.

Are surgery services responsive?

- The service arranged appointment and surgery times to meet the needs of the individual patient.
- Patients were able to self-refer to the hospital or were referred from other cosmetic surgery providers.
- The service had a clear complaints policy, although information displayed regarding this was inaccurate.

However,

- Written information for patients was out-of-date.

Service planning and delivery to meet the needs of local people

- The hospital arranged appointments and surgery dates and times that suited the individual patient.
- When staff received enquiries from patients for services they did not provide they were able to offer the contact details for other providers.

Access and flow

- The hospital provided surgery for patients who had been referred from four other cosmetic clinics, as well as accepting patients who self-referred directly to the hospital.
- Patients were given appointment times to see their surgeons for consolation prior to surgery. On rare occasions when consultations ran late, staff would ensure patients were kept informed.

Meeting people's individual needs

- The only religious and spiritual support available was from a copy of the bible in patient rooms. There were no systems in place to provide support for other faith groups. However, patients were only in hospital for short periods of time.
- A lift was available and there was sufficient space in patients' room and bathrooms for wheelchair access.
- All of the ensuite bathrooms had handles located next to the toilets to help patients who may have restricted mobility, although bath and showers were unsuitable for patients with restricted mobility.
- Staff were able to access interpreters if required.
- No specific facilities were available to support patients with hearing or visual impairment.
- Between January 2015 and December 2015, the service only provided care to patients under the age of 64 years. Therefore, it would be unlikely that the service would be providing care to patients living with dementia.
- Information was available in patient rooms regarding cosmetic surgery and explaining about undergoing an anaesthetic. However, some of this information was out of date. Information about undergoing an anaesthetic was from 2003. The information available regarding cosmetic surgery was published by the Healthcare Commission, rather than the more up-to-date information from the Care Quality Commission (CQC). Patients were not directed to information available for patients about cosmetic surgery on the Royal College of Surgeons (RCS) website as advocated by the RCS professional standards for cosmetic surgery 2016.

Learning from complaints and concerns

- The hospital had a compliments and complaints policy and a procedure which outlined the process taken following the receipt of a complaint. The initial complaint was acknowledged in writing and the patient invited to attend a meeting at the hospital to discuss their complaint further. A full written response would be completed within 20 working days of the complaint. We saw evidence of this policy implemented in response to a complaint in 2014.
- Throughout the hospital there were posters displayed advising patients how to complain. Whilst these posters advised the patients to complain to the registered manager, they also included inaccurate information which advised patients that they could complain to the Care Quality Commission (CQC).

Surgery

- Information supplied to the CQC prior to inspection indicated there had been no complaints during 2015, however we reviewed the hospital's complaints file and found there had been one complaint. We saw evidence of the hospital implementing their complaints policy but the patient had had no further contact with the hospital.
- From January to June 2016, there had been two complaints from patients. We saw evidence of the hospital responding to these complaints according to their policy and the complaints had been discussed at the hospital's medical advisory committee (MAC).
- None of the patients we spoke with were given any information about the hospitals complaints procedure, however all patients said they would be happy to raise any concerns or complaints with the staff at the hospital.

Are surgery services well-led?

- There was no clear documented vision or strategy for the hospital.
- Governance arrangements were not robust.
- Quality assurance systems and audits completed had not identified the issues found on our inspection.
- Policies and risk assessments did not reflect up-to-date practice or current guidance.
- The policy for reporting notifiable incidents, referred to out of date legal regulations.
- Disclosure and barring service (DBS) checks had not been completed for one staff member and one doctor did not have evidence of indemnity insurance in their file.
- The hospital had not made any arrangements to ensure that surgical cosmetic procedures were coded in accordance with SNOMED_CT, to collect Q-PROMS information from patients, or have a system to electronically record details of implants that could be easily accessible in the case of a product recall.

However

- Staff spoke very positively about the leadership of the service, staff felt engaged and enjoyed working at the hospital
- The service sought feedback from all patients regarding the care they had received.

Vision and strategy for this this core service

- There was no clear documented strategy, vision or set of values for the hospital. Staff we spoke with did not know if there was a vision or strategy for the hospital. However, the registered provider did discuss with the inspection team their plans for contracting services for the NHS.
- The hospital had not made any arrangements to ensure that surgical cosmetic procedures were coded in accordance with SNOMED_CT. SNOMED-CT uses standardised codes to describe cosmetic surgical procedures, which can be used across electronic patient record systems.

Governance, risk management and quality measurement for this core service

- The arrangements for governance did not always operate effectively.
- Quality assurance systems and audits completed had not identified the issues found on our inspection. For example, infection control audits for January 2016 and March 2016 scored 100%; however, during inspection we saw dust on equipment such as fans, dust in the corners of patients' rooms, debris in the light fitting of theatre and inappropriate storage of items such as mop heads and linen.
- The service did not have robust arrangements in place to ensure that equipment and medication were in date. Although checks of resuscitation equipment and medications took place, we found some consumable items on the resuscitation trolley and medications that were out of date.
- Whilst the service had a process for reporting incidences, we were not assured that untoward incidents were reported consistently. For example, staff and told us that patients had returned to theatre, however, these had not been reported as incidents.
- Many of the hospital policies and procedures did not refer to up-to-date guidance and best practice, suggesting that comprehensive review of these documents did not take place.
- Certain incidents, events and changes that affect a service or the people using it need to be reported to the Care Quality Commission (CQC).The service had a policy for reporting such notifiable incidents. However, this policy contained information that was out of date. The

policy referred to legal regulations, which were superseded in November 2014 and stated that such notifications needed to be reported to the Healthcare Commission, which was replaced by the CQC in 2008.
- The hospital did not have a risk register, although did keep a log of risk assessments that were reviewed yearly. For example, these included use of latex and the moving and handling of patients.
- Risk assessments did not always reflect up-to-date guidance. For example the risk assessment for needle stick injuries did not consider the use of safety devices nor did it refer to the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. There was evidence in the sharps boxes in theatres that staff regularly re-sheathed needles. This practice is not recommended in accordance with The Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- We reviewed a total of eight staff files and saw evidence that disclosure and barring service (DBS) checks had been completed for seven of these. However, one member of staff had left the hospital to work elsewhere and then returned, but a DBS check had not been completed on their return.
- We checked the staff files for four doctors and saw there was evidence of indemnity insurance for three of them. For the remaining doctor there was evidence that a quote had been obtained for the indemnity insurance, but no record of the insurance was present.
- Whist the service did seek feedback from patients regarding their care, they did not perform quality measurements such as collect Q-PROMS information from patients as recommended by the Royal College of Surgeons (RCS).
- There were hospital medical advisory meetings (MAC) every three months; these were chaired by the registered provider. These meetings were attended by an anaesthetist, a surgeon and the theatre manager. There were no formal terms of reference (TOR) for this meeting and the minutes provided were brief. However, we saw evidence that risk assessments, audit results and complaints, for example, were discussed here. Staff who attended the MAC confirmed they were involved in reviewing practising privileges for potential new staff and reviewing policies.
- Staff told us there were informal staff meeting as required, however there were no set agendas or minutes recorded for these meetings.
- The registered provider was also the responsible officer and we saw evidence that he attended regional responsible officer meetings.

Leadership / culture of service related to this core service

- Staff told us they were well supported by their managers who were visible. Staff we spoke with told us the management team were approachable and they would feel comfortable raising any concerns they may have.
- All staff spoke positively about the leadership within the hospital, reporting leaders were competent in their role.
- Staff told us they felt valued and respected by their employer, they enjoyed working in the team and enjoyed working at the hospital.
- Whilst the leadership and culture of the service was valued and recognised by staff, we had concerns about the effectiveness of leadership due to the number of regulatory breaches found at inspection.

Public and staff engagement

- All patients were asked to complete a satisfaction survey about their experience at the hospital. The service reviewed the responses from patients and produced a report every three months. We reviewed the reports from September 2015 and January 2016 and saw that 98% of patients had completed the questionnaire. Both reports indicated that that feedback from patients was positive and there were no areas identified as requiring improvement.
- Reception staff were able to give an example of how they had influenced a change in the process for following up patients following their consultation.

Innovation, improvement and sustainability

- There was no evidence of improvement or innovation for this service.
- Royal College of Surgeons (RCS) cosmetic surgery certification was launched 2016, with the expectation that by summer 2017 all surgeons currently practising cosmetic surgery in the private sector will have applied for certification in the areas in which they practice. No arrangements were in place for the service to encourage, record and monitor RCS certification by surgeons who carry out cosmetic surgery.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- Ensure systems and processes protect people from healthcare associated infections.
- Ensure policy for reporting notifiable incidents is in line with the CQC (Registration) Regulations 2009.
- Ensure systems and processes are in place so that all incidents are reported and investigated.
- Ensure learning from incidents is used to evaluate and improve practice.
- Ensure processes are in place and followed to guarantee consumables are in date.
- Ensure there is a safe process in place for the management of medicines.
- Ensure safe storage of patients' records.
- Ensure safeguarding policy and practice is in line with current legislation and that staff receive mandatory safeguarding training at the correct level.
- Finalise and implement new documentation that reflects the World Health Organisation (WHO) Surgical Safety Checklist.
- Ensure there is a formal written agreement with the local NHS trust for the transfer of a deteriorating patient.
- Ensure full compliance with the use of the service's preferred early warning system (EWS).
- Ensure there is clear guidance for appropriate risk assessments and screening required preoperatively for patients.
- Ensure all policies reflect up-to-date guidance and care provided reflects best practice.
- Ensure they are meeting all the recommendations from the Review of the Regulation of Cosmetic Interventions (2013).
- Ensure there are robust governance arrangements in place that include ensuring risk assessments reflect up-to-date guidance and that there is a robust system for staff checks.
- Ensure patient information is up-to-date and patients are signposted to information resources to help make an informed decision about their procedure as recommended by the Royal College of Surgeons Standards (2016).

Action the provider SHOULD take to improve

- Consider providing clear guidance describing which operations need to be performed in the theatre with specialist ventilation.
- Consider improving the quality of the documents used for patients records.
- Consider how to ensure preoperative clinics are nurse led or consider changing the way they are advertised to reflect what actually happens.
- Consider developing a training needs analysis for all staff.
- Consider how they meet the requirements of the Duty of Candour regulation.

This section is primarily information for the provider

Requirement notices

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 must assess the risk of, and prevent, detect and control the spread of, infections including those that are healthcare associated. How the regulation was not being met: Staff did not always adhere to recognised good infection control practice procedures, such as using aseptic non-touch technique (ANTT).

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 must ensure that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way. How the regulation was not being met: Some consumable items on the resuscitation trolley and within theatre were out of date. There was inappropriate storage of items such as mop heads and linen.

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

This section is primarily information for the provider

Requirement notices

The provider must ensure the proper and safe management of medicines.

How the regulation was not being met:

Out of date medicines had been prescribed and administered to patients.

Medicines including controlled drugs were left unattended.

There was no process in place for monitoring the use of prescriptions.

There were no protocols for antibiotics prescribing.

There was no process in place for ensuring action when the temperature of the medicine fridge was outside acceptable range.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider must maintain securely an accurate, complete and contemporaneous record in respect of each service user. How the regulation was not being met: Patients' records were not kept securely.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes must be established and operated effectively to prevent abuse of service users. How the regulation was not being met: The provider's safeguarding policy did not reflect current legislation.

This section is primarily information for the provider

Requirement notices

The provider was not able to confirm staff received mandatory safeguarding training at an appropriate level.

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 (a) The provider must assess the risks to the health and safety of service users of receiving the care or treatment (b) The provider must do all that is reasonably practicable to mitigate any such risks. How the regulation was not being met: The provider did not use the World Health Organisation (WHO) Surgical Safety Checklist. There was no formal written agreement with the local acute NHS trust for the transfer of a deteriorating patient. Use of the Early Warning System (EWS) was inconsistent. There was a lack of guidance regarding preoperative risk assessments and screening for patients. Governance arrangements did not ensure that risk assessments were up to date.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must be established and operated effectively. How the regulation was not being met: Policy for reporting notifiable incidents was not in line with the CQC (Registration) Regulations 2009. Reporting procedures for incidents were not robust

This section is primarily information for the provider

Requirement notices

Policies and procedures did not away reflect up-to-date guidance.

Care did not always reflect current best practice.

The provider had not taken steps to meet the recommendations from the Review of the Regulation of Cosmetic Interventions (2013).

Patient information was not up-to-date.

Patients were not signposted to up-to-date advice or information resources to help make an informed decision about their procedure as recommended by the Royal College of Surgeons Standards (2016).

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 Recruitment processes must be established and operated effectively to ensure that persons employed be of good character. How the regulation was not being met: Disclosure and barring service (DBS) checks had not been completed for one staff member and one doctor did not have evidence of indemnity insurance in their file.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The provider must, in relation to premises and equipment, maintain standards of hygiene appropriate for the purposes for which they are being used. How the regulation was not being met: Decontamination procedures for equipment were ineffective.

This section is primarily information for the provider

Requirement notices

There was dust on equipment such as fans and dust in the corners of patients' rooms. Debris had collected in the light fitting of theatre.