Alexandra Health Care Limited

Alexandra Private Hospital

Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Summary of findings

Letter from the Chief Inspector of Hospitals

Alexandra Private Hospital is operated by Alexandra Healthcare Limited. 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.

The hospital provides cosmetic surgery for self-funding patients. 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.

We inspected cosmetic surgery using our comprehensive inspection methodology, on the 14 and 16 June 2016. This identified the provider was in breach of five regulations of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014. These were:

- Regulation 12: Safe care and treatment
- Regulation 17 Good governance
- Regulation 13 Safeguarding service users from abuse and improper treatment
- Regulation 19 Fit and proper persons employed
- Regulation 15 Premises and equipment

The full report of this inspection can be found on the CQC website: https://www.cqc.org.uk/location/1-114136771

We carried out a focused inspection again on the 23 January 2017, to follow up our concerns.

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

At this inspection we looked at the safe, effective and well led domains only.

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

We found the following areas of good practice:

- The hospital was visibly clean and tidy and processes were in place to ensure equipment was cleaned appropriately between use.
- The provider had introduced a new policy relating to the use of using aseptic non-touch technique (ANTT), which is a standardised approach to performing procedures in order to reduce the risk of a healthcare associated infection (HCAI). Staff confirmed their knowledge and understanding of this.
- The provider had introduced monitoring processes to ensure that consumables were in date.
- Medicines were stored securely and in date, and the provider had introduced a new policy for the prescribing of antibiotics, which was in line with national guidance.
- Records were kept securely.
- The provider was working with the local acute NHS trust to formalise the existing agreement for a patient to be transferred to the local acute NHS hospital if their condition deteriorated, as required by the Independent Healthcare Advisory Services.
- Staff 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.
- The provider was actively working to meet the requirements of the Review of the Regulation of Cosmetic Interventions (2013).

However, we also found the following issues that the service provider needs to improve:

Summary of findings

- Governance, risk management and quality measurement were not robust and we were not assured the provider was taking a proactive approach to continuous learning and improvement.
- We did not see sufficient evidence to ensure us that all incidents were reported and lessons learnt and shared.
- Not all policies reflected up to date guidance or reflected the needs of the organisation.
- Disclosure and barring service (DBS) checks had not been completed for the staff member we identified at the inspection on the 14 and 16 June 2016.
- Information advising patient about cosmetic surgery and having an anaesthetic was out of date.
- There was no system to electronically record details of any implants used, which could be easily accessible in the case of a product recall.
- Whilst the provider had incorporated the World Health Organisation (WHO) Surgical Safety Checklist into existing documentation that staff used in theatres not all elements of the WHO had been included. The WHO checklist is a set of safety checks, identified for improving performance at safety critical time points within the patient's intraoperative care pathway. Staff did not undertake child safeguarding training. Whilst the hospital did not care for children, this did not mean that children did not visit the hospital. Therefore, staff should have children safeguarding training as outlined in the Royal College of Paediatric Health intercollegiate document: safeguarding children and young people (2014).
- There was no clear guidance as to which risk assessments and screening were required preoperatively for patients. Staff did not assess patients for their risk of venous thromboembolism (VTE) or consider their psychological well-being preoperatively. Preoperative checks, such as MRSA risk and blood pressure recording undertaken by the registered nurse as part of the pre-operative screening process had not been recorded.
- Fasting guidance for patients undergoing a general anaesthetic did not reflect current best practice.

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

Professor Sir Mike Richards
Chief Inspector of Hospitals

Alexandra Private Hospital

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Detailed findings

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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 manager 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.

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

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

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

We last inspected Alexandra Private Hospital on the 14 and 16 June 2016. This identified the provider was in breach of five regulations of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014. These were:

- Regulation 12: Safe care and treatment
- Regulation 17 Good governance
- Regulation 13 Safeguarding service users from abuse and improper treatment
- Regulation 19 Fit and proper persons employed
- Regulation 15 Premises and equipment

Following this inspection the provider was required to make improvements to ensure they met fundamental standards of care. We carried out a focused inspection again on the 23 January 2017, to follow up these concerns and ensure the provider had made improvements. We gave the provider five days notice of this inspection.

Our inspection team

The team that inspected the service comprised of a CQC lead inspector, one other CQC inspector and a Specialist Advisor for Plastic Surgery (Specialty Training Registrar in Plastic Surgery and Clinical Fellow to Professor Sir Mike Richards, Chief Inspector of Hospitals).

The inspection team was overseen by a Head of Hospital Inspection.

Detailed findings

Facts and data about Alexandra Private Hospital

Alexandra Private Hospital has 21 individual rooms located over two floors and two operating theatres. The hospital provides cosmetic surgery for self-funding patients. Surgery is not performed every day; on average there are four to five days per month when surgery takes place.

In the reporting period from 1July 2016 to 31 December 2016, 123 patients received cosmetic surgery at the Alexandra Private Hospital. Of these, 80 were treated as day cases and 43 patients were required to stay overnight.

We considered information submitted to the Care Quality Commission by the provider that detailed the actions they were taking to make the necessary improvements to the service. We visited the ward and theatre areas. We spoke with five staff including; registered nurse, health care assistant, reception staff and senior managers. During our inspection, we reviewed six sets of patient records. There were no patients and no surgery on the day of our inspection.

The hospital employed two surgeons, two anaesthetists under practising privileges and resident medical officers (RMO). It employed three registered nurses, two care assistants and one receptionist, as well as having its own bank staff that included operating department practitioners (ODPs). The accountable officer for controlled drugs (CDs) was the registered manager.

The service reported no never events, no clinical incidents resulting in harm, no serious injuries, no incidences of hospital associated MRSA, no incidences of hospital associated Methicillin-sensitive staphylococcus aureus (MSSA),no incidences of hospital associated Clostridium difficile (c.difficile), no incidences of hospital associated E-Coli.

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal
- Laundry
- Maintenance of medical equipment
- Pathology and histology

Surgery

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Summary of findings

We inspected cosmetic surgery using our comprehensive inspection methodology, on the 14 and 16 June 2016. This identified the provider was in breach of five regulations of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014. We carried out a focused inspection again on the 23 January 2017, to follow up our concerns.

We found the hospital was visibly clean and tidy and processes were in place to ensure equipment was cleaned appropriately between use. The provider had introduced new policies for the prescribing of antibiotics, which was in line with national guidance and for the use of aseptic non-touch technique (ANTT), which is a standardised approach to performing procedures in order to reduce the risk of a healthcare associated infection (HCAI). Consumables were in date, medicines were stored securely and were in date and records were kept securely.

The provider was working with the local acute NHS trust to formalise the existing agreement for a patient to be transferred to the local acute NHS hospital if their condition deteriorated. Staff used an early warning score (EWS) to identify a deteriorating patient. The provider was actively working to meet the requirements of the review of Review of the Regulation of Cosmetic Interventions (2013).

However, governance, risk management and quality measurement were not robust and we were not assured the provider was taking a proactive approach to continuous learning and improvement. We were not assured the incident reporting process was robust enough to ensure that all incidents were reported and

lessons learnt and shared. Not all policies reflected up to date guidance or reflected the needs of the organisation. Disclosure and barring service (DBS) checks had not been completed for the staff member we identified at the inspection on the 14 and 16 June 2016.

Information advising patient about cosmetic surgery and having an anaesthetic was out of date. There was no system to electronically record details of any implants used, which could be easily accessible in the case of a product recall. The provider did not use all aspects World Health Organisation (WHO) Surgical Safety Checklist.

There was no clear guidance as to which risk assessments and screening were required preoperatively for patients. Staff did not assess patients for their risk of venous thromboembolism (VTE) or consider their psychological well-being preoperatively. Preoperative checks, such as MRSA risk and blood pressure recording undertaken by the registered nurse as part of the pre-operative screening process had not been recorded. Fasting guidance for patients undergoing a general anaesthetic did not reflect current best practice.

Staff did not undertake child safeguarding training. Whilst the hospital did not care for children, this did not mean that children did not visit the hospital. Therefore, staff should have children safeguarding training as outlined in the Royal College of Paediatric Health intercollegiate document: safeguarding children and young people (2014).

Are surgery services safe?

Incidents

At the inspection on 14 and 16 June 2016, we found:

- That whilst the service reported no incidents, we were not 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.
- On the 23 January 2017, we reviewed the provider's policies and saw that the incident reporting policy had been updated and the provider had introduced a duty of candour policy. 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. Whilst the provider had not needed to apply the duty of candour regulation, they demonstrated good understanding of the requirements.
- Between June 2016 and the inspection on 23 January 2017, the provider reported one incident. We saw a member of theatre staff had completed the paper based reporting form, following this incident and the registered manager had investigated this.
- Staff we spoke with confirmed they were aware of the process for reporting incidents. However, there was a lack of clarity as to whose role it was to report. For example, ward based staff said they would not complete an incident report if a patient needed to return to theatre and were unsure if the theatre staff would do this, or not.
- Whilst the provider had taken steps to update policies regarding incident reporting, we were not assured the incident reporting process was robust enough to ensure that all incidents were reported and lessons learnt and shared.

Clinical Quality Dashboard or equivalent

Findings about clinical quality dashboard are detailed in the report of the inspection carried out on 14 and 16 June 2016.

Cleanliness, infection control and hygiene

At the inspection on 14 and 16 June 2016, we found:

- 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.
- Theatre trolley mattresses were damaged and had been repaired with tape, which meant correct decontamination of these items could not be assured.
- 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 associated infection (HCAI).
- There was no clear guidance for identifying those patients who required screening for MRSA.
- On the 23 January 2017, we observed the environment and saw it was visibly clean and tidy. The service had introduced cleaning schedules, which indicated the areas that staff cleaned weekly and those that were cleaned on days when the ward and theatres were in use. We reviewed these for December 2016, and saw they had been completed appropriately.
- We reviewed the provider's infection prevention and control policy, which had been updated. This policy was supported by various protocols, which provided staff with further guidance.
- We reviewed the protocol for the decontamination of reusable equipment and saw it provided guidance for staff on how to decontaminate equipment such as blood pressure recording equipment and mattresses in between use. We saw that appropriate decontamination products were available and staff were able to describe how they would decontaminate equipment in between patient use. However, we saw a damaged theatre trolley mattress, had been repaired with tape, which meant that correct decontamination could not be assured. This had been raised on the inspection on 14 and 16 June 2016. Following the inspection, we saw evidence the provider had ordered a replacement mattress. The provider advised us that additional mattresses were delivered in February 2017.
- The provider had changed the processes for the storage of mop heads to ensure that mop heads were stored appropriately.
- However, the linen cupboard contained items other than clean linen. This meant there was potential for the clean linen to become contaminated; only clean linen should be stored in the clean linen cupboard.
- The provider had introduced a new policy relating to the use of ANTT. We saw from the minutes of staff meetings from September, October and November 2016, the importance of using ANTT was discussed and it had been recorded that staff confirmed their knowledge and understanding of ANTT. We spoke with one registered nurse, who demonstrated an understanding of ANTT.
- The provider had updated the MRSA screening policy, which identified which groups of patient should be screened for their risk of MRSA. The provider had introduced an MRSA risk section on their medical screening form. However, we reviewed six patients records and saw that this section had not been completed. We therefore did not have the assurance that a robust procedure was in place to ensure patients' risk of MRSA was considered.

Environment and equipment

At the inspection on 14 and 16 June 2016, we found:

- Some out of date consumables within theatres and on the resuscitation equipment.
- On the 23 January 2017, we checked numerous consumables items within the ward, theatres and resuscitation trolley and found all were in date.We saw in minutes of staff meetings from September and October 2016, staff had discussed the importance of stock rotation. Within theatres, items that were nearing their expiry date were placed in a container, so they could be used first. The registered manager told us they undertook spot checks of consumables, to provide assurance that consumables were in date.
- Following our inspection on 14 and 16 June 2016, the provider confirmed in writing a voluntary restriction in the use of the rooms on the top floor, as these rooms were not fit for purpose and were in the process of being refurbished. On the 23 January 2017 we saw the provider had completed this refurbishment, although rooms were currently not in use.
- One of the two operating theatres had specialist ventilation, which is required under the Health Technical Memorandum 03-01 specialist ventilation for healthcare premises. At the inspection on 14 and 16

June 2016, we found there was no written guidance to identify which procedures should be performed in which theatre. On the 23 January 2017, we saw the provider had developed this guidance.

Medicines

At the inspection on 14 and 16 June 2016, we found:

- The arrangement for managing medicines was not robust; the medicine policy did not reflect current guidelines, 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.
- On the 23 January 2017, we reviewed the provider's medicine storage and administration policy and saw this had not been updated and did not reflect current best practice. For example, the policy referred 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).
- However, the provider had introduced a new policy for the prescribing of antibiotics. This was in line with the National Institute for Health and Care Excellence (NICE) quality statement 61, which 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.
- All medicines were in date and stored securely. We saw from the minutes of staff meetings dated September 2016, staff had discussed the importance of ensuring robust checks on medicines' expiry dates were conducted. Staff we spoke with were aware of those medicines that were nearing expiry and had taken steps to replace these.
- The provider had introduced a process to ensure staff were able to monitor the use of prescriptions. These were stored securely.
- We checked the temperature of the medicine fridge and noted it to be within the accepted range. We reviewed records for December 2016 and January 2017 and saw that staff consistently checked and recorded the temperature of the medicine fridge. Wee saw from these records that the temperature had remained within the recommended range. Additionally, the provider had introduced a written procedure, which outlined steps staff should take of fridge temperatures were to fall outside of the acceptable range.

Records

At the inspection on 14 and 16 June 2016, we found:

- Records were not kept securely and poor quality photocopied documentation was used.
- On the 23 January 2017, we saw patient records were stored securely in a locked room. We reviewed six patient records, which consisted of photocopied documents; however, these were of acceptable quality.
- We saw in the minutes of staff meetings from September and October 2016, staff had discussed the importance of ensuring patients' records were kept secure.

Safeguarding

At the inspection on 14 and 16 June 2016, we found:

- 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.
- 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.
- On the 23 January 2017, we saw the provider had updated their safeguarding adults policy and this included reference to FGM. However, we saw, for example, responsibilities stated in the safeguarding policy did not reflect those of the organisation, which could lead to inappropriate processes being followed.
- All staff had received adult safeguarding training; and the provider assured us that this included training on FGM.
- Staff did not receive children's safeguarding training. Whilst the hospital did not care for children, this did not mean that children did not visit the hospital. Therefore,

staff should have children safeguarding training as outlined in the Royal College of Paediatric Health intercollegiate document: safeguarding children and young people (2014).

Mandatory training

Findings about mandatory training are detailed in the report of the inspection carried out on 14 and 16 June 2016.

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

At the inspection on 14 and 16 June 2016, we found:

- Staff did not complete formal risk assessments to determine a patient's risk of developing venous thromboembolism (VTE), as advocated by NICE.
- There was no documented evidence that a patient's psychological well-being had been considered as advocated by the Royal College of Surgeons (RCS) professional standards for cosmetic surgery (2016).
- The provider told us, a registered nurse (RN) undertook a pre-operative anaesthetic screen with each patient; however, this was not documented in the patient records.
- The provider had not fully implemented the World Health Organisation (WHO) Surgical Safety Checklist. 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 use of the early warning score (EWS) to identify a deteriorating patient was inconsistent, although patients were monitored regularly following surgery. After our inspection the provider advised they had introduced a new format of the WHO checklist.
- 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).
- On the 23 January 2017, we asked the provider for a copy of their policy or procedure, which detailed the risk assessments or screening staff were required to perform. They were unable to provide this information.
- We reviewed six patient records and saw staff had not completed VTE risk assessments nor was there any documented evidence that staff had considered patient's psychological well-being.
- The provider had changed their medical screening form, to include a section for the RN to document the pre-operative anaesthetic screen. This required the RN to document the patient's blood pressure, weight, height and MRSA risk. However, we reviewed six patients' records and found staff had not completed this section for five of these patients. For one patient the old style document was present that did not include the section for RN to complete.
- The provider had incorporated the World Health Organisation (WHO) Surgical Safety Checklist into existing documentation that staff used in theatres. All elements of the WHO had been incorporated except for the American Society of Anaesthesiologists (ASA) grade, which is a system for assessing the fitness of patients before surgery. However, due to the provider's patient exclusion criteria all patients would be low risk. Following the inspection on 23 January 2017, the provider shared revised documentation with us, which indicated staff were now using the WHO Surgical Safety Checklist in its entirety.
- EWS 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. We saw in minutes of staff meetings from September and November 2016, staff had discussed the importance of using the EWS correctly. We reviewed six patients' records and saw that staff had recorded EWS appropriately.
- We saw evidence that the provider was working with the local acute NHS trust to formalise the existing agreement for a patient to be transferred to the local acute NHS hospital if their condition deteriorated, as required by the Independent Healthcare Advisory Services (2015).

Nursing and support staffing

Findings about nursing and support staffing are detailed in the report of the inspection carried out on 14 and 16 June 2016.

Medical staffing

Findings about medical staffing are detailed in the report of the inspection carried out on 14 and 16 June 2016.

Surgery

Emergency awareness and training

Findings about emergency awareness and training are detailed in the report of the inspection carried out on 14 and 16 June 2016

Are surgery services effective?

Evidence-based care and treatment

At the inspection on 14 and 16 June 2016, we saw:

- The provider had policies that referenced out of date material, or did not reflect current best practice.
- Staff did not always follow best practice guidance.
- The provider did not keep an easily accessible electronic record of implants as stated in the Department of Health Review of the Regulation of Cosmetic Interventions (2013) regulations.
- On the 23 January 2017, we reviewed numerous policies and saw these had been updated, and the provider had introduced new policies where needed.
- 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 being advised to starve from 12 midnight for an operation in the morning and from 12 midday for an afternoon operation.
- 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 may not be easily accessible.

Pain relief

Findings about pain relief are detailed in the report of the inspection carried out on 14 and 16 June 2016.

Nutrition and hydration

Findings about nutrition and hydration are detailed in the report of the inspection carried out on 14 and 16 June 2016.

Patient outcomes

At the inspection on 14 and 16 June 2016, we saw:

- The provider had no processes in place to collect performance measures and supply these to the Private Healthcare Information Network (PHIN). This is a requirement of the Private Healthcare Market Investigation Order (2014).
- The service did not collect any Q-PROMS information from patients. Q-PROMS are patient report outcome measures, which describe the level of patient satisfaction with certain operations. 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).
- On the 23 January 2017, we saw that the provider had taken steps to meet the requirement to collect and supply performance measures to PHIN.
- We saw the provider had collected patient reported outcome measures, using a standardised template, which reflected the RCS Q-PROMS.

Competent staff

Findings about competent staff are detailed in the report of the inspection carried out on 14 and 16 June 2016.

Multidisciplinary working

At the inspection on 14 and 16 June 2016, we saw:

- The provider did not directly communicate with the patients' GPs. This did not reflect recommendations made in the Review of the Regulation of Cosmetic Interventions (2013) which state that details of the surgery and any implant used must be sent the patient's GP.
- On the 23 January 2017, we saw the provider had introduced a standard letter, which was completed with the patient's individual details and sent to the patient's GP. We reviewed six patient records and saw a copy of this letter had been completed for all six patients.

Access to information

Findings about access to information are detailed in the report of the inspection carried out on 14 and 16 June 2016.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Surgery

Findings about consent, Mental Capacity Act and Deprivation of Liberty Safeguards are detailed in the report of the inspection carried out on 14 and 16 June 2016.

Are surgery services caring?

Compassionate care

Findings about compassionate care are detailed in the report of the inspection carried out on 14 and 16 June 2016.

Understanding and involvement of patients and those close to them

Findings about understanding and involvement of patients and those close to them are detailed in the report of the inspection carried out on 14 and 16 June 2016.

Emotional support

Findings about emotional support are detailed in the report of the inspection carried out on 14 and 16 June 2016.

Are surgery services responsive?

Service planning and delivery to meet the needs of local people

Findings about service planning and delivery to meet the needs of local people are detailed in the report of the inspection carried out on 14 and 16 June 2016.

Access and flow

Findings about access and flow are detailed in the report of the inspection carried out on 14 and 16 June 2016.

Meeting people's individual needs

Findings about meeting people's individual needs are detailed in the report of the inspection carried out on 14 and 16 June 2016.

Learning from complaints and concerns

Findings about learning from complaints and concerns are detailed in the report of the inspection carried out on 14 and 16 June 2016.

Are surgery services well-led?

Vision and strategy for this this core service

At the inspection on 14 and 16 June 2016, we found:

- The provider had not arranged for surgical cosmetic procedures to be coded in accordance with SNOMED_CT. This process uses standardised codes to describe cosmetic surgical procedures, which can be used across electronic patient record systems.
- On the 23 January 2017, we saw the hospital had recorded electronically cosmetic procedures in accordance with SNOMED_CT consistently since July 2016.

Governance, risk management and quality measurement

At the inspection on 14 and 16 June 2016, we found:

- 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.
- 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 provider had not made arrangements to ensure they were meeting the recommendations from the Review of Regulation of Cosmetic Interventions (2013).
- On the 23 January 2017, we saw the provider had taken steps to improve governance, risk management and quality measurement, but processes were not always robust or fully embedded. There was no formal risk register.
- We saw the provider had taken steps to review and update policies, and in the main, these were relevant and based on up to date practice. However, we saw, for example, responsibilities stated in the safeguarding policy did not reflect those of the organisation, which could lead to inappropriate processes being followed. The MRSA screening policy stated that patients who

were transferred into this hospital would be screened; however, the provider did not accept patients from other hospitals. We were therefore not assured policies reflected the needs of the organisation.

- Whilst the provider had taken steps to update policies regarding incident reporting, these polices were not embedded as there was a lack of clarity as to whose role it was to report incidents. We were not assured the provider was taking a proactive approach for continuous leaning and improvement.
- The provider had not completed the disclosure and barring service (DBS) check for the one member of staff we identified at the inspection on the 14 and 16 June 2016. However, following the inspection we saw evidence that the provider had started this process.
- The provider told us the one doctor who did not have evidence of indemnity insurance in their file no longer worked at the hospital.
- However, the provider had increased quality assurance, by introducing cleaning schedules and by the senior team performing regular spot checks of the environment and equipment.
- The provider demonstrated they were addressing the recommendations from the Review of Regulation of Cosmetic Interventions (2013).

Leadership / culture of service related to this core service

Findings about leadership / culture of service related to this core service are detailed in the report of the inspection carried out on 14 and 16 June 2016.

Public and staff engagement

At the inspection on 14 and 16 June 2016, we saw:

- That information available in patient rooms regarding cosmetic surgery and general anaesthetics was out of date. Additionally, patients were not directed to information about cosmetic surgery on the Royal College of Surgeons (RCS) website as advocated by the RCS professional standards for cosmetic surgery 2016.
- On the 23 January 2017, we saw signs on the reception desk, which encouraged patient to access information about cosmetic surgery on the RCS website.
- However, patient information available in patient rooms had not been updated. Information about undergoing an anaesthetic was from 2003. The information available regarding cosmetic surgery from 2005 and was published by the Healthcare Commission which preceded the Care Quality Commission (CQC). This meant patients may not have received up to date information regarding their care and treatment.

Innovation, improvement and sustainability

At the inspection on 14 and 16 June 2016:

- The provider had not considered how they were going to encourage, record and monitor Royal College of Surgeons (RCS) certification by surgeons who carry out cosmetic surgery. RCS cosmetic surgery certification was launched in 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.
- On the 23 January 2017, we saw the provider had produced guidance on this and could discuss the implication and action they were going to take.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The provider must ensure there is clear guidance as to which risk assessments and screening are required preoperatively for patients, and ensure these are performed.

Action the hospital SHOULD take to improve

- The provider should ensure systems and processes for incident reporting are embedded to ensure all incidents are reported, investigated and used to evaluate and improve practice.
- The provider should ensure all patient information is up-to-date.
- The provider should ensure they maintain an electronic register of implants, in line with the Review of the Regulation of Cosmetic Interventions (2013).
- The provider should ensure all policies are up to date guidance and reflect the needs of the organisation.
- The provider should continue to work with the local acute NHS trust to formalise the existing agreement for a patient to be transferred to the local acute NHS hospital if their condition deteriorated, as required by the Independent Healthcare Advisory Services.
- The provider should ensure the use of World Health Organisation (WHO) Surgical Safety Checklist is fully embedded.
- The provider should ensure staff receive appropriate safeguarding training.
- The provider should ensure fasting times for patients undergoing general anaesthetic reflect best practice.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 1(a) assessing the risk to the health and safety of service users receiving the care or treatment. **How the regulation was not being met** • There was no clear guidance as to which risk assessments and screening were required preoperatively for patients. • Staff did not assess patients for their risk of venous thromboembolism (VTE) or consider their psychological well-being preoperatively. • Preoperative checks, such as MRSA risk and blood pressure recording undertaken by the registered nurse as part of the pre-operative screening process had not been recorded.