

Look Younger Clinic

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

Ratings

Overall rating for this location

Are services safe?

Are services effective?

Are services caring?

Are services responsive?

Are services well-led?

Summary of findings

Letter from the Chief Inspector of Hospitals

Look Younger Clinic is operated by Bexhill Locum Services Limited. The service saw patients on a day care basis, there were no overnight beds. Facilities include one operating theatre, one consultation room and one procedure room.

The service provided cosmetic surgery for patients over the age of 18. We inspected surgery as a core service.

We received information of concern and as result we carried out an unannounced responsive inspection on the 13 June 2019.

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

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

Services we rate

Not rated overall.

We found the following areas of unsafe practice.

- The service did not control infection risk well. Staff did not use control measures to protect patients, themselves and others from infection.
- The design, maintenance and use of facilities, premises and equipment did not keep people safe. Staff did not manage clinical waste well and substances hazardous to health were not risk assessed and stored securely.
- Systems and processes for assessing and responding to risk were not effective. Staff had no systems in place to identify and quickly act on patients at risk of deterioration.
- The service did not have enough staff with the right training, skills and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- Staff did not keep an accurate and detailed records of patients care and treatment. Not all consultations were recorded.
- The service did not use systems and processes to safely prescribe, administer, record and store medicines. Some medicines were found to be out of date.
- The service had not recorded any patient safety incidents. Processes were not in place to investigate any clinical incidents.
- The service did not always provide care and treatment based on national guidance and evidence-based practice. It was not clear if staff had read the policies and there was no version control. There was no clear audit programme.
- Managers did not monitor effectiveness of care and treatment. This meant there was no way of assessing the quality of care or improving the service.
- The service did not always make sure staff were competent for their role. Managers did not appraise staff's working performance. There were no staff competencies.
- The provider did not operate effective governance processes throughout the service and safeguard high standards of care.

Summary of findings

- The service did not use systems to manage performance effectively. The provider did not identify, mitigate or manage risks in order to deliver a safe, effective service.
- Staff did not document their assessment of patients' pain or document when pain relief was given or how effective this was.
- The service had not developed a process for patients to feedback about their care.
- The service did not always take into account patient's individual needs. No adaptations had been made for patients living with a disability.

However, we also found the following areas of good practice.

- Staff worked together as a team to benefit patients.
- Staff supported patients to make informed decisions about consent to treatment.
- Staff treated patients with kindness.
- Staff involved patients and relatives in decisions about their care and treatment.
- Patients could access the service when they needed it.

Following this inspection, we took immediate enforcement action and suspended the service for a three month period. 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 three requirement notices that affected surgery. Details are at the end of the report.

Nigel Acheson

Deputy Chief Inspector of Hospitals

Overall summary

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery		Surgery was the main activity of the clinic. We did not rate this service.

Summary of findings

Contents

	Page
Summary of this inspection	
Background to Look Younger Clinic	7
Our inspection team	7
Why we carried out this inspection	7
Information about Look Younger Clinic	7
The five questions we ask about services and what we found	9
<hr/>	
Detailed findings from this inspection	
Outstanding practice	25
Areas for improvement	25

Look Younger Clinic

Services we looked at

Surgery.

Summary of this inspection

Background to Look Younger Clinic

Look Younger Clinic is operated by Bexhill Locum Services Limited. The service opened in 2015. This was the first inspection. It is a private cosmetic clinic in Sussex. The service accepts patient referrals from outside this area including international patients.

The clinic has had a registered manager in post since 2015.

The unannounced responsive inspection took place on the 13 June 2019.

Our inspection team

The team that inspected the service comprised of a CQC lead inspector, a CQC clinical fellow, and a specialist advisor with expertise in surgery. The inspection team was overseen by Catherine Campbell Head of Hospital Inspection.

Why we carried out this inspection

We carried out this inspection because we received information of concern and as result we carried out an unannounced responsive inspection on the 13 June 2019.

Information about Look Younger Clinic

The clinic is registered to provide the following regulated activities:

- Surgical procedures.
- Treatment of disease, disorder and injury.

During the inspection, we visited all areas within the Look Younger Clinic location. We spoke with three staff including the registered manager, medical staff and the practice manager. We spoke with one patient and one relative. During our inspection, we reviewed 12 sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection.

The clinic had not been inspected before.

As this was a responsive inspection the clinic did not submit any pre inspection activity data. On average the service saw one patient a day and on some working days had no patients. We were told the clinic had seen 160 patients in 2018.

The service had one lead doctor who carried out most of the procedures and was the registered manager. There was a second doctor and a practice manager.

Track record on safety

- There were no reported never events.
- Two clinical incidents, 0 no harm, 1 low harm, 0 moderate harm, 1 severe harm, 0 death, zero complaints.

Services accredited by a national body:

None

Summary of this inspection

Services provided at the hospital under service level agreement: None reported

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Are services safe?

This service was Not rated

- The service did not control infection risk well. Staff did not use control measures to protect patients, themselves and others from infection. The premises did not appear to be clean, there were no cleaning schedules available. Hand hygiene was poor. Personal protective equipment was not always used appropriately. In theatre we saw poor aseptic non-touch technique. Decontamination was not always done effectively, and no water flushing was taking place.
- The design, maintenance and use of facilities, premises and equipment did not keep people safe. Staff did not manage clinical waste well and substances hazardous to health were not risk assessed and stored securely. There were no current health and safety assessments resulting in hazards within the working environment. Resuscitation equipment was inadequate and not checked effectively. Some resuscitation medicines stock was out of date.
- Systems and processes for assessing and responding to risk were not effective. Staff had no systems in place to identify and quickly act on patients at risk of deterioration. Observations of the patient were not carried out during or after the procedure. Initial patient assessments were not completely documented. No safe surgery checklist was completed. No observed swab or instrument checks were made.
- The service did not have enough staff with the right training, skills and experience to keep people safe from avoidable harm and to provide the right care and treatment. There were no qualified nurses or operating department assistants employed.
- Staff did not keep accurate and detailed records of patients care and treatment. Not all consultations were recorded. There was concern about the accuracy of the documentation.
- The provider did not have systems and processes to safely prescribe, administer, record and store medicines. Some medicines were found to be out of date. There was no medicine policy in place. There was no medicines in place to manage local anaesthetic toxicity.

Summary of this inspection

- The service had not recorded any patient safety incidents but told us there had been two in the last year. Processes were not in place to investigate, learn from or prevent clinical incident reoccurrence. There was no documented evidence of shared learning and changes in practice.

Are services effective?

This service was Not rated:

- The service did not always provide care and treatment based on national guidance and evidence-based practice. It was not clear if staff had read the policies and there was no version control. There was no audit programme to monitor the quality of care delivered or to ensure best practice guidelines were followed.
- Managers did not monitor effectiveness of care and treatment. This meant there was no way of assessing the quality of care or improving the service.
- The service did not always make sure staff were competent for their role. Managers did not appraise staff's working performance. There were no records of staff competencies.
- Staff did not document their assessment of patients pain or document when pain relief was given or how effective this was.
- However, we found the following good practice.
- Staff worked together as a team to benefit the patient.
- Staff supported patients to make informed decisions consenting for their procedure.

Are services caring?

This service was **Not rated**:

- The service did not respect patients dignity. We observed a patient who was left exposed for long periods during the procedure.
- There was no process to capture the views of the patients who used the service. This meant the provider missed an opportunity to learn and improve the service.

However, we found the following good practice

- Staff treated patients with kindness.
- Staff involved patients and relatives in decisions about their care and treatment.

Are services responsive?

This service was **Not rated**:

Summary of this inspection

- The service did not always take into account patient's individual needs. No adaptations had been made for patients living with a disability. There was no access to a translation service.
- There was no assessment or pathway for patients to have a psychological assessment before surgery.
- There was no complaints recorded and we could not check that the policy would be followed.

However, we found the following good practice

- The service planned and delivered services to meet the needs of their patients.

Are services well-led?

This service was **Not rated**:

- The provider did not operate effective governance processes throughout the service and safeguard high standards of care. There was no oversight of patient outcomes or audits. There was no systematic approach to continually improve the service and safeguard standards of care.
- The service did not use systems to manage performance effectively.
- They did not always identify risks, planning to eliminate or reduce them.
- There was no clear vision and values in place.
- The provider did not always engage well with patients to plan and manage appropriate services.

Detailed findings from this inspection

Surgery

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are surgery services safe?

Mandatory training

- **The service provided mandatory training to all staff.**
- All three clinic staff had completed one day of mandatory training which included but was not limited to health and safety, basic life support, moving and handling and information governance. The one day introduced twelve mandatory topics and provided basic training only.
- The risk of staff not having sufficient training in key skills was not always recognised as none of the mandatory training was studied in any detail, for example, staff did not show an understanding of basic infection control practices and health and safety requirements.

Safeguarding

- **Systems and processes to protect patients from abuse were in place.**
- Staff had access to a safeguarding policy and contact details for the local safeguarding board were included within this policy. The policy had been put in place in 2015 and had a review date of 2019. There was no version control or ownership and it was not clear when the policy would be reviewed.
- Staff had received a basic introduction to safeguarding on their mandatory training day.
- Staff knowledge about safeguarding was basic but they were aware of the need to report any concerns. There had been no safeguarding referrals made.

Cleanliness, infection control and hygiene

- **The service did not have effective systems in place to protect patients against cross infection.**
- The environment did not appear clean. Dust was seen in the hallways and procedure room. The consultation room had dust on high and low surfaces. Wall mounted cupboards on the first floor landing could not be closed due to the condition of the doors. The inside of these cupboards were thick with dust.
- In the procedure room and theatre, there was no coving which meant the flooring was not compliant with the Department of Health's Health Building Note (HBN) 00-09: Infection control in the built environment. In clinical areas there should be a continuous return between the floor and wall to allow for easy cleaning.
- The hallway from theatre to the toilets had carpet which could not be easily cleaned when spills occurred. Department of Health's Hospital Building Note (HBN) 00-09: infection control in the built environment states 'Spillage can occur in all clinical areas, corridors and entrances' and 'in areas of frequent spillage or heavy traffic, they can quickly become unsightly'. During the procedure we observed the patient walking from theatre to the toilet and leaking fluid from wounds was seen running into the carpet.
- There were no cleaning schedules available. The cleaning was carried out by the practice manager and doctor using a detergent and chlorine disinfectant. We were told this was done on a daily basis and in theatre after each patient, however there were no records of this. There were no cleaning audits.
- There was an environmental infection prevention and control audit carried out between 2017/2018. This showed actions needed to be taken for example to ensure staff had access to appropriate personal

Surgery

protective equipment (PPE) including visors. There was no action plan and no visors were seen to be used by staff. Audits are important to assess the measures put in place to provide a safe and clean environment.

- Alcohol-based hand gel was located in theatre but was not always used consistently. For example the doctor gelled his hands but put on non sterile disposable gloves before letting his hands dry properly. On another occasion there was no gelling of hands prior to putting gloves back on. This was not in line with policy or best practice. In addition, we observed that no staff challenged other staff members who did not clean their hands correctly.
- There were hand hygiene posters however it did not inform staff how to use the gel. No hand hygiene audits were carried out.
- There was access to personal protective equipment such as gloves and aprons, but these were not always used correctly. We saw a staff member use the same pair of gloves when they were answering the phone and when leaving the operating room to answer the door. Gloves can transfer bacteria in the same way hands can, this meant as staff did not remove their gloves to answer the phone or door, there was potential for cross infection. We saw that no staff challenged other staff who were wearing personal protective equipment incorrectly.
- We observed good scrub technique by the operating doctor.
- In theatres we saw poor aseptic non-touch technique (ANTT). One member of staff put on non sterile gloves and put a sterile drape on the trolley. There was good asepsis in setting up the trolley and disposables, but the same pair of gloves touched the bin and door as well as the trolley. There was constant touching of waste bin throughout with hands rather than using foot pedal.
- Staff did not monitor the use of swabs during the procedure. Dirty swabs were put back onto the clean trolley. Dirty swabs were put into the bin during the procedure by the doctor and no count was seen to be made.
- Staff did not follow the National Institute for Health and Care Excellence (NICE) guideline (CG)74, Surgical Site Infection. There was inadequate cleaning and draping of the operative area. Staff were seen to be applying then reapplying drapes with non sterile gloves.
- We observed a syringe being used at least twice to inject into the bag of fluid. This is a single use item. On a second occasion the needle was used four times in succession to inject fluid under the surface of the skin. The needle was re sheathed afterwards.
- Decontamination of reusable surgical instruments was completed on site. The decontamination process achieved compliance but the lack of a dedicated dirty to clean flow and the location of the washer drier in the kitchen area and the lack of a hand wash basin were significant concerns.
- The decontamination room was located close to the theatre room and adjacent to the kitchen. The doctor had completed a decontamination course and oversaw all aspects of the process.
- The decontamination room contained an ultrasonic bath used to start the instrument cleaning process before instruments were put into the washer disinfectant which was located in the kitchen area.
- The instruments were then brought back into the decontamination room to go into one of the two steam sterilisers. The validation book was compliant with the daily and weekly testing requirement in line with HTM01/05. The instruments were dried and stored in line with requirements.
- We asked about the magnifying glass which is part of the requirement HTM01/05 to inspect the instruments for any debris but this could not be located.
- Two small autoclaves were located in the decontamination room. The compliance log book was fully completed and the service report for this equipment was in date.
- Random checks of decontaminated equipment were made and two were found to have expired in February and September of 2018. This meant the service could not guarantee the integrity of instruments.
- In theatres there was a fridge not used for drugs and the freezer section was used solely for ice packs. We saw ice

Surgery

packs being used from the freezer to numb the patients skin. Gel ice packs were not decontaminated appropriately, they were cleaned with clinical wipes before being applied directly onto the skin after skin prep had been done. After use they were cleaned in the hand wash sink and wiped with a clinical wipe before being put back into the freezer.

- Needles were not disposed of in line with best practice. We observed re sheathing of needles and sharps not disposed of at point of use. When needles were removed the skin was not cleaned with a swab which meant fluids leaked onto the sheet underneath the patient.
- No water flushing was taking place. Taps need to be flushed two to three times a week to prevent pseudomonas and legionella. Low use tap flushing is covered under Department of Health and Social Care: (HTM 04-01). There was no designated water safety advisor and no water testing was taking place.
- Staff wore theatre scrubs and were bare below the elbows to prevent the spread of infections in accordance with national guidance. In theatres staff did wear theatre scrubs, aprons and gloves but did not wear masks or sterile gowns.

Environment and equipment

• The design, maintenance and use of facilities, premises and equipment did not keep people safe.

- The clinic was located in a Georgian building in the town centre. The front door to the building was secured by a key pad and any visitors to the clinic would use an intercom to speak to staff and gain access. The clinic was located on the first and second floor of the building.
- The first floor and half landing gave access to rooms for consultation, theatre, decontamination and kitchen. Also, storage cupboards and two single sex toilets. The second floor and half landing gave access to a room for procedures, a staff room and spare room. There was no lift.
- A fire risk assessment of the clinic had been completed by a third party June 2019. There was an action plan which included clearing certain areas of the building to ensure all relevant persons could be evacuated safely. There was evidence that some actions from the plan

had been actioned including repairs to the fabric of the building, some areas of the clinic being cleared and evidence that a carbon dioxide monitor had been ordered.

- Two fire extinguishers located on the first and second floor were in date. No fire evacuation training or planning had been carried out and this was picked up on the fire report to be actioned.
- The room labelled as a theatre had a scrub area, but no recovery attached. All patients had their procedures done under local anaesthetic and if necessary could rest and recover in the consultation room located next door.
- The consultation room had a desk, chair, a bed and assorted furniture. In this room a plug with trailing wires was a potential trip hazard. This was positioned under the water fountain and posed a hazard to water splashing as there was no drip tray. This was a potential electrocution risk and was brought to the attention of the staff during the inspection.
- There was no resuscitation trolley but there was a box in theatre containing a range of needles and one cannula and infusion set to administer medications directly into the vein. There was a limited range of equipment to maintain a patients airway, there were airways from baby to adult size, and an adult face mask this was the only means of administering oxygen if required.
- The box contained a bag of intravenous fluid (Gelofusin) that expired in 2017, the only medication it contained was injectable adrenaline. There was an information sheet on chlorphenamine but no medication. When asked about the doctor said it was a mistake missed by the check.
- There was an automated defibrillator. There were records of monthly checks of the resuscitation equipment and since August 2018 until the date of the inspection. The checks had been made by the same member of staff. This did not give assurance that all clinic staff were involved in checking equipment or were knowledgeable of the equipment stored there. Nor did it give us assurance the checking process was undertaken in a meaningful way to identify expired items.
- We did not see any information, such as the Resuscitation Council algorithms, available to follow in the case of an emergency.

Surgery

- The air conditioning unit that supplied the theatre room had a ducting system that extended from the theatre through the consultation room out to the rear of the property. The system was new and dust free, but it was noted that it was poorly sealed.
- No risk assessments were completed of hazardous substances (COSHH). Washer detergent was stored on a shelf in the decontamination room, the room was secured by a key pad.
- Three of the rooms on the premises did not contain a sink for hand washing. This included the decontamination room, consultation room where patients would be cared for pre and post operatively. The procedure room had no sink and staff told us this room might be used for minor surgical procedures.
- A glass cabinet containing stock items in the corridor was unlocked. Ten random stock items were checked, and all items were in date.
- In the procedure room two pieces of sterile equipment including a retractor had expired in September and February of 2018. A random stock check in theatre found 11 pieces of equipment to be out of date. Four probes which expired in Dec 2017 and seven retractors expired in 2018. There was a water bath in theatre to warm bags of fluids. This had been serviced.
- We were told that the kitchen area was not used to prepare hot drinks for the patient. This area would be non compliant to provide this service with the washer disinfectant located there. In addition, the storage of cleaning mops in the kitchen and the lack of a hand wash sink would make this non compliant with environmental health and food hygiene regulations.
- There was a warming blanket for patients in place, we did not see this used. There was a water bath in theatre to warm bags of fluids. All equipment had been serviced and was next due in June 2020. The service had a contract in place for the testing of electrical equipment and this had been completed recently.
- There was no sharps policy and in theatres the sharps bin was not appropriate for the clinic as it was orange topped which is for blades and blood taking. It should have been a yellow lidded bin for the disposal of sharps and medication.
- There was no evidence of adherence to EU directive 2010/32/EU Prevention from sharps injuries in the hospital and healthcare setting May 2010. Staff should have introduced blunt drawing up needles.
- There was no waste policy and we observed poor streaming of waste with clinical and general waste not clearly identified and disposed of separately. This meant the service was non-compliant with HTM01/07 the management and disposal of healthcare waste.

Assessing and responding to patient risk

• **Systems and processes for assessing and responding to risk were not effective.**

- There was no set criteria or policy for selection of people who used the service. The doctor made a clinical judgement based on the information obtained at the first assessment of the patient. This appointment would be with the operating doctor. We were told a patient history would be taken and the patient would be asked to see their own GP to arrange for a blood test to check their blood count and kidney function. We did not see evidence of these tests within the patient records.
- The patients were asked to arrange for an abdominal scan before surgery was undertaken, to rule out any abnormalities such as a hernia that might complicate surgery. Patients would be put in contact with a private clinic for this to be completed.
- The doctor was asked to demonstrate evidence of his assessment of new patients and we saw an email that was sent to patients following the initial appointment. This contained limited information. The doctor was unable to provide any clinical records to demonstrate assessment of full medical history, social history, an examination or discussion of the patient's concerns, views and expectations. When asked about this we were told the service did not document patient assessments because this could then be disputed by patients.
- Patients were given information on the potential risks of a procedure. For liposuction the risks included pain, hair loss, allergic reactions and the possibility of infections. Documentation around risk was signed by the patient. The patient told us they were given clear information about risk before any procedure.
- The Look Younger Clinic website advertises the brazilian buttock lift (BBL) procedure. We were made aware of the

Surgery

British Association of Aesthetic Plastic Surgeons (BAAPS) statement (03/08/2018) regarding this procedure prior to the inspection. BAAPS distributed a recommendation to all members, that due to the possible complication an embolism (a clot of fat) and a potentially fatal outcome for patients, they should refrain from performing BBLs, at least until more data is available. When asked, the doctor stated that during the procedure they did not inject the fat into the muscle and subsequently it did not carry the same risk.

- We were concerned that patients were put at risk at the time of surgery because of the lack of safety measures and systems in place to mitigate this. On the inspection, we observed a liposuction procedure performed by the doctor and assisted by the HCA (approximately 5 hours duration) and identified a number of areas of concern.
- Both doctors, undertaking surgery, did not have an up to date qualification in intermediate or advanced life support. This was not in line with current standards and guidance by the Academy of Medical Royal Colleges.
- Operating areas were marked but staff did not carry out the World Health Organisation (WHO) 'Five Steps to Safer Surgery' check list at the start or end of the procedure. When asked about this the doctor said that it was not done because they discussed the patient the day before. The WHO check list is a national core set of safety checks for use in any operating theatre environment.
- A surgical swab and instrument count were not carried out during or at the end of the procedure. When asked about and the operating doctor said that it was not done because the incisions were too small for a retained foreign body.
- There was no monitoring of patient observations during the procedure and no use of the national early warning score (NEWS) tool, which was used across the service to monitor the patient and to identify patients at risk of unexpected deterioration in line with National Institute for Health and Care Excellence (NICE) Guidance.
- In the case that we observed, the patient's blood pressure and heart rate was taken once pre-operatively. No observations were taken either intra operatively or post operatively prior to discharge. When asked about this staff told us that it was because the patient was awake throughout the procedure and therefore would be able to report any symptoms such as a 'tachycardia', a fast heart rate.
- We were concerned about the skills and expertise of the practice manager assisting the doctor and their ability to support in the care of a deteriorating patient. When they were asked about how they would take patient observations they were unaware of what respiratory rate was and how this was measured.
- We observed that it was halfway through the procedure that the patient was asked about any allergies. This should be checked at the start of any procedure.
- Procedures were done under local anaesthetic; general anaesthetic was not used. The consultant surgeon told us he would ring the emergency service if needed, if sepsis was suspected the service would refer the patient to the accident and emergency department. There was no sepsis policy in place.
- During the procedure tumescent local anaesthesia was used. This is the administration of diluted local anaesthetic in large volumes just under the surface of the skin which results in tissues becoming firm and tense. A slow infiltration is recommended to decrease patient discomfort during administration of tumescent local anaesthesia.
- At times during the procedure, both the doctor and practice manager left the operating room without explanation, leaving the patient unattended except for a member of the CQC inspection team who was observing. This meant that nobody was monitoring the fluids being given to the patient.
- We were told that the surgeon would refer the patient to the local hospital if they were not fit for discharge. There was no formal agreement in place.
- At the time of our inspection, it was not standard process to refer patients back to their GP or to advise the patients' GP of any procedures to ensure consistency of care. We raised this with the registered manager who told us patients were asked but in nearly all cases they did not want their GP to be informed. This conversation was not documented in the patient records.

Surgery

- The resuscitation policy stated that in the case of patient collapse the staff would call the emergency services.

Staffing

- **The service did not have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.**
- The service did not employ any registered nursing staff or operating department practitioners (OPDs) to support during cosmetic surgical procedures at the time of our inspection.
- During cosmetic procedures, such as liposuction, three staff members and the patient were in theatre. The surgeon completed the surgery and was assisted and supervised by a second doctor. The practice manager fetched equipment and other supplies and supported the patient.
- No locum medical staff were used. The service did not use bank or agency staff.

Records

- **Staff did not keep an accurate and detailed records of patients' care and treatment.**
- Records were stored in a locked filing cabinet in the corridor on the second floor and the registered manager held the keys. Patient access to this floor was limited to one consultation room which we were told was rarely used.
- During the inspection we looked at a random selection of 12 patient notes and we noted the following. On the 19, 20 and 23 April 2018 we noted three patient records showed the same pulse and blood pressure recorded on admission to the clinic. It appeared there was one patient each day.
- The next three working days the 24, 25 and 26 April 2018 three patient records had the same blood pressure recording and two had the same pulse recording. In November 2018 on the 2, 6, 14, 18 (2 patients) and 25 November all patients had the same pulse and blood pressure recorded.
- We asked the operating doctor about these observations at the time of the inspection and we were

told records were completed on the computer and the template may not have cleared correctly before entering the data. This was not in line with RCS Professional Standards for Cosmetic Surgery 2016 which states doctors must maintain accurate, clear, legible, comprehensive and contemporaneous records.

- Patient records were typed and contained limited patient identifying information. They contained information on the patient history, a brief patient assessment and risk assessment, the consent and clinical procedure undertaken. The patient's weight was not recorded.
- There was no documentation of a medical assessment and examination at initial consultation only an email was seen that showed the patient had attended for an initial consultation. Patients were advised to see their GP to discuss the procedure with them. There was no record of whether this had taken place.
- We were told no discharge letter was sent to the GP as most patient's chose not to inform their GP of the procedure. There was no record of this conversation with the patient. This was not in line with guidance NICE QS:15 statement 12: patients experience coordinated care with clear and accurate information exchange between relevant health and social care professionals.
- On all patient records it was documented that a swab count had been performed however during the inspection we did not observe any swab count taking place.

Medicines

- **The service did not use systems and processes to safely prescribe, administer, record and store medicines.**
- No medicine policy was in place at the service this meant there was a risk that medicines were not managed consistently within the service and practices varied.
- At the time of inspection, we did not observe any documentation or prescription for some of the medicines given to the patient. We did not see any documentation of analgesia given before, during and after the procedure.

Surgery

- There was some documentation on the operation note of medicines used as part of the liposuction procedure such as the local anaesthetic and the solution used to dilute this.
- The local anaesthetic was checked by the two doctors before dilution and administration.
- We saw the giving set used to give the local anaesthetic was not properly primed before being connected to the patient.
- No measures to manage local anaesthetic toxicity were in place in the service. The administration of too much local anaesthetic can lead to toxicity causing severe consequences such as arrhythmias and cardiac arrest. The Association of Anaesthetists of Great Britain and Ireland guidance on this topic was not being followed.
- An oxygen cylinder was in place and in date. A second cylinder was seen to be freestanding outside the theatre. It was not secured to the wall and there was a risk to both patients and staff that this might fall and cause an injury.
- We found one bag of infusion fluid, Sodium Bicarbonate expired August 2017, this was brought to the attention of the doctor at the time of the inspection and it was removed from use.

Incidents

- **The service had not recorded any patient safety incidents. Processes were not in place to investigate any clinical incidents.**
- There was no evidence of an adverse incident log.
- Before the inspection the clinic had reported a serious patient incident to CQC. A root cause analysis of the incident was submitted but this was not on a templated document and did not follow a methodical logical investigation. The doctor took the decision to no longer perform this type of procedure. It was not clear if duty of candour had been applied as this was not documented.
- The doctor told us there had been one other low risk incident, but this was not clearly documented.
- The surgeon told us that he discussed any incidents or near misses with his staff however there was no evidence of this.

- There was no incident or duty of candour policy in place.

Safety Thermometer (or equivalent)

- **Staff did not routinely collect safety information and share it with staff, patients and visitors**
- Venous thromboembolism assessments (VTE) were not routinely completed. Venous thromboembolism is a condition in which a blood clot forms in a vein. Patients could spend several hours undergoing a cosmetic procedure, placing them at risk of a blood clot.
- If patients gave a previous history of blood clots they were provided with special compression stockings. Compression stockings are used before and after surgery to prevent blood clots developing in the leg.

Are surgery services effective?

Evidence-based care and treatment

- **The service did not always provide care and treatment based on national guidance and evidence-based practice.**
- There were some policies in place, but these were not always relevant to the service. Policies appeared to be prepared by a third party and there was no named ownership or version control. At the bottom of the page there was a sticker that stated the policy had been reviewed in 2019 but it was not clear who had completed this review.
- There was a list at the front of the policy file for staff to sign that they had read and understood the policies but there was only one signature of the lead doctor. This meant it was unclear whether staff had read or were following the policies.
- Effective systems were not in place to audit compliance with national guidance and evidence of its effectiveness. Audits were limited and completed on an ad hoc basis, and there was no clear audit programme.
- The operating doctor told us that he discussed any concerns and patient outcomes with other doctors undertaking similar procedures, these doctors were based abroad so much of the communication was done on line. There was no written confirmation of these discussions.

Surgery

Nutrition and hydration

- **Staff gave patients enough food and drink to meet their needs and improve their health.**
- Staff provided patients with refreshments bought in from local shops. The patients were given fluids and sandwiches if necessary. We were told that no food or hot drinks were prepared on site.
- All patients had their procedure done under local anaesthetic, so no patients were nil by mouth.

Pain relief

- **Staff did not assess or monitor patients effectively to see if they were in pain.**
- We saw that on arrival the patient was given one oral pain relieving tablet and during the procedure was given a further two tablets.
- The patient was given the same tablets on discharge, but no information was given of possible complications. There was no record made in the patient records of the drug given.
- We observed staff did not always check with the patient that the local anaesthetic had worked before inserting instruments and needles into the abdomen.
- On occasions the patient told us they were not in pain when the needles were inserted but the nonverbal actions implied they were in discomfort during part of the procedure. There was no standardised pain scoring tool in place.

Patient outcomes

- **Managers did not monitor effectiveness of care and treatment and use the findings to improve the service. They did not compare local results with those of other services to learn from them.**
- Staff told us they did not document patient outcomes but told us that out of the 160 procedures completed in 2018, there were two cases developed infections post procedure.
- One patient developed sepsis following discharge from the clinic. The doctor was aware of this and had reviewed his practice and no longer carried this procedure. He had reported this case to CQC.

- Staff told us that they used patient feedback as an outcome measure. However, we did not see a policy, process or written documentation to demonstrate this.
- The service did not take part in any benchmarking, peer reviews or research. It did not routinely collect and report on patient reported outcome measures (Q-PROMs) for patients receiving liposuction procedures. Completion of PROMs pre- and post-operatively allows for patient's own measurement of their health and health related quality of life and how this has been changed by surgical intervention.

Competent staff

- **The service did not always make sure staff were competent for their roles. Managers did not appraise staff's work performance.**
- Staff had access to a training policy which referred to annual appraisals for staff, but one staff member had not had an appraisal in the five years they had been employed at the clinic. The second medical staff member had only recently joined the staff fulltime.
- The role profile for practice manager was not sufficiently detailed in outlining her scope of practice. This staff member had previously worked as a healthcare assistant and we saw actions being taken that were not supported by a competency assessment.
- The doctor was registered with the General medical Council (GMC) but was not on the specialist register. He was currently supervised by the second doctor employed by the clinic which was a temporary requirement of his registration to practice. He did have a named responsible officer.
- The surgeon had Membership of the British College of Aesthetic Medicine. There was evidence that he had undergone some observational training relevant to specialty on four occasions in the last two years.

Multidisciplinary working

- **Staff worked together as a team to benefit patients.**
- The two doctors and practice manager worked together well to support the patient attending the service.

Seven-day services

Surgery

- The service was open five days a week from 9am to 5pm, later if a patient was still recovering from the procedure. There was occasional opening of the service on a Saturday depending on patient demand.

Health promotion

- We did not inspect this aspect of the service as this was a responsive inspection.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- **Staff supported patients to make informed decisions about their care and treatment.**
- Following their initial enquiry patients attended the clinic for an appointment to discuss the procedure with the operating doctor. Information about the procedure and risks were available in hard copy to discuss and would then be sent to the patient electronically for them to print, complete and sign.
- Following a fourteen-day cooling off period the patient would confirm their consent and attend for any treatment. Patients signed consent forms prior to any procedures.
- The patient records did not provide date evidence of the two separate consultations. We were told this information was stored electronically but staff were unable to demonstrate this to us. All consent forms seen were signed by the patient but not by the doctor and this was brought to his attention at the time of the inspection.
- An audit of consent had been completed between January and April 2019 and 72 patients were included showing that a two stage consultation and consent was completed for 100% of patients.
- We saw a consent form was signed by patients to have photos taken for the medical records.
- We were told verbal consent would be taken during the procedure if the doctor wanted to video the procedure and put on the website. An email would be sent post procedure with a link to the video. Patients would be emailed to ask them if they could use the photos for the website. A positive response from the patient would be considered as consent.

- The patient undergoing a procedure on the day of inspection stated that she understood both what was to be done and possible complications.

Are surgery services caring?

Compassionate care

- **Staff treated patients with kindness.**
- Feedback from the patient on the day of inspection confirmed they were looked after with kindness. This was their second visit to the clinic, they returned as there had been no problems following the previous procedure and they were satisfied with the outcome.
- We did see that staff introduced themselves to the patient and when a second doctor entered the room he asked the patient's permission to be present in the room.
- We observed a patient undergoing a procedure and their privacy and dignity was not always respected by staff as they were left exposed for long periods of time. Staff did not check how the patient was feeling being so exposed.
- The clinic did not complete a patient satisfaction survey.
- Positive patient testimonials were published on the website. The clinic kept a file of cards and emails from patients praising the professionalism and kindness of the staff.

Emotional support

- **Staff did not always provide emotional support to patients.**
- During the procedure the patient was left for periods of time whilst the doctor and HCA left the theatre room. No information was given to the patient as to why they were being left and nothing was said to the inspector present either.
- Patients were not contacted on the day following the procedure, but they were given the contact details for the surgeon and told to make contact if they had any concerns.

Understanding and involvement of patients and those close to them

Surgery

- **Staff involved patients and families in decisions about their care and treatment.**
- Staff communicated with patients, so they understood their procedure. Good explanation given of what was to happen and how the patient would feel.
- We did not observe a discussion with the patient about the cost of the procedure, but all patient notes held a record that this conversation had taken place.
- The next of kin was allowed to be with the patient at the completion of the procedure and was present in the procedure room.

Are surgery services responsive?

The service planned and delivered services to meet the needs of their patients.

- The service was open Monday to Friday 9am to 5pm and occasionally on a Saturday depending on patient demand.
- The service was located on the first and second floor of a Georgian house which meant stairs and hallways were narrow and not wheelchair accessible from the ground floor. There was no lift at the premises which meant certain patients living with a disability would not be able to access the clinic.
- The surgeon informed us that he was coming to the end of the lease on this property and had identified a new premise that would be more accessible and appropriate and was looking to move there at the end of the year.

Meeting people's individual needs

- **The service did not always take account of patient's individual needs.**
- There was no specific support for patients living with a learning or other disability. There was a wheelchair located by the theatre room, for patients that might need assistance from theatre to the toilet. However as there were steps within the hallway it was hard to see how the wheelchair could be used.
- There were single sex toilets available but neither of these were adapted for patients living with a disability.
- There were no leaflets available in different languages and no access to a translation service.

- There was no bariatric equipment in place. We were told that given the nature of the surgery bariatric patients would not be seen as appropriate for the specialised surgery carried out at the clinic. However, when assessing a patient's suitability for surgery there was no specified body mass index limit suggesting that bariatric patients might be accepted for surgery.
- There was no formal documented psychological assessment of patients undergoing cosmetic surgery. The doctor told us that an assessment would be carried out informally at the initial assessment. There was no formalised pathway for patients requiring psychological support. We were told that this was being developed.
- Post operatively the patient would stay in a hotel overnight, accompanied by someone at their own arrangement.
- A follow up appointment was arranged six weeks after surgery, we were told that only 40% to 50% of patients would attend this appointment.

Access and flow

- **Patients could access the service when they needed it.**
- All patients self-referred to the clinic and booked their first appointment by email or telephone. Patients could get appointments quickly and at a time to suit them.
- The operating doctor would arrange to see all patients, so appointments were not cancelled.
- Patients had access to a central telephone number for the clinic, this was available Monday to Friday 9am to 5pm.

Learning from complaints and concerns

- **There was a complaints policy in place. There had not been any official complaints to review.**
- The policy set out timelines for feedback to the complainant but there were no formal complaints to review to see if the policy had been followed. Staff told us that all complaints would be responded to within a few days.

Are surgery services well-led?

Leadership

Surgery

- **There was a small team who identified the registered manager as the leader of the service.**
- Looking Younger was a small location with three members of staff. The registered manager who was the doctor had worked with the practice manager for five years. The third member of staff, a second doctor who had worked on an occasional basis up until two weeks before the inspection was now employed full time.
- The lead doctor took responsibility for the all aspects of the clinic with the other staff supporting him.
- The staff worked closely together. There were no recorded team meetings.

Vision and strategy

- There was no clear vision and values in place. However, the registered manager told us they hoped to grow the service and move into a more appropriate environment by the end of the year.

Culture

- All patients attending the clinic were issued with a copy of the terms and conditions of the service and information on cost and methods of payment.

Governance

- **The provider did not operate effective governance processes, throughout the service and safeguard high standards of care.**
- There were no formal governance meetings or any oversight of patient outcomes or feedback. There was no benchmarking of practice. It was noted that any changes of practice for example stopping the use of antibiotics was decided by the doctor with no documented rationale.
- There was no oversight of any audits undertaken, of which there were very few. There was no clinical audit plan in place.
- Policies were limited and not always appropriate to the service, these were not reviewed or updated in line with current guidance.
- There was no system in place to identify what training was required for the different staff and highlight when training was out of date.

- There were no clear processes or policy setting out who would investigate clinical incidents should they occur and how impartiality would be maintained, and oversight ensured.

Managing risks, issues and performance

- **The service did not use systems to manage performance effectively. They did not always identify risks, planning to eliminate or reduce them and so running a safe service.**
- There was no clear policy in place identify when serious incidents occurred how this would be processed and managed and lead to improvements and a safe service.
- There were no emergency generators in place in the case of failure of essential services. There was no business continuity plan.
- There was no risk register. The registered manager identified the main risks as the potential risk of a patient having a cardiac arrest, the poor state of the environment and the difficulty of completing decontamination on site. However, this what not clearly documented with risk assessments and plans to reduce or eliminate this risk.
- The registered manager did not always recognise the risks within the service. For example, the lack of resuscitation equipment and medicines, also the lack of intermediate life support training for the medical staff. Additionally, the risk around staff competencies, the monitoring of patient condition and the accessibility to the patient in theatre in the case of an emergency.
- There were no environmental or infection prevention and control audits were carried out. We were therefore not assured the service monitored their systems and used results to improve patient safety.

Managing information

- We did not inspect this aspect of the service as this was a responsive inspection.

Engagement

- **The provider did not always engage well with patients to plan and manage the service.**

Surgery

- The clinic website was clear and easy to follow with information about the procedures, before and after pictures, videos and information about all the staff members.
- Effective processes were not in place to engage with patients. We were told the service was in the process of developing an online feedback facility, but this was not yet established.

Learning, continuous improvement and innovation

- **There was limited evidence that the service was committed to learning and continuous improvement.**
- The service did not take part in learning from external review including those relating to mortality and death.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **MUST** take to improve

- The provider **must** ensure all staff have completed all mandatory training and that it is up to date, including the appropriate level of life support.
- The provider **must** ensure all staff have regular appraisals.
- The provider **must** ensure all staff are trained and knowledgeable in infection prevention and control and deliver safe care.
- The provider **must** ensure the premises is fit for purpose, is kept clean and cleaning must be done in line with current legislation and guidance.
- The provider **must** ensure storage of resuscitation equipment is secure and tamperproof and contents are in line with current guidance
- The provider **must** ensure the use of an appropriate National Early Warning Score (NEWS) tool to ensure patients' deterioration is recognised at the earliest opportunity and that staff are trained in its use.
- The provider **must** ensure all staff have the appropriate training, knowledge, skills and competencies to provide safe care and treatment and to be able to provide the appropriate level of support in an emergency in line with current guidance.
- The provider **must** ensure all substances hazardous to health are risk assessed and stored securely.
- The provider **must** ensure waste is handled safely and in line with guidance.
- The provider **must** ensure appropriate safety checks are carried out prior to and during any surgical procedure.
- The provider **must** ensure a risk assessment is in place setting out the safe transfer of patients from the operating theatre to an ambulance in the case of an emergency. Any advice received from the ambulance service or others should be clearly documented and recorded.

- The provider **must** ensure that patient records are accurate and record every part of the patient journey.
- The provider **must** ensure medicines are prescribed, administered, recorded and stored securely.
- The provider **must** ensure effective processes are in place to investigate clinical incidents and complaints should they occur. It is also important that the person identified to complete such investigations has the skills and knowledge necessary to do so.
- The provider **must** ensure policies and procedures are version controlled and contain review dates.
- The provider **must** ensure systems are in place to audit compliance with national guidance and there is a clear programme of regular audit including clinical audit.
- The provider **must** ensure staff monitor patients effectively to see if they are in pain.
- The provider **must** ensure patient outcomes are audited and recorded.
- The provider **must** consider how the service could be benchmarked in relation to other services.
- The provider **must** ensure the staff take into account patient's individual needs.
- The provider **must** ensure a working system is in place to recognise, assess and manage risks.

Action the provider **SHOULD** take to improve

- The provider **should** have an appropriate method of recording staff training and processes to identify when training has expired.
- The provider **should** complete and record regular hand hygiene audits.
- The provider **should** have processes to liaise with the patients' GP to ensure consistency of care.

Outstanding practice and areas for improvement

- The provider **should** ensure regular, planned team emergency scenario training takes place at the service so all staff know how to work together in the service environment if a medical emergency was to happen.
- The provider **should** ensure staff understand their duties in relation to duty of candour and policies are drawn up to reflect this.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment <ol style="list-style-type: none">1. Care and treatment must be provided in a safe way for service users.2. Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include<ol style="list-style-type: none">a. assessing the risks to the health and safety of service users of receiving the care and treatment;b. doing all that is reasonably practical to mitigate any such risk;c. ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely;d. Ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way;g. the proper and safe management of medicines.h. assessing the risk of, and preventing, detecting and controlling the spread of infections, including those that are health care associated.

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance <ol style="list-style-type: none">1. Systems and processes must be established and operated effectively to ensure compliance with the requirements in this Part.

This section is primarily information for the provider

Enforcement actions

2. Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to
 - a. assess, monitor and improve the quality and safety of the services provided in carrying on of the regulated activity (including the quality of the experience of the service users in receiving those services);
 - b. assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;
 - c. maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

Regulated activity

Surgical procedures
Treatment of disease, disorder or injury

Regulation

- Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment
1. All premises and equipment used by the service provider must be
 - a. Clean
 - b. Suitable for the purpose for which they are being used
 - e. properly maintained, and
 2. The registered person must, in relation to such premises and equipment, maintain standards of hygiene appropriate for the purposes for which they are being used.