Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Healthcare Inspection (announced)

HQ Hair transplants, Cardiff

Inspection date: 08 March 2021

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that people in Wales receive good quality healthcare

Our values

We place patients at the heart of what we do. We are:

- **Independent**
- **Objective**
- **Caring**
- **Collaborative**
- **Authoritative**

Our priorities

Through our work we aim to:

Provide assurance:	**Provide an independent view on the quality of care**
Promote improvement:	**Encourage improvement through reporting and sharing of good practice**
Influence policy and standards:	**Use what we find to influence policy, standards and practice**

1. What we did

Healthcare Inspectorate Wales (HIW) completed an announced inspection of HQ Hair Transplants on the 08 March 2021.

Our team, for the inspection comprised of two HIW inspectors.

HIW explored how the service complied with the Care Standards Act 2000, requirements of the Independent Health Care (Wales) Regulations 2011 and met the National Minimum Standards for Independent Health Care Services in Wales.

In February 2021, a remote quality check was undertaken of the service. This quality check identified a number of serious concerns about the safety and management of the service. As a result, the service's registration was suspended until a full on-site inspection could be undertaken.

The inspection report below details the findings of the on-site inspection, however throughout this report reference is made to the findings from the quality check. The report from the quality check is provided as an annex to this report and can be found after the improvement plan section.

Further details about how we conduct independent service inspections can be found in Section 5 and on our website.

2. Summary of our inspection

Overall, we were assured that the service was able to provide safe and effective care to its patients.

We found during the course of the day that the service had taken appropriate action in relation to the findings from the quality check, and had responded in a manner which showed a commitment to ensuring the service was compliant with the regulations.

The environment was well maintained, and there were arrangements in place to ensure patients were kept safe.

This is what we found the service did well:

- The service had good arrangements in place for collecting, reviewing and sharing feedback
- The environment was well maintained and there was arrangements for cleaning and decontamination of the service and equipment
- We saw that there were appropriate arrangements in place for the employment, training and development of staff.

This is what we recommend the service could improve:

- The service must ensure that medicines are handled in line with the policies; and
- The service must ensure that staff are protected from the risk of Hepatitis B.

There were no areas of non compliance identified at this inspection.

However, during the earlier Quality Check, we identified the service's governance arrangements were not robust and that insufficient action had been taken in response to a Legionella risk assessment.

These are serious matters and resulted in the issue of a non compliance notice to the service. As a result, this on-site inspection was undertaken to test a wider range of regulatory compliance. , Following the on-site inspection HIW has received sufficient assurance of the actions taken to address the improvements needed.

3. What we found

Background of the service

HQ Hair Transplants is registered to provide an independent hair transplant service at 44 Charles Street, Cardiff.

The service provides day surgery for hair transplant procedures.

The service was first registered on 15 August 2019..

The service employees a staff team which includes one clinical specialist, one service manager, one relations manager and four hair technicians.

Quality of patient experience

We spoke with patients, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.

We found that the consulting rooms were well maintained and provided the necessary dignity and confidentiality to service users.

The use of modern technology to allow patients access to a range of information was welcomed by the service, and new methods of consultation had been introduced shortly before the Covid-19 pandemic to give patients privacy and the opportunity to consider the treatment options in their own time.

The service was well regarded by its patients and has excellent feedback reports.

During the course of the inspection, no patients were in attendance due to the restrictions on the service. As a result, the quality of patient experience part of the inspection did not consider any patient views collected directly from patients.

Dignity and respect

The registered manager told us that there were comprehensive arrangements in place to ensure patients were treated with dignity and respect. Since the COVID-19 pandemic, the vast majority of consultations were being undertaken via video call. Consultations included an initial consultation with the clinic owner to discuss the advantages and risks to a hair transplant. Following this, a second consultation would be arranged with the clinician, again confidentially and via an online service.

On the day of the surgery itself, the patient would be the only patient being treated that day. We were told that basic arrangements such as knocking before entering a patient room was observed at all times.

Patient information and consent

There was a statement of purpose and separate patients' guide as required by the regulations. These were available to patients upon request and set out

information about the services offered, how they could be accessed and the arrangements for consent to treatment. There was also an up to date written policy on obtaining valid patient consent.

The requirements relating to informed consent were discussed with the registered manager. The registered manager stated that initial consent from the patient would be discussed during the consultation following a discussion around the risks, benefits, and treatment plan.

We noted that these discussions included treatment options, which in the instances reviewed, included non-surgical options to support the patient to make an informed decision.

Patients were then asked to consider this information and written consent was sought shortly before the procedure.

Communicating effectively

We saw evidence that what the patient can expect from the procedure is communicated well during the lead up to the surgery. Patients received two separate consultations, to allow them time to consider any further information they would like before making a decision. We were told that the patient was also kept fully informed during the course of the day so they could understand what was happening.

Following the procedure, there was a comprehensive post-operative care package in place, and patients were seen at multiple intervals during the first week. Patients were then free to contact the service for 12 months following the procedure if they required information and advice.

For those who faced barriers, we were told by the registered manager that there were translation services available. We also saw evidence that a patient who had a hearing impairment had been treated successfully with additional arrangements in place.

The clinician was available on his mobile should there be any queries or emergency complications either before or following the procedure.

Care planning and provision

A comprehensive care plan was put in place for all patients before completion of the second consultation. This provided the patient the opportunity to consider a range of options, including an option to not continue with the surgery.

We were told that only one patient was scheduled to undertake surgery each day. Upon arrival, their identity was checked, and they were introduced to the team. From this, the care plan was discussed with the patient a final time to ensure that the risks and benefits had been fully considered, before consent was sought.

Equality, diversity and human rights

The service had a privacy and confidentiality policy that aimed to ensure that all service users were treated in accordance with the principals of dignity and respect.

The setting was on multiple levels and there were no facilities within the building to be able to facilitate treatment for wheelchair bound patients. However, the service had arrangements in place with other clinics where they refer patients to receive care.

The setting was easy to find and there was clear signage on the outside of the building. There was adequate signage to the fire exits.

Citizen engagement and feedback

The service requests patient feedback from all clients following their treatment. This was captured via a feedback form, and the results of these were discussed with staff during team meetings. Feedback was also captured via social media, Google and Trustpilot, and likewise these were discussed with the team on a regular basis.

Delivery of safe and effective care

We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.

The clinic was well maintained, and there was a range of infection prevention and control arrangements in place to ensure the service was compliant with the latest guidance.

There were a range of policies, procedures and risk assessments in place to ensure that safe and effective care could be provided.

We noted that the service must ensure that all medicines are kept in line with their policies.

Managing risk and health and safety

We found that the service had taken steps to identify hazards and reduce the risk of harm. We saw that an environmental risk assessment had been completed and actions identified to manage and mitigate risks.

We saw that fire safety equipment was placed around the service and fire exits were clearly signposted. This meant that equipment and information was available for staff and patients and they could exit the building safely in the event of a fire. We also saw that the equipment had been serviced recently, however during the recent quality check it was found that there had been a gap in the servicing of this equipment. We found that governance arrangements were now in place to ensure that these were serviced on time every year.

During the earlier quality check, it was discovered that the actions highlighted on the Legionella[1] risk assessment had not been undertaken. This resulted in a non-compliance notice being issued to the service. We saw evidence during the course of the on-site inspection that the all of actions from this risk assessment had now been completed to an acceptable standard.

[1] Legionella is a bacteria that can be found in water systems, that can cause an illness called Legionella's disease.

Infection prevention and control (IPC) and decontamination

During a tour of the service we found all areas to be clean, tidy and clutter free. The service had an up to date infection control policy. This provided a general overview of the arrangements to reduce cross infection at the service. We also saw a sample of monthly COVID-19 risk assessments which were now being completed by all staff.

We were told that there were comprehensive arrangements in place before patients were permitted to enter the building. Prior to a patient being invited to attend the service, we were told a COVID-19 screening questionnaire would be undertaken, to minimise the risk of transmission of COVID-19 between staff and patients. Upon arrival at the service, we observed that visitors would have their temperature taken, and undertook further COVID-19 screening questions before being permitted to enter the premises. Masks were provided to patients to wear for the duration of their time at the service.

We observed that all staff were wearing appropriate Personal Protective Equipment (PPE[2]) throughout the visit and PPE was available for patients and visitors upon admission. We found during our tour that hand wash was available at all hand washing basins and alcohol gel stations were located appropriately through the service.

There were also posters located in the theatres and patient areas, providing guidance on appropriate methods of donning[3] and doffing[4] PPE.

We saw that an appropriate cleaning policy was in place. We found that there were suitable cleaning schedules to ensure areas were cleaned appropriately. We reviewed a sample of these and found them to be complete. We noted that all actions highlighted on the clinic maintenance review had been completed in a timely manner.

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[2] Personal Protective Equipment (PPE) is equipment that is designed to protect the user in an environment against health and safety risks. In this service, this included items such as masks, gloves, gowns and face shields.

[3] Donning is the process of effectively applying PPE.

[4] Doffing is the process of safely removing PPE.

Nutrition

Patients were provided with lunch during the day of their treatment. We saw evidence that dietary requirements were checked prior to providing food and patients were catered for depending on their needs.

We were told that sugary food and drinks, as well as fluids were provided at all times during the course of the day, to support the patient during the long sessions and to combat any chances of patients feeling faint or unwell.

Medicines management

We saw that there was a comprehensive policy in place for medicines management within the service. This policy included details of procedures for all staff working at the service.

We saw that all medicines were stored either in a locked cabinet, or in a lockable fridge. During the tour, we noted that the fridge was currently unlocked. The service must ensure that medicine fridges must be kept locked at all times, in line with the service's policy. Fridge temperatures were checked and recorded daily to ensure medicinces were kept in line with manufacturers guidelines.

We noted that medications were routinely recorded upon administration, which cross checked appropriately with patient records. Records were kept to a high standard, and the use of medication was well detailed in patient treatment plans.

We saw evidence of an up to date medicinces audit and an antimicroial prescribing audit in place.

The emergency kit was well stocked and equipment was in date. We saw during this check that the emergency kit contained Midazolam[5], which contradicted the service policy that no controlled drugs were kept on site. Following a conversation with the surgeon and the registered manager, it was agreed that the Midazolam would be disposed of in line with controlled drugs guidelines. We were provided with evidence from the pharmacy to show that this medication had been disposed

[5] Midazolam hydrochloride is a benzodiazepine medication used for anesthesia, procedural sedation and to reduce agitation.

of appropriately. The service must ensure that all medicines are kept in line with their policies.

Improvement needed

The service must ensure that all medicines are kept in line with their policies, including:

- Medication fridges to be locked when not in use
- The keeping of controlled drugs

Safeguarding children and safeguarding vulnerable adults

The service had written policies on protection of vulnerable adults and safeguarding children and young people. These included actions that needed to be taken around safeguarding and included details on the action that should be taken if abuse was suspected.

We saw evidence that all staff had completed safeguarding training appropriate to their role.

Medical devices, equipment and diagnostic systems

The majority of the tools used during the procedure was single use, however we saw evidence of a Service Level Agreement in place for the safe sterilisation of multi-use equipment.

We were told that all staff were trained in using the equipment to the manufacturer's guidelines. We saw evidence that these guidelines were available to staff.

We saw confirmation from the manufacturer that the equipment was being kept and maintained as per the guidelines provided upon purchase.

Safe and clinically effective care

The registered manager confirmed that patients are awake during the course of the procedure, and are provided with pain relief and a numbing agent. We were told that patients are not able to feel the procedure.

We noted that there were arrangements in place for gathering evidence of Hepatitis B vaccination from their staff. However, the registered manager confirmed that they did not currently have evidence of Hepatitis B immunity for

all staff. This meant that staff could not be certain that they were suitably protected from Hepatitis B.

The registered manager provided evidence that this had been requested approximately six weeks prior to the on-site inspection, however the results had not yet been received. The service must ensure that until immunity can be evidenced, all staff are protected from the risk of Hepatitis B with individual risk assessments detailing mitigation actions that provide protection for both staff and patients.

Improvement needed

The service must ensure that all staff are suitably protected from Hepatitis B.

Participating in quality improvement activities

The service had one registered surgeon, who undertook the surgeries with support of the hair technicians. The surgeon is a registered member of the British Association of Hair Restoration Surgery (BAHRS), and we saw evidence that they regulary attended quality improvement and learning events.

We were told that the registered manager was working with BAHRS to develop nation-wide standards for training hair technicians.

We were told that the surgeon undertook regular appraisals as part of his professional registration.

Information management and communications technology

Information was stored off site using a records management system. Records were updated in real time and stored as per the service's records management policies.

All staff had received training as part of their employment induction process, and had signed to confirm they agreed to store patient information in line with the service's policies.

Records management

During the inspection, we did not have a specialist peer reviewer present. As such, we were unable to complete a clinical assessment of patient records.

However, we reviewed a sample of records and assessed them in line with the regulations. We found that these were completed to a standard which met the requirements of the regulations.

Quality of management and leadership

We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how the service review and monitor their own performance against the Independent Health Care Regulations and National Minimum Standards.

The registered manager was responsible for the management of the service and demonstrated a commitment to providing a safe and high quality service to patients.

We saw that, following the quality check, a range of governance arrangements had been put in place to ensure that regulatory requirements in relation to staff training and managing risk were met.

Governance and accountability framework

During the quality check, it was found that there was not robust governance arrangements in place in the service to ensure it was compliant with risk management and training arrangements. This resulted in the issuing of a non-compliance notice. During the course of the on-site inspection, we were shown evidence of a range of governance arrangements which had been established as a result of the quality check. The actions taken since the quality check provided sufficient assurance that the requirements set out in the regulations can now be met by the service in a timely manner.

The services available at the time of our inspection were in accordance with the conditions of registration with HIW. The certificates of registration were displayed as required by the regulations.

An up to date statement of purpose and patients' guide were available, as referenced above, these set out information about the service as required by the regulations.

As described earlier in the report there were a range of policies available for the management of the service, which had been recently reviewed.

Dealing with concerns and managing incidents

There was a written complaints procedure available on the website. This set out the timescales for acknowledging and responding to complaints and in accordance with the regulations; the contact details of HIW were also included.

Although we did not see evidence of any complaints received to date, we were able to confirm that there was a complaints file available, and the registered manager explained the process for recording complaints, and how they would be responded to.

Workforce planning, training and organisational development

We identified during the quality check process that staff training on required areas such as safeguarding had expired. These were completed ahead of the video call element of the quality check so all staff had up to date training. The registered manager was required, as part of the quality check process, to report on governance arrangements which would be put in place to ensure training was completed at required intervals. During the course of this inspection, we were shown that the registered manager had put electronic and hard copy governance arrangements in place to ensure that this did not happen again.

Workforce recruitment and employment practices

At the time of the inspection there was four members of technician staff, as well as the registered manager, clinic owner and clinical manager. We noted that all staff had appropriate DBS and identify checks in place, alongside job applications and employment references.

Annual appraisals were undertaken, with regular updates. We were also told that staff were often invited to attend sector wide learning and conferences, to allow them to continue to develop their skills.

4. What next?

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Where we identify any serious regulatory breaches and concerns about the safety and wellbeing of patients using the service, the registered provider of the service will be notified via a non-compliance notice. The issuing of a non-compliance notice is a serious matter and is the first step in a process which may lead to civil or criminal proceedings.

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

5. How we inspect independent services

Our inspections of independent services may be announced or unannounced. We will always seek to conduct unannounced inspections because this allows us to see services in the way they usually operate. The service does not receive any advance warning of an unannounced inspection. In some circumstances, we will decide to undertake an announced inspection, meaning that the service will be given up to 12 weeks' notice of the inspection.

Feedback is made available to service representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

HIW inspections of independent healthcare services will look at how services:

- Comply with the Care Standards Act 2000
- Comply with the Independent Health Care (Wales) Regulations 2011
- Meet the National Minimum Standards for Independent Health Care Services in Wales.

We also consider other professional standards and guidance as applicable.

These inspections capture a snapshot of the standards of care within independent services.

Further detail about how HIW inspects independent services can be found on our website.

Appendix A – Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
We noted during the course of the day that the emergency kit contained Midazolam, which contradicted the service policy that no controlled drugs were kept on site.	Midazolam is a controlled drug, and can be dangerous if either given in error or if this was easily accessible to patients.	The HIW inspection manager raised this issue with the Registered Manager and owner, who proceeded to arrange for the immediate disposal of the Midazolam with a pharmacist.	We were provided with evidence that this had been appropriately disposed of.

Appendix B – Improvement plan

Service: HQ Hair Transplants

Date of inspection: 08 March 2021

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Delivery of safe and effective care				
The service must ensure that all medicines are kept in line with their policies, including: • Safe storage of medicines The keeping of controlled drugs	15. Medicines management	Medcines Cupboard key log and safe is installed. Keys are signed in and out daily by clinic manager.	Ciara Lawless	Daily
The service must ensure that all staff are suitably protected from Hepatitis B.	7. Safe and clinically effective care	All staff have been Hep B vaccinated All Hep B levels have now been obtained for current staff.	Ciara Lawless	Upon recruitment of staff

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): Ciara Lawless

Job role: HQ Hair Clinic Manager

Date: 30 April 2021

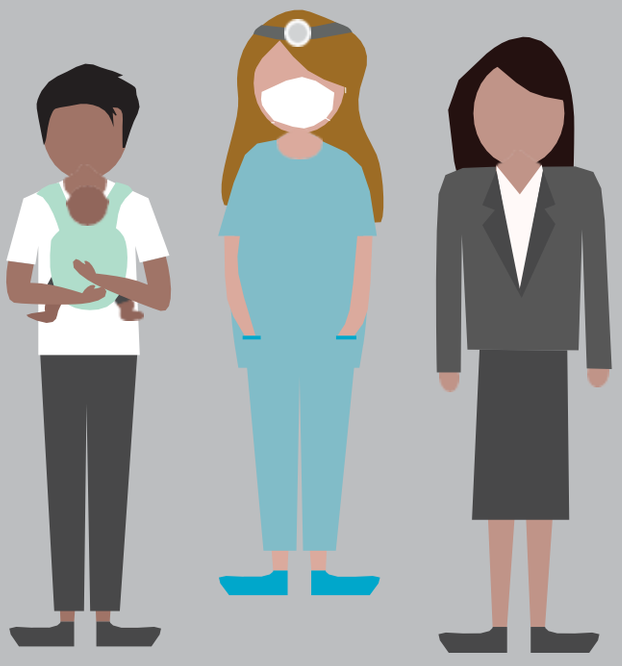
Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

HeadQuarters Hair Transplant Limited

Activity date: 25 February 2021

Publication date: 09 June 2021



Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of HeadQuarters Hair Transplant Limited as part of its programme of assurance work. HeadQuarters Hair Transplant Ltd offers hair transplants for men of all ages suffering from baldness or hair loss.

HIW's quality checks form part of a new tiered approach to assurance and are one of a number of ways in which it examines how healthcare services are meeting the Care Standards Act 2000, Independent Health Care (Wales) Regulations 2011 and other relevant regulations. Feedback is made available to service representatives at the end of the quality check, in a way which supports learning, development and improvement at both operational and strategic levels.

Quality Checks are a snapshot of the standards of care within healthcare settings. They are conducted entirely offsite and focus on three key areas; infection prevention and control, governance (specifically around staffing) and the environment of care. The work explores arrangements put in place to protect staff and patients from COVID-19, enabling us provide fast and supportive improvement advice on the safe operation of services during the pandemic. More information on our approach to inspections can be found here.

We spoke to the registered manager on 25 February 2021 who provided us with information and evidence about their setting. We used the following key lines of enquiry:

- How are you ensuring that all patients (including vulnerable/at risk groups) are able to access services appropriately and safely? In your answer please refer to both the practice environment and processes to enable patients to access appointments
- What changes have you implemented in light of COVID-19 to ensure infection prevention and control standards are maintained?
- How has the clinic and the services it provides adapted during this period of COVID-19?

Environment

During the quality check, we considered how the service has designed and managed the environment of care to keep it as safe as possible for patients, staff and visitors. We reviewed recent risk assessments and questioned the setting on the changes they have made in response to COVID-19 to maintain safety and patient dignity.

The following positive evidence was received:

We found that the service has conducted some risk assessments and updated relevant policies and procedures to meet the additional demands stemming from the COVID-19 pandemic.

In order to protect staff and patients at the clinic, the registered manager informed us that the front door is locked at all times to prevent members of the public and delivery personnel from entering the clinic unattended. We were told that appropriate notices are on display in the lobby area and an intercom in place for visitors to ring and await to be escorted by staff.

Any patients who needed to see the clinician face to face, attended the clinic by invitation and pre-booked appointment only. Staff admitting patients onto the premises wear appropriate personal protective equipment (PPE). All patients who require face to face services are screened for symptoms of COVID-19 and are required to self-isolate before their appointment and receive a detailed risk assessment.

The following areas for improvement were identified:

We were provided with a copy of the legionella risk assessment report which was undertaken on 19 February 2020, by an external company. The risk assessment identified a significant number of issues to be addressed, some of which required immediate attention. The registered manager was unable to provide us with evidence to demonstrate that any of the recommendations identified in the risk assessment had been acted upon. Our concerns regarding the legionella risk assessment report were dealt with under our non-compliance process. This meant that we wrote to the clinic, immediately following the quality check, requiring that urgent remedial actions were taken. Details of the immediate improvements we identified are provided in Appendix A.

The registered manager verbally assured HIW that regular checks are undertaken on the emergency medical kit, but could not provide any documentary evidence to substantiate this statement. The registered manager must ensure all checks of the emergency drugs and equipment are logged.

The self-assessment form completed in advance of the quality check stated that the gas boiler was due for servicing on 22 February 2021. The certificate was forwarded as evidence before the video call took place. We asked the registered manager for a copy of the previous gas

service certificate to evidence that there was no gap in the annual service requirements. We were advised that this information was not available. However, this was checked during the service's registration in October 2019. Therefore the next service was due by October 2020, at the latest, and not February 2021. The registered manager confirmed that there was no system in place to ensure such matters were monitored. The registered manager must ensure that a system is put in place to ensure that the gas boiler is serviced at the required intervals.

We found that a similar situation had occurred with annual fire safety checks. The most recent fire safety equipment service had been undertaken in September 2020, but the previous certificate expired in July 2020. This pre-dated the current registered manager's appointment, but the registered manager confirmed that there was no system in place to monitor this type of annual servicing requirement. The registered manager must ensure a system is put in place to ensure that fire safety checks and equipment servicing take place at the required intervals.

Infection prevention and control

During the quality check, we considered how the service has responded to the challenges presented by COVID-19. We considered how well the service manages and controls the risk of infection to help keep patients, visitors and staff safe. We reviewed infection control policies, cleaning and hygiene regimes and access to training.

The following positive evidence was received:

We saw evidence of an up to date policy for the prevention and control of infection. The policy has been amended to reflect the management of COVID-19.

The registered manager confirmed that staff have received COVID-19 updates via regular team meetings. Furthermore, a WhatsApp[6] group has been set up in order for staff to be immediately kept updated with any changes. Regular communication has ensured everyone has up to date advice and guidance on COVID-19.

The registered manager also confirmed that all staff have received training, by the hair transplant surgeon, on the correct use of PPE, including the donning, doffing and safe disposal

[6] WhatsApp Messenger is a cross-platform instant messaging application that allows iPhone, BlackBerry, Android, Windows Phone and Nokia smartphone users to exchange text, image, video and audio messages.

of used equipment.

The registered manager confirmed that cleaning schedules have been increased at the clinic. We were told that the use of personal protective equipment (PPE) has been optimised with adequate stocks sourced and monitored on a regular basis by the registered manager.

We were told that, at the beginning of the COVID-19 pandemic, the clinic was closed to members of the public as per government guidelines. We were also informed that the clinic had to close for one week during January 2021, due to a member of staff testing positive for COVID-19. We were told that all staff were immediately required to self-isolate and arrangements put in place for all staff to be tested for COVID-19. We saw evidence that the premises had been cleaned, decontaminated and sanitised by an external company whilst staff were self-isolating. The registered manager confirmed that no other staff members tested positive to COVID-19 and the clinic reopened to the public the following week.

The following areas for improvement were identified:

The registered manager advised us that regular spot checks / audits of hand hygiene, cleaning standards, donning and doffing of PPE were undertaken as part of the infection, prevention and control (IPC) regime. However, none of these were recorded and no evidence was provided to substantiate the registered manager's statement. The registered manager must ensure all audits / spot check are logged and any issues identified are addressed through the implementation of an action plan.

The registered manager confirmed that individual staff COVID-19 risk assessments[7] had not been undertaken. The registered manager was unaware of this requirement and advised that the only action they had taken to ensure staff were safe to work was to confirm with each member of staff that they were happy to continue to work during the pandemic. The purpose of the risk assessment is to identify staff who may be more vulnerable should they contract COVID-19 and enable the employer to take steps to make reasonable adjustments to keep them safe. The registered manager must ensure all staff working at the clinic receive a detailed Covid-19 risk assessment.

[7] 'This Risk Assessment Tool has been developed to help people working in the NHS and Social Care in Wales to see if they are at higher risk of developing more serious symptoms if they come into contact with the COVID-19 virus. The tool helps you understand whether you may be at greater risk and helps you and your line manager to choose the right actions for you based on your level of risk'.

The registered manager confirmed that the majority of staff working at the clinic had received the appropriate health checks for their roles. The registered manager informed us that two trainee hair technicians were currently in the process of being immunised for Hepatitis B. The registered manager confirmed that both members of staff are aware of the additional prevention measures to be taken until they have been fully immunised. However, no individual risk assessment had been carried out. The registered manager must ensure that both members of staff receive an individual risk assessment which should be signed by the staff members and copies maintained on staff files.

Governance / Staffing

As part of this standard, HIW explored whether management arrangements ensure that staff are suitable in their roles and are appropriately trained in order to provide safe and effective care. We reviewed recent risk assessments and questioned the setting on the changes they have made in response to COVID-19 to maintain safe practices.

The following positive evidence was received:

We were provided with a copy of the clinic's Statement of Purpose which conformed to the Independent Health Care (Wales) Regulations 2011.

We looked at a sample of policies and procedures the service had in place, such as; acceptance and discharge of patients, consent, recruitment of staff, medicines management and infection prevention and control policy. We saw that these policies had been reviewed and updated and also contained review dates and / or were version controlled.

We were told that there are no current staff sicknesses and there are no current vacancies at the service.

The following areas for improvement were identified:

On 04 January 2021, the registered manager was notified of HIW's intention to conduct a quality check, with the video call to take place on 18 January 2021. HIW agreed to postpone the quality check for a month at the request of the registered manager. Records presented by the registered manager confirmed that staff had recently renewed their mandatory training between 10 January and 18 February 2021. We asked the registered manager for copies of the previous year's training records to evidence that there was no gap in meeting training requirements. We were informed that this information was not available and the registered manager advised that the training had lapsed for some staff members. There was no system in place to monitor training requirements. The registered manager must ensure that a system is put in place to monitor staff

training requirements.

It was evident from discussions with the registered manager that they lacked awareness and understanding of the standards and regulations. The registered manager must improve their knowledge and understanding of the relevant regulations and standards.

The issues identified throughout this report demonstrated that there is a fundamental lack of governance in place to ensure that regulatory compliance is maintained and that risks relating to the health, safety and welfare of people are identified, assessed and managed. The registered provider and registered manager must ensure that there is appropriate governance processes and management systems in place to ensure that the service is operating in line with national standards, and adhering to the Independent Health Care (Wales) Regulations 2011. Our concerns regarding the governance arrangements were dealt with under our non-compliance process. Details of the immediate improvements we identified are provided in Appendix A.

What next?

Where we have identified improvements during our check, which require the service to take action, these are detailed in the improvement plan below.

Where an improvement plan is required, it should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the Quality Check.

As a result of the findings from this quality check, the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

Independent Clinic: HeadQuarters Hair Transplant Limited

Date of activity: 25/02/2021

Description of non-compliance / Action to be taken	Regulation	Service Action	Responsible Officer	Timescale
The registered provider must take appropriate action to remedy all actions identified in the legionella risk assessment dated 19 February 2020.	The Independent Health Care (Wales) Regulations 2011, Regulation 26 (2) (a)	All recommended actions have been undertaken and completed. Please refer to Water Policy and recommended actions spread sheet.	Ciara Lawless	26/02/2021
The registered provider must take appropriate action to ensure that the governance arrangements in place at the clinic are robust and enable the provider to regularly assess the carrying on of the establishment against the requirements of the Independent Health Care (Wales) Regulations 2011.	The Independent Health Care (Wales) Regulations 2011, Regulation 19	All Governance arrangements have been updated, logged on our CRM, visual spreadsheet has been compiled please see attached. And all contractors scheduled in advance. All actions have been completed, and seen by inspecting officer today.	Xavier Rush	06/03/2021

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Representative:

Name (print): XAVIER RUSH

Role: Responsible Person

Date: 08/03/2021