

# The Cadogan 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

### Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

# Summary of findings

## Letter from the Chief Inspector of Hospitals

The Cadogan Clinic is operated by Personal Health Service Ltd. The service provides medical outpatient appointments and day surgery, predominantly for cosmetic procedures. It also provides mole and skin cancer treatments. Facilities include four operating theatres, outpatient and diagnostic facilities.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 1 December 2016, along with an unannounced visit to the hospital on 8 December 2016.

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

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

### Services we do not rate

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

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

- The number of theatre and post-recovery care staff was lower than national recommendations although the risk register stated that these were being followed.
- Compliance with the World Health Organisation (WHO) safety checklist and the '5 steps to safer surgery' was low, and although improvement in compliance with the WHO checklist was being made, main elements, such as the face to face briefing of all staff and a debriefing, were still not occurring.
- There were unclear processes for responding to the 'crash bell' which could mean that no one would be available to respond.
- A number of policies, although updated in the last year, did not reflect up to date national guidance. This included consent guidance for under 16s which was not correct.
- There were very limited competency records held for staff members.
- Safeguarding training had not been completed for some staff as is a requirement in healthcare settings.
- There were inconsistencies between what the MAC chair and senior managers told us and what we observed staff doing.

However, we found the following areas of good practice:

- All clinic staff we observed treated patients with respect and dignity throughout all interactions at the clinic. Feedback from patients was overwhelmingly positive about the caring nature of the staff looking after them.
- The clinic was responsive to feedback and complaints raised by patients and had made improvements to their services as a result.
- The clinic followed best practice guidelines and was determined to set realistic expectations for patient's outcomes after surgery. This resulted in a low number of complaints about the procedure.
- Clear information was provided to patients about the cost of their treatment or procedure.

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

# Summary of findings

**Professor Sir Mike Richards**  
**Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

### Service

#### Surgery

### Rating Summary of each main service

Cosmetic surgery was the main activity of the clinic. There were some dermatology outpatient services and mole and skin cancer services and we have reported on these within the surgery report. We regulate cosmetic surgery services but we do not currently have a legal duty to rate them.

# Summary of findings

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# The Cadogan Clinic

## Services we looked at

Surgery

# Summary of this inspection

## Background to The Cadogan Clinic

The Cadogan Clinic is operated by Personal Health Service Ltd. The clinic opened in 2008. It is a private clinic in Chelsea, London. The clinic accepts referrals from local independent GPs and self-referrals from patients living in London and nationally.

The clinic is based at the main address in Sloane Street and an overflow office is used locally that provides space for some of the administration team.

The clinic had two previous registered managers that had been in post from January 2014 to August 2016. The clinic had informed the CQC that there was a vacancy for their registered manager in September 2016 and Guy Mayou, the new manager was appointed and was registered with the CQC in November 2016.

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

## Our inspection team

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

## Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive inspection program. This was an announced inspection.

## How we carried out this inspection

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 1 December 2016, along with an unannounced visit to the hospital on 8 December 2016.

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?

- Is it responsive to people's needs?
- Is it well-led?

During the inspection, we visited the whole clinic. We spoke with 17 staff including; registered nurses, health care assistants, reception staff, visiting consultants, operating department practitioners, and senior managers. We spoke with five patients and also received 14 'tell us about your care' comment cards which patients had completed prior to our inspection. During our inspection, we reviewed three sets of patient records.

# Summary of this inspection

## Information about The Cadogan Clinic

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

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

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 hospital/service has been inspected three times, and the most recent inspection took place in August 2013 which found that the clinic was meeting all standards of quality and safety it was inspected against.

Activity (July 2015 – June 2016)

- In the reporting period July 2015 to June 2016 there were 3,662 day case episodes of care recorded at the clinic; all of these were funded by insurance or self-paying patients. Of these, a small proportion (76 cases) were children and young people under 18 years old and all of these were carried out under local anaesthetic.
- There were 17,216 outpatient total attendances in the reporting period; all of these were funded by insurance or self-paying patients.
- The majority of cosmetic surgery procedures were conducted under general anaesthetic (97%). Whilst the majority of non-cosmetic surgery was conducted under local anaesthetic (99%).

34 surgeons, 29 anaesthetists, six physicians and three radiologists worked at the hospital under practising privileges. The Cadogan Clinic employed nine registered

nurses, three operating department practitioners, five care assistants and 28 non clinical staff, as well as having its own bank staff. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety

Between January 2016 and November 2016 there were:

- No never events
- Clinical incidents: 11 no harm, nine low harm, six moderate harm.
- No serious injuries
- No incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA)
- No incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA)
- No incidences of hospital acquired Clostridium difficile (c.diff)
- No incidences of hospital acquired E-Coli
- Fifteen complaints

### Services accredited by a national body:

- Mole check (medical) – only mole service in the UK accredited by the British Skin Foundation

### Services provided at the clinic under service level agreement:

- Emergency and critical care transfers
- Oxygen and medical gases
- Cleaning services
- Sterilisation services
- Laundry
- Maintenance of medical equipment
- General pathology
- Histopathology



# Summary of this inspection

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### **Are services safe?**

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

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

- The policy for screening patients for MRSA did not match the pre-assessment questionnaire it referred to.
- The number of staff in theatre and post-recovery care did not follow national guidance.
- There were unclear processes for responding to the 'crash bell' which could mean that no one would be available for response.
- The '5 steps to safer surgery' was not being followed and compliance to the WHO checklist was poor.

We also found the following areas of good practice:

- Compliance with venous thromboembolism risk assessments was high
- There was a low rate of surgical site infections.

### **Are services effective?**

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

We found the following areas of good practice:

- Two external assessments for governance had been commissioned by the clinic management and, although actions were not complete, there had been work started to improve on the findings noted.
- The clinic was submitting data with regard to patient outcomes, although this was a new requirement and therefore results were not yet published.
- There was a robust review process for unplanned re-attendances.
- A 'one stop shop' clinic provided a complete service for vascular patients.
- The clinic offered Mohs surgery, a highly effective method of treating common skin cancers.

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

- A number of policies had not been updated with national guidance.

# Summary of this inspection

- The consent policy gave incorrect information about consent of children.
- The audit plan was not followed and that meant that there was limited assurance of processes being followed.

## Are services caring?

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

We found the following areas of good practice:

- All clinic staff we observed treated patients with respect and dignity throughout all interactions at the clinic.
- Feedback from patients was overwhelmingly positive about the caring nature of the staff looking after them.
- Clear information was provided about costs of treatment and procedures.

## Are services responsive?

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

We found the following areas of good practice:

- The clinic was responsive to feedback and complaints raised by patients and had made improvements to their services as a result.
- There was clear discharge information given to patients with multiple numbers for them to call in the event of a problem following discharge.
- The clinic had responded to complaints from patients by adapting the layout of the reception area to include a private payment room.

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

- The admissions policy did not reflect that the clinic was carrying out minor procedures under local anaesthetic on children under 16 years old.

## Are services well-led?

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

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

- Risk registers referred to mitigating actions that were not being followed.

# Summary of this inspection

- There had been a lack of permanent theatre clinical leadership over the previous year which had led to poor governance systems.
- The Medical Advisory Committee (MAC) and senior management did not appear to have oversight of the low compliance of the '5 steps for safer surgery.'

We also found the following areas of good practice:

- Staff were positive about the team work and their interactions with colleagues and visiting consultants.
- The clinic carried out patient feedback surveys on the telephone as well as collecting forms in order to receive feedback from the public and improve services.

# Surgery

Safe	
Effective	
Caring	
Responsive	
Well-led	

## Are surgery services safe?

The main service provided by this clinic was surgery. The outpatient's service provided at the clinic included some dermatology, including mole and skin cancer services, and a large number of surgical consultations. We have therefore reported on the outpatient's service within the surgery core service.

### Incidents

- Between January 2016 and November 2016 there were 25 clinical incidents reported. 11 of these were of no harm, nine of low harm and six of moderate harm. The moderate harm incidents recorded were incorrect sharps disposal, missing keys, a specimen not labelled, two incidents of development of haematoma's following surgery and one of graft requiring resitting.
- The number of incidents reported was low and concerns staff raised with us during the inspection such as lack of staffing had not been raised as incidents, indicating that there may be an issue of under-reporting. An external assessment carried out in July 2016 had identified low levels of incident reporting and identified extra staff training was required. Staff had received refresher training on incident reporting in October 2016.
- The main themes of incidents reported were needle stick injuries of staff. We asked staff about sharps procedures and found that there had been an incident the day before the inspection, when a staff member had been unaware of the correct process after the injury. This had been corrected by another staff member but it shows that learning from sharps incidents was not completely embedded within the clinic.
- All staff we spoke with were aware of how they would report incidents. A form would be completed and emailed to the line manager. We saw copies of completed forms and the investigation and identified

learning that followed the incident. However, there was not a forum where learning from complaints and incidents was discussed. In the minutes of the theatre team meetings that we saw, the importance of reporting incidents was highlighted but learning from previous incidents was not referenced. Some staff we spoke with were unaware of incidents that had taken place within the clinic.

- One staff member told us of an incident with a defibrillator, when it was returned from repair without a battery and therefore didn't work when tested off charge. They told us how the process for testing it had changed following the incident report in order to make sure that it always worked on and off charge.
- As part of the review of incidents, the relevant policy was reviewed to identify if there needed to be any changes. In one example of this, the controlled drugs policy was amended following an incident.
- There had been no deaths within the clinic in the last 12 months and consequently there had not been any mortality and morbidity reviews.
- The duty of candour is a regulatory duty that relates to openness and transparency, and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. This means providers must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. Staff we spoke with were aware of the duty of candour and principles for being open and honest. We saw a record of an incident where a patient specimen had gone missing. There was clear documentation of an offer of a face to face meeting and written apology following the event in line with the duty of candour principles.

# Surgery

## Cleanliness, infection control and hygiene

- All areas that we inspected were clean. We looked at equipment and found consistent use of 'I am clean' stickers on equipment, showing when it had last been cleaned.
- The clinic conducted an infection control audit in November 2016. This found that although audits on hand hygiene were completed, action plans were not used to identify learning and improve practice. However, it found good compliance in all other areas assessed, including cleanliness of rooms, equipment and training received.
- Between January and November 2016 there had been 20 surgical site infections (SSIs) identified. This was an average rate of 0.85% in proportion to the number of operations undertaken which is low. All the SSIs were reviewed quarterly by the integrated governance committee and also the Medical Advisory Committee (MAC). A microbiologist acted as an external advisor for the clinic and was a member of the MAC. We saw minutes of the most recent integrated governance committee where the new microbiologist confirmed that the number of hospital acquired infections was extremely low.
- The clinic had produced an MRSA policy in March 2016, which stated that routine screening would not be done but patients at risk would be identified from the pre-assessment questionnaire. Three questions were listed within the policy that would identify this risk factor on the questionnaire however these were not part of the blank one we were shown. There was only a question asking if the patient had a history of infections. The telephone pre-assessment interview structure also did not ask these specific questions. This meant that it was not clear how exactly patients at risk of MRSA would be identified for testing.
- A service level agreement (SLA) was in place with a local acute hospital for the sterilisation of surgical instruments. They were removed and new equipment was delivered every day. We were told that this worked smoothly most of the time.
- Clinical waste disposal was provided through a SLA with an external provider. Waste was kept outside the clinic in a locked outbuilding and collected weekly for disposal.
- A hand hygiene practice and theory assessment had been conducted in December 2015. Out of the 14 staff

completing the practical assessment, the average score had been 84%. Fifteen staff had completed the theory assessment and there was lower level of achievement with the average result being 61%. Results for the more recent assessment in November 2016 showed that the average result for the practical was 92% which showed improvement but there was a reduction in the theory assessment results to an average of 61%. There was an action plan in place that if a member of staff scored less than 90% on the practical assessment it should be repeated in a month, however we did not see any additional action plans for the theory assessment or targets the provider had for overall results.

- We observed adherence to 'bare below elbows' and theatre dress codes throughout the inspection.

## Environment and equipment

- The clinic was situated over three floors within the building in London. Theatres were located in the basement, with the ground floor used for reception, three outpatient consultation rooms, aesthetic treatment rooms, including laser treatment rooms with warning lights outside and a small office space. The first floor had a further consultation area that was allocated to one visiting consultant.
- The clinic had three operating theatres. Two were used for major procedures under general anaesthetic and had ventilation systems that ensured 25 air changes per hour in accordance with current guidelines. The third theatre was used for procedures under local anaesthetic and could provide ventilation up to 15 air changes per hour.
- There was also a recovery area with two bays and two 'ambulatory care' areas. One ambulatory care area had four beds in and the other had chairs. These were used for monitoring patients after they were stable enough to leave the recovery area. Patients who had a general anaesthetic were assisted into a wheelchair from the recovery area and wheeled round to the bedded ambulatory care area by the recovery nurse. Patients recovering from a local anaesthetic procedure sat in the seated ambulatory care room.
- On the day of the unannounced visit when we entered the recovery area we found that it was cluttered due to two unused trolleys that were present with equipment on them. The recovery room was a small area and the extra trolleys made it difficult to locate space when a patient was brought in from theatre to be recovered.

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- There was lift access to the theatre floor; however it was too small to fit a bed or stretcher in the event of an emergency transfer. We were told that if a patient became unwell they could be moved out of the department via a basement exit and some outdoor steps. We were told that staff had practiced an emergency scenario to test this in May 2016. This training had included evacuation training from the basement floor theatre area using an evacuation slide which staff reported was extremely difficult to get up the steps outside. No report or action plan had been produced following this training.
- An external health and safety visit had been undertaken in November 2015 and 34 actions that needed to be completed were identified. Some of these had been documented as completed, however 16 were listed as outstanding or had no information assigned to them. One of these actions that was identified was that equipment was blocking the fire exits in the storage area next to the changing room. A general clutter risk from fire and emergency access in the theatre department was noted during a safety inspection checklist completed in November 2016. The action from this stated this was part of the deep clean risk assessment. However, we saw that there was still a large amount of equipment within this area during the inspection which could be an issue in the event of an urgent evacuation.
- Eye protection for lasers was available and we observed all staff and the patient wearing these during a procedure.
- All electrical equipment that we looked at within the theatre area had stickers on it showing that it had been safety tested. We also saw 17 servicing records for theatre equipment, including infiltration pumps and suction to show that they had been serviced within the last 12 months.
- The clinic had a contract with an external company for maintenance and servicing of all equipment. The equipment used within the consulting rooms had stickers on it showing it had been serviced in the last year.
- A resuscitation equipment trolley containing equipment for both adults and children was available within the recovery room area and was kept closed with a seal. The seal was checked daily and there was a checklist confirming this and that the full contents were checked every month. When we checked the trolley during the inspection we found that although there were six cannulas (a small plastic tube inserted into the vein for administration of intravenous drugs) out of date, all other equipment was within its expiry dates. A grab bag with resuscitation equipment was available to be taken to the other floors within the clinic if there was an emergency. A case with drugs required in the event of anaphylaxis (severe allergy) was also available and kept sealed as well, as a case for emergency response to extravasation, which is if a drug given intravenously leaks into the skin.
- A checklist was completed daily for checking of equipment including oxygen, suction, alarm system and monitors the recovery room. In addition, a full expiry check of disposable equipment was completed monthly. We saw a checklist completed for one theatre for equipment, including the anaesthetic machine, suction, trolley. Apart from nine days, when there were no procedures, the list had been completed.
- There was only one capnography monitor in the recovery room to monitor the amount of carbon dioxide (CO<sub>2</sub>) in exhaled air. As there were occasions when two patients may be within the recovery area at the same time, this did not follow Association of Anaesthesia, Great Britain and Northern Ireland (AAGBI) guidelines which states that all patients with tracheal tubes in place should be monitored with continuous capnography. When we visited the clinic on an unannounced visit, the capnography machine was broken and away being repaired, so no monitoring tool was available. We asked an anaesthetist about the contingency for this and, although we were told that recovery could be undertaken in the theatres, this was not done on the day of our visit.
- There was no dedicated difficult airway trolley available in the recovery area; however difficult airway equipment was accessible from the theatres and recovery. This included a recently purchased fibre optic light and a 'QuickTrach' emergency airway device if a patient developed airway concerns post anaesthesia.
- A fluid warming cupboard was available within the recovery area. We saw no checks during our inspection to confirm the temperature of the fluid. We asked two members of staff about the fluid and both were unaware of the temperature ranges that were suitable and how they would know if the temperature was too high to administer, although they stated there was an alarm on the cabinet if the temperature got too low.

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Managers told us later that there were temperatures displayed on the warming cupboard and a daily chart of temperatures recorded, however staff were not able to point these out to us at the time of the inspection.

- We were told by staff during the inspection that there were no forced air warmers (devices for keeping patients warm during surgery) used for patients during their surgery, although warm air was used around standard blankets in the recovery area. Senior management later stated that these were available for use in both theatre and recovery. However, warm blankets were often used instead. They told us that an audit had been conducted of 20 patients having operations of one hour or more who had warm blankets used rather than forced air warmers during surgery. The temperature of each patient exceeded 36.5°C (normal temperature) on arrival in recovery.
- We saw a patient who had received an implant as part of their procedure, was provided with an 'implant passport' which recorded all the details of their implant and was given to the patient on discharge.

## Medicines

- The clinic had an agreement with a visiting pharmacist advisor to oversee the medicines management arrangements.
- An annual medicines management audit had been completed by the clinic in September 2016. This audit had identified some failings, including out of date medicines, inappropriate temperature control, non-qualified clinic staff accessing medications inappropriately and flammable medications not stored correctly. Some actions had been identified in an earlier audit undertaken in December 2015, but the September audit found that they were still outstanding. During our inspection, we looked at all of the areas identified from the audit and found no out of date medicines, fridge temperatures were monitored and only registered staff accessed medicines.
- Medicines were stored securely and appropriately. Medicines were ordered on an average every two weeks from an external supplier. A maximum stock number was identified for each medicine held to prevent over-stocking. Medicines requiring cold storage were stored in locked fridges and the temperature monitored

daily. A container was held in the pharmacy cupboard for out of date medicines for disposal which would be destroyed when full. There was no record kept of this which is not in line with best practice.

- The clinic held some emergency medicines (such as adrenaline for anaphylaxis and medicines for cardiac arrest) which were checked regularly and in date. The procedure for an emergency was to call 999. An algorithm for malignant hyperthermia, a possible side effect of a muscle relaxant drug, Dantrolene was easily accessible if required.
- Controlled drugs (CDs) were stored securely and checked regularly by nurses. The clinic policy stated that a CD audit would be carried out by the visiting pharmacist advisor on a quarterly basis. We saw records of these audits completed. We checked the CD stock records and found that stock numbers of drugs matched those in the book and the documentation was completed as needed.
- Fentanyl, a very strong painkiller, was used post operatively. However as there was none stored within the recovery area and nurses had to request it from the operating theatre. We were told that sometimes the anaesthetist would provide drawn up fentanyl for the recovery area when handing over the patient. If this was not used then the fentanyl would be disposed of. Although we were told a record was not always kept of this disposal, when we reviewed the register, we saw some occasions where it had been documented.
- The clinic had conducted an audit in April 2016 on prescribing of Tramadol, a strong pain killer, prescribed as a 'To Take out' (TTO) medication for patients on discharge. The audit found that out of 30 patient records checked; all but one of the criteria was below the aim of 100% compliance with prescribing legislation. Most criteria were above 85%, however one was below 30% compliance. There was an action plan listed for improvement which included a re-audit in July 2016; however this had not been done.
- Consultants with practicing privileges wrote prescriptions for patients receiving day surgery and included medicines to be administered in recovery and for any medicines dispensed to take home following the surgical procedure. Some of the consultants who attended regularly had their own prescription pads

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printed and these were kept securely in the clinic on days they were not present. Other consultants would use a blank prescription printed from the computer which meant there was no method of monitoring if one was printed off and used inappropriately.

- The theatre prescription chart included allergy information, however the prescription for discharge medication did not. Medicines reconciliation information (which is a process used to ensure safe and appropriate prescribing) was not included.
- The clinic audit schedule specified that medicine management audits should be completed by the external pharmacy advisor three times during the year. We saw audit records to show that these were completed. However, the audit schedule also identified medicines stock control audits would be undertaken twice in the year, which was not consistent with the medicines policy. This policy stated stock control audits and reconciliation of items purchased was to be undertaken every three months. The medicines management audits we were provided with assessed storage and ordering process compliance but did not audit actual ordering to check for stock control and reconciliation of items purchased and used and therefore were not consistent with the policy requirements.
- Safety alerts and information about medicines was passed from the Central Alerting System to the clinic manager who would arrange actions and update a log that was kept on the shared drive. Although we reviewed the policy we were unable to view examples of this or ask staff for specific examples. Out of the eight full time employed nurses we saw records that three had completed medicines management training and drug calculation assessments however the last completed training for the remainder was unknown.

## Records

- Patient records were a mixture of paper and electronic records. Paper records were scanned into the electronic record each week so that full information was held centrally. Visiting consultants wrote notes during a consultation and then their secretary would type these up into the electronic record. We looked at two sets of patient electronic records and found them to be comprehensive with forms, such as the pre-assessment

medical questionnaire within the documentation. A record scanning audit was undertaken in June 2016 that showed 97% compliance with only one page that had not been scanned in.

- The major procedure record included a venous thromboembolism (VTE) risk assessment that was completed prior to surgery. A record we viewed on our inspection had this completed and the September 2016 records audit showed this was completed in 100% of the 10 cases audited.
- All patients having day surgery at the clinic were required to complete a pre-admission self-assessment form. This was reviewed by the admission nurse who would then carry out a telephone pre-assessment if required. The nurse would use a decision tree to determine if the anaesthetist needed to review the pre-assessment before admission of the patient.
- Some consultants, with patients' consent, kept their own, additional, records of patients. This was referred to within the clinic record policy.
- Patients would consent to their GP being provided with information about their procedure. Some staff told us that the GP was not informed routinely even if the patient had consented to this. However, the administrator informed us that copies of the immediate discharge letter and the consultant's discharge letter were sent to the patient's GP, unless permission had not been obtained, within four weeks, as stated in the clinic records policy.
- Records audits for major procedures, minor procedures and pre-operative questionnaires were planned to be carried out three times a year. Only one major procedure record audit had been carried out in September 2016 and it had not audited all the criteria. The partial audit results showed 95% compliance which included criteria for patient details, prescription charts and theatre scrub counts. However six criteria had not been completed including compliance of the pre-op checklist, nursing notes and discharge checklist. Non-completion of these elements brought the audit results down to 66%. There was no action plan listed on the audit results that we were given.
- A theatre register record audit had been partially undertaken in November 2016. This was intended to review the accuracy of the theatre register against the



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patient's notes. However the results that we were provided with were incomplete as only the theatre register had, therefore an overall percentage compliance could not be calculated.

## Safeguarding

- The clinic had a lead safeguarding nurse and a policy for both safeguarding adults and children. The safeguarding children's policy had been reviewed in 2015, however it did not reference two key documents. One was the intercollegiate document 'Safeguarding children and young people: roles and competences for healthcare staff' that was published by the Royal College of Paediatrics and Child Health in 2014. The second was the March 2015 updated 'Working together to safeguard Children. Despite the safeguarding adult's policy being reviewed in November 2016, this did not reference the Care Act 2014 which included key information relating to adult safeguarding.
- Clinical staff received training annually from an online package that provided training at level two and for some staff an enhanced package at level three. Some non-clinical staff did not receive any training in safeguarding, which does not follow government guidance which states that all staff working in healthcare settings should receive a minimum of level one training.
- Records provided to us prior to the inspection showed that 75% of permanent staff had completed adult safeguarding training within the last year, with the majority completing it in November 2016. Only 44% of staff had completed child safeguarding training at level two and one member of staff had completed the enhanced level three child safeguarding training.
- We were told that consultants seeing children would receive annual training from another hospital where they were employed. However, when we reviewed records only one consultant out of eight was confirmed as having had training in December 2016 and this was only to level two, which is not in line with intercollegiate guidance stating that those working directly with children should be trained to level three. This meant that the clinic was not able to provide assurance that those seeing children had received the required level of training.

## Mandatory training

- Staff received mandatory training for either basic or intermediate life support (ILS), safeguarding adults and children, infection control, health and safety, fire safety, manual handling and aseptic non-touch technique.
- We saw records of staff mandatory training which identified numbers of staff who were up to date and who had training booked. We asked for the clinic target for mandatory training however this was not provided to us. Their records showed that 100% of staff required to do ILS had completed it.
- Paediatric basic life support had been completed by 94% of staff that required it and additionally by two visiting consultants. In addition one nurse was trained in paediatric intermediate life support. The clinic did not carry out any surgery for paediatrics under general anaesthetic and so did not require any further enhanced training.
- The clinic did not provide information governance training. This means that the clinic did not follow the requirements of the information governance toolkit for qualified providers. The records policy stated the elements of data protection, and we were told that this had been circulated to staff members, however the clinic did not have a method of knowing that this had been read and understood by staff.

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

- The clinic had a strict admissions criteria and no patient was admitted unless they were low risk patients. This was measured using the American Society of Anaesthesiologists (ASA) scoring system and only patients who scored one or two on this system were able to have surgery at the clinic. Information used to assess this score was taken from a medical questionnaire that was given to the patient prior to their surgery. The clinic did not routinely ask for further information about a patient's medical history from their GP or conduct a pre-assessment clinic. This could mean that there was a risk that a complete medical history was not received prior to surgery.
- The clinic did not offer routine pre-assessment clinics. The clinic process was that patients would complete a medical questionnaire, which would be reviewed by the pre-assessment nurse and anaesthetist. If concerns were raised from this, a telephone or, occasionally, a face-to-face pre-assessment, by either the nurse or anaesthetist, would be conducted. Guidance from the

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Royal College of Anaesthetics does state that most patients undergoing elective surgery should attend a pre-operative preparation clinic, but recognises that in certain circumstances healthy patients having minor day-case surgery can have telephone assessments. The clinic's assessment process meant that this guidance was not followed for all patients. However, managers told us there were plans to introduce a pre-assessment clinic.

- Clinic staff told us they asked female patients if there was any chance that they may be pregnant prior to surgery, but did not routinely carry out pregnancy tests. However information provided to us following the inspection was that 113 pregnancy tests had been carried out by the clinic through an external laboratory between February and December 2016. National Institute for Health and Care Excellence (NICE) guidance states that all pregnancy testing discussions, including risk of anaesthesia and the procedure to a foetus should be documented. We checked one record and found that documentation of pregnancy discussions had been undertaken.
- The clinic used Total intravenous anaesthesia (TIVA), a technique of anaesthesia which involves use of intravenous drugs to anaesthetize the patient without the use of inhalational agents. As this was not used regularly in other hospitals, all anaesthetists undertook a shadow procedure at the clinic to make sure that they were confident in administering this type of anaesthetic.
- The clinic's admissions policy stated that an early warning score (EWS) was used in order to identify any 'at risk' patients following a procedure. This followed Intensive Care Society guidelines (2002). This was not an active guideline and latest intensive care society guidance stated that NICE guidance 50 should be followed. We saw documentation of EWS in both recovery and ambulatory care. The ambulatory care documentation had clear guidance on actions if a score was raised, such as calling the anaesthetist for advice; however the recovery paperwork did not.
- The clinic had conducted three audits in 2016 to monitor compliance with the (WHO) Surgical Safety Checklist (sign-in, time-out, sign-out). This had been identified as an issue from December 2015. However, the first 2016 audit was only undertaken in August and showed only 49% overall compliance with the three steps of the WHO checklist. This had improved slightly in an audit undertaken on 1 November to 61% overall and improved again to 77% on the last audit undertaken on 28 November 2016. The audits had not included monitoring of compliance with pre and post list briefing and debriefing, which together with the WHO checklist completes the '5 steps to surgical safety', shown to reduce avoidable harm during procedures. The final audit report listed actions to improve compliance including a new form and record re-audit. It also recommended that an observational audit and a review of incidents should be conducted, but the audit had been completed too close to our inspection for actions to have been done. We observed the sign in and sign out sections completed for a procedure and this was done appropriately; however, a record set that we reviewed on the day of the inspection did not have full completion of the sign in and out.
- We were not able to see the pre-list briefing on the day of our inspection as we were told it had been carried out earlier than usual. Staff we spoke with gave inconsistent reports about pre-list briefings. Some staff told us that the day of our inspection had been the first day that one had been conducted, while others told us that they would usually sign the form once the information from the briefing had been cascaded to them. Others said that they were carried out 99% of the time. We were told the anaesthetist and surgeon had not attended the briefing that morning. This was not in line with best practice. On the day of our unannounced inspection, we saw a briefing sheet that was completed and signed by the lead nurse in theatre. This was made available for staff and visiting consultants to read as they entered the theatre area. However, a whole-team face to face briefing had not occurred.
- There was no access to blood products on the premises, in case the patient had a major haemorrhage during a procedure. The clinic had a major haemorrhage policy and this stated that if necessary blood products could be ordered in an emergency from a local laboratory.
- Clinic staff told us that general anaesthetics were only conducted prior to 1pm. This meant that time was given for patient recovery during the afternoon if required. We observed an anaesthetist staying in the recovery room until the patient was self-ventilating, however we were told that this sometimes did not happen as they went to prepare for the next case. Anaesthetists would stay in the clinic until the patient was awake and then be available for 24 hours following the procedure.

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- There was an emergency button available in all areas of the clinic. However the clinic did not have a dedicated team of people that would respond in the event of an emergency as relevant staff would be operating on a patient in the operating theatre. Some staff reported that the recovery nurse would respond, however this would not happen if they had a patient in recovery. This meant that it was unclear who would assist in the event of an emergency. Although nine staff from the theatre area had completed internal training in May 2016 for a collapsed patient scenario, there had been no formal report or documented learning points, so it was not known what had been covered or the outcomes from it. Resuscitation drills had been recommended twice a year in an external assessment completed in July 2016, however staff we spoke with said that this hadn't been done.
  - The clinic had a service level agreement with a local independent hospital for critical care services. If emergency transfers were required, clinic staff called 999 to transfer a patient to an NHS hospital.
  - It was the operating surgeon's responsibility to assess the patient's suitability for surgery and refer them for psychological assessment if required. We saw documentation in the two electronic records we checked that this had been assessed by the surgeon. However it did not detail whether any questions had been asked about a patient's mental health or whether they were taking any anti-depressants. Although current medication was asked about on the medical questionnaire, which would indicate if a person was taking anti-depressants, this should be part of the psychological assessment process and not done separately. The RoFCAR cosmetic procedures checklist was used by the consultant to help establish the rationale for surgery. (The RoFCAR is named after the two hospitals where the tool was developed). However this does not cover all of the recommendations by the Royal College of Surgeons professional standards for cosmetic surgery, published in April 2016.
- registered nurses, four HCAs and two operating department practitioners (ODP). In addition to this, a number of bank staff were used and any additional shifts were covered by agency staff. One porter was employed under a bank contract so nursing staff carried out additional general tasks, such as restocking equipment, as well as nursing duties.
- The clinic had listed clinical staffing levels on its risk register as a moderate risk and outlined that Association for Preoperative Practice (AFPP) guidelines were followed as its mitigation. However on the day of our unannounced visit, we saw that both theatres were running with only one registered nurse as the scrub practitioner, one healthcare assistant and one ODP. Although there was an additional nurse circulating between both theatres, this did not follow the AFPP guidelines that state there should be a minimum of four staff; two scrub practitioners, one circulating nurse and an ODP. We looked at a diary of theatre staff planning held on the ward and noted that it was common to only have three members of staff per theatre. If a member of theatre nursing staff was sick, we were told the recovery nurse would be moved into the theatre and the ODP would recover their patient. On the day of our unannounced inspection, there was only one nurse within the ambulatory care area when two were required. We were told that another bank nurse had been requested and was due to come in later, during the recovery period of patients.
  - During our inspection, we observed that there was only one nurse allocated to the recovery area. This had been raised by a staff member during a staff meeting in June 2016, however the practice had not changed at the time of our inspection, almost six months later. This did not follow immediate post-anaesthesia recovery safety guideline published by the AAGBI where it states there should be no fewer than two staff present when there is a patient in a post-anaesthesia care unit (PACU). As there were two theatres used for general anaesthesia, there was also potential that two patients may be cared for at the same time in the recovery room. The AAGBI guidelines and the AFPP guidelines state that patients must be observed on a one to one basis by an anaesthetist or registered PACU practitioner until they are awake and stable. The recovery nurse told us that they had on some occasions, recovered two patients alone, although they had not reported this as an incident. On the day of our inspection, we observed that

## Nursing and support staffing

- Total full time clinical staff for the clinic included six nurses, three nurse specialists and five healthcare assistants (HCAs). This included outpatient and theatre staff.
- The clinic did not use an acuity tool to plan their theatre staffing. The theatre permanent staff consisted of six

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when there was one patient in the recovery room, a second patient's procedure finished and the decision was made to recover them in the operating theatre overseen by the ODP, which meant that there was an appropriate level of patient care. We raised this with the clinic manager and were informed that the new clinical lead had been working within the recovery area, when available following their appointment, until other staff could be appointed.

- There was one full time nurse vacancy at the time of our inspection. Between 40 and 90 shifts each month were filled by bank staff. Between one and seven shifts each month were filled by agency staff.
- We were told that sometimes theatre staff would ask for bank or agency staff to be provided and this was not actioned by senior managers, or they were booked but then cancelled. We were told by managers following the inspection that cancellations would occur on occasion if a sickness vacancy needed to be covered at short notice. Several people would contact permanent, bank or agency staff to cover and this could mean that extra staff were overbooked and therefore they were cancelled
- There was only one full time nurse with recovery competencies. This nurse worked full time and would also cover some of the Saturday clinics. We asked about the process for when they took leave and were told that an agency staff member would be used or the ODP would recover the patient, although this could lead to a delay in the next case.
- There were a small number of paediatric local anaesthetic procedures undertaken. Clinical managers told us that where possible they would organise separate lists for paediatrics and a bank paediatric nurse would be asked to attend on those days, however we did not view any records of when this had occurred.
- Some staff we spoke with in the theatre environment felt that there were adequate staff levels to provide safe and effective care for patients. However others raised concerns about the staffing levels, as they felt that if there was an emergency, then they may not be able to respond appropriately. There was no back up provision if there was short notice sickness.

## Medical staffing

- Consultants who worked at the clinic were required to maintain current practicing privileges in line with The Cadogan Clinic practicing privileges policy to be eligible

to work on site. At the time of our inspection, there were 72 consultants with practising privileges at the clinic, which was a mix of medical consultants, surgeons, radiologists and anaesthetists.

- Of the total number of consultants, 31 had not completed an episode of care at the clinic between July 2015 and June 2016, which may mean that they may be unfamiliar with the clinic practices when they next arrived.
- Consultants were clinically responsible for the patients under their care, and were required to review their patients following the operation. We were told that consultants would remain at the clinic until the patient had left the recovery area and some told us they would remain until the patient was ready to go home. The amount of follow up consultations would depend on the procedure. For liposuction, a consultant told us they would arrange follow up consultations the day after the procedure and at one, three, and six weeks, and three and nine months.

## Emergency awareness and training

- The clinic had last conducted a fire evacuation drill in June 2016. All fire extinguishers we saw at the building were within their service dates.
- The clinic did not have an emergency generator, but had an isolated power supply and an uninterruptable power supply system that provided continuous off grid (battery) power for one hour. We saw records of servicing and testing for this system that was carried out by an external company.

## Are surgery services effective?

### Evidence-based care and treatment

- A number of policies that we reviewed had not been updated to incorporate current guidance. This included: the admissions policy, which had not been updated with current NICE, Royal College of Anaesthetics or AAGBI guidelines; the consent policy, which referenced out of date guidance from 2001 and the safeguarding policy, which did not refer to the Intercollegiate Standards of 2014. However the infection control policy had been updated following the latest NICE guidelines.

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- Liposuction procedures were documented on a 'Smartlipo tracking sheet' which contained information about the temperature and laser used for each area of liposuction.
- The clinic had commissioned an external assessment against the CQC framework in July 2016. A number of high risk actions were identified on this. Some had been completed, such as incident reporting refresher training, however others had not, including review of the admission criteria and audit of the pre-assessment questionnaire.
- The clinic had commissioned an external independent expert to conduct a review of the whole theatre process that was completed in August 2016. A report had been provided with some clear actions about what was needed for improvement. The clinic had commenced some of the recommendations, such as introducing WHO checklist audits.
- The clinic offered Mohs surgery, which is considered to be a highly effective technique for removing two of the most common skin cancers by a number of organisations.
- The clinic had an annual plan for audits. These included medicines management, infection prevention and medical records. However many of the audits planned on the schedule had not been completed such as all but one medical record audit and medicines stock control. Some staff we spoke with were aware of some audit templates, however said that they were not suitable for the nature of the work the clinic undertook, so they had not been done.

## Pain relief

- All staff used the same pain assessment score of '0-3' when asking patients about their pain levels.
- We saw a patient complaining of pain after surgery. The nurse responded to this quickly and checked the drug chart to see what had been prescribed before administering pain relief. Fentanyl, a very strong painkiller, was available for pain relief post operatively, however there was none stored within the recovery area, so the nurse had to request it from the operating theatre. This might be difficult to arrange if there was only one nurse available in recovery and had the potential to disturb another surgery procedure.
- A discharge form completed for each patient included guidance on pain relief that should be taken

- A comment card received from a patient stated 'my pain and needs were cared for immediately'

## Nutrition and hydration

- The clinic followed the AAGBI guidelines for directing fasting periods prior to surgery. Although the admissions criteria referenced guidelines from 2001, rather than the more recent 2011 guidelines.
- All patients were given anti-sickness medication during their operation and would be prescribed anti-sickness medication for use after the operation if required.
- All patients were provided with food and drink after surgery, which was usually a sandwich or salad and this was part of the discharge checklist within the major procedure care pathway documentation.

## Patient outcomes

- The clinic had submitted data to an external company since September 2016 as part of the newly introduced Patient Reported Outcome Scores (PROMS) for the specific procedures of mammoplasty, rhinoplasty, blepharoplasty, rhytidectomy, abdominoplasty and liposuction. The first outcome data for this was expected in January 2017.
- The clinic had been submitting data to the Breast and Cosmetic Implant Registry (BCIR) since October 2016. We saw a log that showed what submissions had been made.
- All revisions and unplanned returns to surgery were reviewed by each consultant as part of their revalidation. The Medical Advisory Committee also discussed each individual of these revisions and returns. In 2015, there had been 15 planned revisions, (where a patient returns for a subsequent operation after surgery) and seven unplanned returns to theatre. Between January 2016 and November 2016, there were 17 planned revisions and three unplanned returns to theatre. In addition to this, we saw benchmarking that had been done for all clinical cases between January 2012 and October 2016 for one consultant, compared to other hospitals where he carried out procedures, and this showed that as a percentage the clinic was comparable to other hospitals.
- The clinic had been submitting data to the Private Healthcare Information Network (PHIN) since April 2016. We saw a record of the data that had been submitted by the clinic for this. Information from PHIN was due to be published by April 2017 and so was not yet available.

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- For liposuction, we were told by a consultant that they would take measurements during follow up consultations at one day, one, three, and six weeks, three and nine months. This would be used to assist in measuring the results.
- All consultant surgeons and anaesthetists were required to maintain current practising privileges in line with the clinic's practising privileges policy. This policy ensured consultants took responsibility for maintaining their own clinical competence and had adequate professional insurance to practice. To maintain their practising privileges, consultants were also required to show evidence of annual appraisal and General Medical Council (GMC) revalidation.
- The Medical Advisory Committee (MAC) approved the granting and removal of practising privileges. All consultants had to upload supporting documentation annually for review. The MAC had suspended the privileges of one consultant due to inexperience of day case surgery in the last 12 months. Senior managers also told us of a further example the previous year where a surgeon had poor conduct within the theatres and had his practising privileges withdrawn.
- We were told that nurses and healthcare assistants had supervision carried out by senior nurses within the department; however as it was not recorded formally, we could not confirm this.
- We saw some competency documentation completed for nurses including competency for photodynamic therapy. However we did not see competencies completed for other procedures such as skin excisions that staff were assisting with. We were also informed of an HCA who was carrying out scrubbing duties within the theatre and we were not provided with any competencies that they had completed for this task, such as an accredited training course. When we raised this with the clinical manager, they were aware of this, and planned to review this, however they told us that the HCA was carrying this out under supervision, which we were unable to coöperate.
- We saw documentation detailing whether staff had received an appraisal. 90% of the staff that been in post for over six months had completed an appraisal. Staff who had been in post less than six months had only had performance targets set. We asked staff about appraisals that they had received. One said that their recent appraisal had been the first in many years since starting work at the clinic and felt that, as there had not

been any goals set within them, it had not been a helpful process for their development. However another staff member said that they were happy with their recent appraisal and thought they were getting appropriate support towards their clinical development. Outpatient staff we spoke with told us they had received regular one to one meetings, supervision and yearly appraisals.

## Multidisciplinary working

- A number of external advisors were used by the clinic for specific areas. This included infection control, health and safety, microbiology, pharmacy, laser protection and integrated governance. We saw minutes of clinic meetings such as the integrated governance and the MAC that demonstrated how these advisors worked with the clinic to improve quality of care.
- We observed a handover of a patient from theatre to the recovery nurse. The anaesthetist carried out part of the handover but did not mention that the patient had allergies. The nurse carried out a handover of the procedure, however did not mention information such as dressing type or any drainage in place.
- The clinic offered a 'one stop shop' for vascular assessment where patients considering surgery could arrive and have a detailed scan, consultation and have a plan for their treatment agreed on the same appointment.
- The clinic had agreements in place for emergency transfers with a local acute NHS hospital and also non-emergency transfers with a local independent hospital. We were told this was a very rare occurrence and there had been none in the last year.

## Access to information

- Patient records were a mixture of paper and electronic records. Paper records were scanned into the electronic record each week so that full information could be held.
- The clinic had ultrasound access on site and results could be provided instantly. Access to pathology and histopathology was provided by external laboratories. Samples would be collected by courier and would be transmitted to the clinic electronically usually within 24 hours. Mycology results were processed by an external hospital laboratory and were sent directly to dermatology consultants.

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## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consultants were able to provide a comprehensive explanation of the consent procedures. After the cooling off period, (time given to the patient to consider whether they wanted to proceed with the surgery) the patient would complete a consent booklet along with the medical questionnaire and this would list the risks of the surgery. A further two-stage consent and sign in consultation would happen on the day of surgery and some consultants telephoned their patients the day before the surgery.
- Consent audits had been carried out within the audit of safe surgery in August and November 2016. This audited 10 records each time for the consent form availability, legibility, signed by the doctor and no abbreviations used on the form. In the August 2016 audit compliance was 95% and this had improved to 100% in November 2016.
- We looked at two sets of patient records and found clear documentation in both sets about consent and signed consent forms had been scanned into the records.
- The clinic had a cancellation of procedures policy where it was stated that there was a 14 day 'reflection and cooling off; period following consultation with the surgeon. It stated that within this period all fees would be refunded in full. There was an option for patients to waive this cooling off period and to do this they had to complete a patient waiver form that would need to be discussed and agreed with the surgeon. Two records that we reviewed had a clear gap of over 14 days from final consultation to the surgery procedure.
- The clinic's consent policy was updated in August 2016 and did include a paragraph on consent for children and young people. However, it did not refer directly to Gillick competence, a recognised term used in medical law to determine whether a child under 16 years old is able to consent to their medical treatment. The policy referred to Department of Health Guidance from 2001 which has since been archived and was updated in 2009. This meant that the policy stated that a parent could consent if a competent child refused; however this is not the case in non-emergency operations and means that the policy does not follow current law.
- Mental Capacity Act (2005) (MCA) training was not part of the mandatory training package so we were unable to establish when staff had last received training for this.

Staff we spoke with had knowledge of the MCA principles and advised us that it would be extremely unlikely that a best interest decision would be required due to the services the clinic provided.

## Are surgery services caring?

### Compassionate care

- The clinic collated a Net Promoter Score (NPS) by telephone call backs each quarter and additionally from their own patient feedback survey each quarter. The response rate for the NPS survey was variable with between seven and 330 responses for each of the months. For their patient feedback survey, an average of 37 responses per quarter had been received which was around 19% of patients having procedures. For the patient survey, the overall average was 9.5 out of 10 indicating that patients were happy with the care that they had received. The NPS scores were more variable with an average of 48% rating care as nine or 10 compared to 20% rating care between one and six.
- All of the comment cards that we received were positive about the care that patients had received at the clinic. One said 'Staff were amazing, I felt instantly comfortable and well cared for'. And another stated 'Truly appreciated the friendliness, care and effort from everyone at the clinic.'
- We spoke with four patients within the outpatients department and all told us they were treated with dignity and respect at the clinic. They told us staff spent time with them and put them at ease. They told us that staff were "calm and relaxed" and "all staff were really helpful".
- Interactions we saw between staff and patients were compassionate, empathetic and respectful and one patient described the staff as "very caring".
- A small private room was used in the surgery area for taking consent on the day of procedure and marking for location of the surgery. The use of this room meant that patient's privacy and dignity was maintained. Patients were provided with a dressing gown that they could wear over their gown while waiting for surgery and moving between rooms within the theatre area to protect their dignity.
- The clinic had a chaperone policy and consultants told us how they always had a chaperone with them when conducting any intimate examination of the patient. We

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observed a chaperone present during a consultation and examination. The policy did not identify the recovery area as somewhere requiring a chaperone although this was an area where a lone member of staff was caring for patients in a vulnerable condition.

- The clinic planned surgery so that male patients would have procedures where possible on separate days to female patients in order to ensure dignity.
- We observed all staff introducing themselves to patients as they met them at each stage.

## Understanding and involvement of patients and those close to them

- Patient co-ordinators provided support and gave information to patients on non-clinical matters such as appointments and costs.
- Consultants we spoke with were able to tell us about the importance of setting patient expectations prior to surgery so that patient's would understand what the final outcome would be. We observed a consultation where the surgeon made it clear what could be achieved with surgery to the patient. We were told of a further example where a patient had arrived on the day of surgery and had new expectations that they had not discussed with the surgeon. The surgeon made the decision not to carry out the procedure in order that they could have a further discussion with the patient about expectations of outcomes.
- The service used a RoFCAR checklist as part of the pre-surgery assessment and this is best practice in determining realistic expectation of the outcome of surgery.
- One patient we spoke with said they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.
- One comment card we received stated 'Provided lots of informative information from all of the team at the Cadogan Clinic.'

## Emotional support

- We observed a procedure being conducted under local anaesthetic and saw that the nurse who was present reassured the patient throughout the procedure.

- Patients were positive about the emotional support they received from staff especially around the choice of treatment options available to them. We saw that staff were empathetic towards patients and spent time alleviating patients concerns and anxieties.
- One comment card received back stated 'I was particularly nervous and everyone involved worked hard to put me completely at ease.'

## Are surgery services responsive?

### Service planning and delivery to meet the needs of local people

- The clinic planned some theatre lists on a Saturday, which was reported as popular with patients. We looked at records and found that 15 Saturday sessions had been run between January 2016 to July 2016.
- The clinic produced a brochure on skin treatments that provided costs of some treatments for patients. The website also provided clear information on the cost of procedures and identified that this was variable but would be confirmed by the consultant prior to having the procedure.

### Access and flow

- Patients could be referred to the clinic by their GP or could contact the clinic directly through the website, email or telephone. There were three patient booking staff based at a different location, who responded to enquiries made via the clinic's website or by patients who called the clinic directly for appointments. Patient's considering surgical procedures would have a consultation with a patient advisor and this would be followed by a surgical consultation. Following this appointment, subsequent consultations could be offered or the surgery booked.
- Patients we spoke with told us they were offered a choice of appointment time according to their need and availability.
- Patients in outpatients told us they were mainly seen on time or within few minutes of their appointment. We were told consultants might take more time with a patient, which would extend the waiting time. However we were told that patients were always informed of any delays and we observed this during our visit.



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- The clinic reviewed average wait times for theatre and this was reviewed at the medical advisory committee (MAC) meeting. Between January and July 2016 the average wait times had been 45 minutes for a general anaesthetic and 25 minutes for a local anaesthetic. Communication about this had been circulated to the consultants to improve this time and this was due to be reviewed at the end of 2016.
- The clinic had an admission policy that had set criteria for those that could be included for treatment. However the criteria stated that patients were 16 years or older and the clinic currently carried out some minor procedures for children under the age of 16 so the policy did not reflect this.
- Patients were provided with a general discharge information sheet which included phone numbers that they could use to contact the clinic after their operation. All patients having specific procedures were also provided with an advice sheet with more specific aftercare advice. We saw an example of this for labiaplasty. This included an out-of-hours, on-call mobile number and was answered by nurses or ODPs, who would each cover this duty for a month. In addition, all patients had a 24 hour contact number of the surgeon that carried out their operation. The anaesthetists were responsible for their own patients and would be contactable on a mobile for 24 hours after the operation. The anaesthetists that we spoke with had not had to return to the hospital for any concerns.
- All patients would be contacted within 24 hours of their surgery by a nurse from the clinic to review how they were recovering. Patients would then be reviewed in an outpatients appointment and they would have a date for this prior to discharge.
- The clinic did not carry out any unplanned surgery. If patients had an issue after surgery they would be provided with a phone number for their consultant. In an emergency the patient would be directed to an acute hospital accident and emergency department. For non-emergency issues, the patient would be reviewed by their consultant and if they required a revision, this would be arranged as planned surgery.
- From January 2016 to November 2016 there had been a total of 64 cancellations which consisted of 39 general anaesthetic procedures and 25 local anaesthetic procedures. As part of this being reviewed, an action had been planned to update the clinic cancellation policy and also the pre-assessment process.

## Meeting people's individual needs

- Staff we spoke with told us that there was a local Arabic translator that they would use if an Arabic speaking patient required a translation service. In addition, a large number of staff working within the clinic spoke additional languages and they would use this resource if required.
- We observed a consultation with a patient on the day of surgery when final consent was being requested. The patient did not speak English, however the consultant spoke the same language as the patient and therefore was able to explain the procedure and gain consent for photographs and the procedure. However during another observation we saw a patient's family member translating for them which is not best practice.
- We observed a patient who was having surgery on the day of our inspection who had special dietary requirements that were not suitable for the usual selection offered. The clinic had arranged a special delivery of food from an alternative shop that met the needs of this patient.
- Patients attending for the first time had a longer appointment to allow time to ask questions.
- The clinic waiting area was small, however it provided for patient's needs by making drinks, magazines and newspapers available for those waiting.

## Learning from complaints and concerns

- The clinic did not have a specific area about raising a complaint on the website and we did not see any specific leaflets about complaints. However, there were leaflets requesting feedback available in different departments.
- The clinic had received 15 written complaints since January 2016 to November 2016. Seven of these were in related to outcomes after surgery, three were about the consultant, three were about the service, one was about nursing and one about finance. Complaints were all reviewed at the integrated governance committee. There had been investment in finance and senior management in order to improve the patient experience following these complaints.
- The clinic had made some changes in response to comments received from the quarterly NPS survey including: improved reception staffing, more selection

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of drinks, increased product training for reception staff; clearer pricing and timing for dermatology appointments and adapting the payment room for greater privacy.

- A visiting consultant told us that in response to patient's feedback they had agreement from senior managers to trial a new innovative, made to measure, surgical stocking (used to prevent blood clots forming) that was hoped to be more comfortable for patients.
- Meeting minutes of the skin team for June and October 2016 showed that complaints and patient feedback were discussed.

## Are surgery services well-led?

### Leadership / culture of service

- The values of the service had been developed with the staff. These were: 'Our patients are our number one priority; providing world class private healthcare; hand-picked team of the very best staff; the best consultants, the best care; efficiency; ethics.'
- The clinic had a new managing director who had been in post since July 2016 and was appointed as the registered manager in November 2016. His vision, together with the agreement of the clinic owners was to improve the clinic's clinical leadership. Since his arrival he had made new appointments and additionally contracted an external consultant had been contracted to identify improvements that were required. In interviews with us he demonstrated his experience of the health sector and his passion for driving improvement.
- The clinic had recently appointed a new post of a clinical lead role and this manager had only been in place for about two weeks prior to our inspection. There was also no theatre manager in post. Some staff reported that it had been very difficult working in the theatre area without clinical leadership and when they raised concerns these were not acted upon by senior managers.
- Some staff we spoke to within the theatre area said that senior management were not visible in the department unless they had a specific question. This was supported in the staff surveys carried out where 35% of the 26 staff who responded disagreed that communication between senior leaders and employees was good.

- All staff we spoke with reported that they enjoyed working at the clinic as they got on with their colleagues well and said there were good team working relationships with colleagues. In the 2016 staff survey, over half of the respondents agreed that they had a good working relationship with their line manager in the staff survey. In addition, no respondents reported a poor working relationship with consultants with most (85%) very positive about the relationship. However some clinical staff reported to us that they felt there was a disconnection between managers and clinical staff and that this meant they felt that they were sometimes not listened to. An example was identified within the staff meeting minutes of June 2016 where the issue of only one staff member in recovery had been raised and this had not changed by the time of our inspection.
- The most recent quarterly meeting had included an agenda item on the results of the 2016 staff survey and had noted the areas of concern.
- Quarterly meetings were held externally and were open to all staff. They provided an opportunity for staff to socialise with each other afterwards. A staff member also told us of a BBQ that had been provided for all staff at the clinic owner's house over the summer.
- We reviewed four staff records for those who had most recently joined the clinic and found that they all had disclosure barring certificates held within their files.

### Vision and strategy for this service

- The vision of the service was to provide high quality, integrated private healthcare in a discreet setting. In addition the service intended to be a centre of excellence for skin conditions and provide a range of treatment options so that the right service could be provided for each patient.
- Senior managers also spoke of their vision to improve education, training and development of staff and this was intended to be achieved under the new appointment of the clinical lead.

### Governance, risk management and quality measurement

- The governance structure of the clinic was led by an integrated governance (IG) group that would review information from sources including audits, incidents and complaints. This IG meeting took place each quarter and attended by leads from each department. The group discussed, incidents and learning, infection

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control, health and safety, patient outcomes, training and reviewed policies; and minutes were sent to the Medical Advisory Committee (MAC). The expectation was that minutes of the meeting were to be shared in local team meetings. However, although we were told that team meetings were held fortnightly for theatre staff, there were limited notes available to us to review these meetings. The content of the theatre meeting notes that we saw did not include specific learning about incidents, although did mention some audits which meant that it was unclear how information was shared fully up and down the organisation.

- The MAC met quarterly and reviewed practising privileges, clinical governance, adverse events, infection control, patient feedback and finances. The chair of the MAC reported that they were listened to and able to input into change. There was regular contact between managers and the MAC chair and he reported a good working relationship.
- Surgery outcomes were reviewed by the MAC at the weekly performance meeting. If there were concerns about the performance of a specific consultant, a review of their practising privileges took place. Senior managers told us of an example the previous year where a surgeon had poor conduct within the theatres and had his practising privileges withdrawn.
- Meeting minutes of the MAC showed that members were not aware of the results from the WHO safety checklist audits. In the MAC meeting minutes of June 2016 that we reviewed, a request for introduction of a safety huddle pre-surgery was made. This had been discounted on the basis that the WHO checklist was always completed. However, results from the audit of the checklist in August were very low at 49% compliance and there was an indication that from an external assessment that compliance had also been low in December 2015. These audit results were not mentioned in the minutes from September 2016, indicating that there was lack of awareness at this level, of the importance of these safety audit results.
- Senior managers we spoke with told us that they were assured of safety due to the process of daily theatre huddles. However MAC minutes did not support the suggestion of huddles and we had conflicting reports that these daily huddles or briefings occurred and on the morning of one of our visits found that this was not done and a briefing sheet was used to share

information. This showed that there was a discrepancy between what senior managers believed was occurring; what the MAC view was and what was actually happening.

- A weekly management meeting was held and issues and feedback from this was reported to be cascaded to staff in quarterly staff meetings and also communicated to the IG meeting.
- We saw minutes from three staff meetings held in 2016. Those held in February and June 2016, focused on the business side of the clinic and plans for increasing growth. The one held in November 2016 looked at clinical performance and adverse events and complaints which meant that this key information was being shared with staff.
- A risk register was in place that had been reviewed in November 2016. It included 35 risks of which none were graded as high level risks after mitigating actions. There were no dates of when risks had been added to the register so it was unknown how long some had been on there, but it included risks that we identified on our inspection, such as clinical leadership. We found one of the risk mitigation actions was not being followed in regard to staffing, where it was stated AFPP recommendations were in use when in fact they were not.

## Public and staff engagement

- The clinic collated a Net Promoter Score (NPS) by telephone call backs each quarter and additionally from their own patient feedback survey each quarter. Their patient feedback forms were placed in several areas around the clinic. The results were reviewed at the IG and MAC meetings.
- There were staff meetings that occurred every quarter, however not all staff were able to attend these as the clinic still had to carry out work at these times. The theatre staff members had separate team meetings. We were told that these happened fortnightly, although records for these were only held for two meetings in July, One in August and one in November 2016. The outpatient clinicians providing skin services, had two meetings over 2016, in June and October.
- The clinic carried out staff surveys each year. In both the 2015 and 2016 approximately 35% of respondents had disagreed that communication between senior leaders and employee was good and 25% disagreed that strong performance was recognised. A new question was

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introduced in the 2016 survey which asked 'How comfortable do you feel voicing your concerns to management?' Although most of the respondents had responded that they were comfortable, 21% of them staff had said that they were not comfortable.

## **Innovation, improvement and sustainability**

- The clinic was a joint winner of 'Best Cosmetic Surgery Clinic UK 2016' at the My Face My Body Awards.
- We were informed of a number of new and improved techniques undertaken at the clinic, including a breast

measuring device, breast surgery technique and the management of combined procedures known as the 'mommy makeover'. Many surgeons had also had research published, although none within the last 12 months that our inspection reviewed.

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

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the provider **MUST** take to improve

- The provider must ensure that they comply with national guidance for theatre and immediate post recovery care staffing.
- The provider must ensure that the WHO safety checklist is carried out and documented 100% of the time.
- The provider must ensure that there is a robust, rehearsed, response plan in the event of a sudden patient deterioration and the crash alarm sounding.
- The provider must ensure that its policies reflect current clinical guidelines.
- The provider must make sure that the consent policy is updated to reflect current legislation for consent of children under 16 years old.

### Action the provider **SHOULD** take to improve

- The provider should take prompt action to ensure that the clinic follow guidance set out within the information governance toolkit for any qualified provider.
- The provider must take prompt action to ensure that all staff have appropriate level safeguarding training, including visiting consultants who receive training elsewhere.

- The provider should ensure that the '5 steps to safer surgery' is embedded throughout the clinic.
- The provider should ensure that there is always the ability to monitor capnography for all patients within the recovery area who have their airways maintained with a tracheal tube or supraglottic device.
- The provider should ensure that the clutter is removed from the theatre area so that the area can be evacuated in the event of an emergency.
- The provider should ensure that all theatre staff are aware of the correct temperature ranges of fluid taken from the warming cupboard and actions if it is too high to administer.
- The provider should consider review of its pre-assessment arrangements to ensure that all patients receive pre-assessment in line with Royal College of Anaesthetics guidance.
- The provider should review the recovery documentation to ensure there is clear guidance for staff on actions in the event of raised early warning scores.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

#### Regulated activity

Surgical procedures  
Treatment of disease, disorder or injury

#### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Care and treatment was not provided in a safe way for service users because;

1. Roles were not delegated in the event of a crash alarm.
2. There was no clear back up provision for a response to a deteriorating patient if the recovery nurse was unavailable.
3. There was only one capnography machine in the recovery area and on one day of the inspection it was broken and was therefore unavailable.

Regulation 12 (2)(b)(f)

#### Regulated activity

Surgical procedures  
Treatment of disease, disorder or injury

#### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Systems and processes were not established and operated effectively because;

1. A large number of policies referenced out of date guidance and consequently did not reflect current requirements.
2. The consent policy did not reflect current legislation for consent of children under 16 years old.
3. The medical screening questionnaire did not reflect the MRSA guidance.
4. There was extremely low compliance with the WHO safety checklist and the '5 steps to safer surgery' were not embedded.

This section is primarily information for the provider

## Requirement notices

5. The clinic stated that AfPP guidance was followed to determine theatre staffing however records showed that this regularly fell below this guidance.

Regulation 17(2)(a)(b)

### Regulated activity

Surgical procedures

Treatment of disease, disorder or injury

### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

There were not sufficient numbers of suitably qualified, competent skilled and experienced persons deployed because;

1. There were insufficient recovery nurses when more than one patient was being treated within the recovery area.

Regulation 18(2)(a)