

The Private Clinic Limited - Bristol

Quality Report

92c Whiteladies road

Bristol

BS8 2QN

Tel:0117 317 9035

Website:www.theprivateclinic.co.uk

Date of inspection visit: 11,12 and 18 October 2016

Date of publication: 18/01/2017

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

Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected The Private Clinic Bristol as part of our programme of comprehensive inspections of all independent healthcare providers between 11 and 12 October 2016, with a further announced visit on the 18 October 2016.

This inspection was a comprehensive inspection covering the key questions of safe, effective, caring, responsive and well led.

We do not currently have a legal duty to rate cosmetic surgery services or the regulated activities they provide but we highlight good practice and issues that service providers need to improve.

Are services at this clinic safe?

- Medical gases were stored in a room which did not have any warning signs on doors highlighting that the cylinders were stored in there.
- Risks associated with procedures were not always recorded or legible, and surgeon's detailed consultation letters were not integrated into the clinic's patient care records.
- The Private Clinic limited (the provider) collected information about safety, which was monitored centrally and was shared with clinic managers through a structured governance framework.
- There were good infection prevention control systems in place and there was evidence of changes to procedures following adverse incidents.

Are services at this clinic effective?

- The service followed National Institute for Clinical Excellence (NICE) guidance on the use of Endovenous Laser Ablation (EVLA) for the treatment of varicose veins.
- The systems used for granting and reviewing practicing privileges were thorough and doctors provided evidence of their clinical experience. Doctor's levels of indemnity insurance and skills were monitored using a central database.
- Consent forms for some procedures were not clearly labelled and contained information about all possible treatments which was not always edited to reflect which treatment a patient was undergoing.

Are services at this clinic caring?

- Staff understood the impact cosmetic surgery could have on patients and were compassionate in their approach to their patient's needs.
- Staff treated anxious patients with kindness and compassion.

Are services at this clinic responsive?

- Patients did not wait long for care or treatment and could access appointments at a time to suit them.
- Staff took the time to minimise waiting times for patients and operating lists had been adjusted to increase procedure time slots when lists had previously overrun.
- Psychological assessments were not recorded in patient notes, and patients were unaware if they had received an assessment as part of their consultation.
- There was evidence that alternative treatment options were discussed with patients, and the clinic offered multiple follow-up appointments after procedures.

Are services at this clinic well-led?

- The clinic had set out its vision and values; however some staff were unaware of the vision.
- Monitoring of risk registers was done centrally by the provider and was accessible to all clinics, however, some staff were unsure how to access them.
- The clinic followed General Medical Council guidance on the honest marketing of cosmetic procedures.

Summary of findings

We saw several areas of outstanding practice including:

- There was a clear culture of learning from clinical incidents with evidence of discussions held and action taken as a result to prevent further incidents.
- Nursing staff had identified and been trained in a type of massage which helped enhance patient aftercare.
- The registered manager had a virtual forum where they could go for help and advice.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the clinic must:

- Ensure all patient care records and notes are complete, legible and contain all appropriate assessments and relevant medical history, including risks associated with procedures.
- Ensure consent forms are appropriately titled and clearly explain the procedures patients are consenting for.
- Provide adequate safety signage for rooms where medical gases are stored.

In addition the clinic should:

- Consider using safety cannulas for all patients requiring intravenous medication.
- Consider venous thromboembolism (VTE) risk assessments for all patients undergoing surgical procedures in line with best practice guidance.
- Record evidence of psychological assessments in patient records for all patients undergoing surgery for cosmetic reasons.
- There should be consideration for sharing safety data which is collected centrally with the registered managers at the locations such as The Private Clinic Bristol.
- Consider replacing the resuscitation trolley with one which can be sealed with tamper evident tags.
- Ensure all staff are up to date with required mandatory training.
- Monitor the quality of the consent process and document this.
- Consider including doctors' summary letters in patient records.
- Consider ensuring all medical notes are recorded in black ink.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Overall summary

Our summary of our key findings from our inspection are as follows;

- Consent forms for some procedures were not clearly labelled and contained information about all possible treatments which was not always edited to reflect which treatment a patient was undergoing.
- Safety cannulas were not being used, and a sharps injury had been reported as an adverse incident.
- The service did not routinely carry out venous thromboembolism (VTE) risk assessments for all patients undergoing surgical procedures.
- Resuscitation equipment was not stored in a trolley with tamper evident tags.
- Medical gases were stored in a store room but did not have any warning signs on doors to the room.
- Patient records were not always complete or legible and surgeon's summary letters were not included in patient notes.
- Risks associated with procedures were not always recorded, or were illegible.
- Staff were not up to date with some training and records were not up to date.
- Psychological assessments were not recorded in patient notes.
- There were no prescription audits which checked the quality of the prescriptions filled out.

Summary of findings

- The clinic monitored some clinical outcomes from surgical procedures including ultrasound assessments of treatment effectiveness for varicose vein treatments.
- There was no audit of consent forms.
- One treatment room was visible from the road, meaning consultations could be viewed from outside.
- Clinical staff were unaware of translation or interpretation services.
- Most staff were aware of the values for the clinic, however some staff were unaware of the vision for the clinic.
- Risk registers were held centrally and were accessible to all clinics, however, some staff were unsure how to access them.
- The clinic was not using coding for its surgical procedures.
- One doctor working under practising privileges at all clinic locations was not on the Voluntary General Medical Council specialist register, which was a condition of the Provider's granting of practising privileges.

However;

- Staff had a clear understanding of local safeguarding procedures which were clearly displayed.
- Safety data was collected centrally by the provider to look for trends and was shared with clinic managers through a structured governance framework.
- All staff had received a minimum of basic life support training.
- There was a detailed infection prevention control audit which showed good compliance.
- Agency nurses and anaesthetic staff had thorough inductions, and provided evidence of their clinical practice to the clinic.
- The clinic followed National Institute for Clinical Excellence (NICE) guidance for varicose veins treatment.
- The clinic had received good patient feedback and had started collecting Friends and Family Test data.
- The clinic benchmarked patient satisfaction data against other clinics within the business.
- Staff had undertaken specialist training to help enhance the aftercare given to patients.
- There was a thorough process for granting practicing privileges for doctors working at the Private Clinic Bristol, and the clinic held evidence of competencies on site.
- Staff were compassionate in their approach to patient's needs.
- Patients could have multiple follow-up appointments and all patients were given a 24 hour emergency phone number.
- Staff treated anxious patients with kindness and compassion.
- Alternative treatment options were discussed with patients.
- Patients waited four to six weeks for their procedures.
- Operating lists had been adjusted to minimise delays following patient feedback.
- The clinic took account of patients' individual needs including dietary requirements.
- The clinic was a member of the Independent Healthcare Sector Complaints Adjudication Service (ISCAS) and the Centre for Effective Dispute Resolution (CEDR).
- Leaders were very visible and approachable.
- The registered manager had a virtual forum for help and advice from their peers in other clinics.
- Doctor's levels of indemnity insurance and skills were monitored both in clinic and centrally using a database.
- There was evidence of improvements made as a result of infection, prevention control audits.
- The clinic followed General Medical Council guidance on the marketing of cosmetic procedures.

Summary of findings

Our judgements about each of the main services

Service

Surgery

Rating Summary of each main service

Our findings were:

- Consent forms were not clear and did not clearly say which procedure it was for.
- Safety cannulas were not being used.
- The service did not routinely carry out venous thromboembolism (VTE) risk assessments for all patients.
- Resuscitation equipment was not stored in a trolley with tamper evident tags.
- Medical gases were stored in a store room but no warning signs were displayed on the door.
- Patient records were not always complete.
- Surgeon's summary letters were not included in patient notes.
- Risks associated with procedures were not always recorded.
- Staff were not up to date with some training and training records were not up to date.
- Psychological assessments were not recorded in patient notes.
- There were no prescription audits.
- The clinic did not monitor outcomes from all surgical procedures.
- There was no audit of consent forms.
- One treatment room was visible from the road meaning consultations could be viewed from outside.
- Clinical staff were unaware of translation services.
- Most staff were aware of the clinics values for the clinic, however some were unaware of the vision.
- Risk registers were held centrally and were accessible, however, some staff were unsure how to access them.
- The clinic was not using coding for its surgical procedures.
- One doctor working under practicing privileges across all of the registered locations was not on the General Medical Council (GMC) specialist register.

However;

Summary of findings

- Staff had a clear understanding of local safeguarding procedures.
- Safety data was collected centrally and was shared through a governance framework.
- All staff had received a minimum of basic life support training.
- There was a detailed infection prevention control audit which showed good compliance.
- Agency nurses and anaesthetic staff had thorough inductions
- The clinic followed National Institute for Clinical Excellence (NICE) guidance for varicose veins treatment.
- The clinic had received good patient feedback.
- Staff had undertaken specialist training to help enhance aftercare.
- There was a thorough process for granting practicing privileges for doctors working at the Private Clinic Bristol.
- Doctors provided evidence of their clinical experience.
- Staff were compassionate in their approach to patient's needs.
- The clinic collected Friends and Family Test data.
- Alternative treatment options were discussed with patients.
- Patients could have multiple follow-up appointments.
- All patients were given a 24 hour emergency phone number.
- Staff treated anxious patients with kindness and compassion.
- Patients waited four to six weeks for their procedures.
- Operating lists had been adjusted to minimise delays.
- The clinic took account of patients' individual needs.
- The clinic was a member of the Independent Healthcare Sector Complaints Adjudication Service (ISCAS) and the Centre for Effective Dispute Resolution (CEDR).
- Leaders were very visible and approachable.
- The registered manager had a virtual forum for help and advice.

Summary of findings

- There was evidence of improvements made as a result of infection, prevention control audits.
 - The clinic followed GMC guidance on the marketing of cosmetic procedures.
-

Summary of findings

Contents

Summary of this inspection

	Page
Background to The Private Clinic Limited - Bristol	10
Our inspection team	10
How we carried out this inspection	10
Information about The Private Clinic Limited - Bristol	11

Detailed findings from this inspection

Outstanding practice	34
Areas for improvement	34
Action we have told the provider to take	35

The Private Clinic Bristol

Services we looked at

Surgery;

Summary of this inspection

Background to The Private Clinic Limited - Bristol

The Private Clinic Bristol is a small independent clinic, which is part of the larger organisation, The Private Clinic Limited. The Private Clinic Bristol offered minor cosmetic surgery services to private patients. They do not see any NHS patients. There are no inpatient beds and the clinic has one operating theatre. No surgical treatments or procedures are carried out on children or young people at The Private Clinic Bristol.

The clinic provided a range of treatments and procedures not all of which are subject to CQC registration. The clinic

undertakes Vaser liposuction, Endovenous Laser Ablations (EVLA), and phlebectomies which are subject to CQC registration under the regulated activities: diagnostic and screening, surgical procedures and treatment of disease, disorder or injury.

The clinic had a registered manager who had been registered with the Commission since May 2016.

The Private Clinic had been judged compliant on our last inspection under the previous inspection methodology.

Our inspection team

Our inspection team was led by:

Inspection Lead: Louise Couzens, Inspector, Care Quality Commission.

The team included another CQC inspector and a specialist registrar plastic surgeon.

How we carried out this inspection

The purpose of this inspection was to look at how cosmetic surgery services were delivered at The Private Clinic.

To get to the heart of patients' experiences of care, we always ask the following five questions of every service provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to peoples' needs?
- Is it well-led?

Prior to our inspection, we reviewed a range of information we held about the organisation. We asked other organisations to share what they knew about the hospital. These included the local clinical commissioning group, the local council, Health watch Bristol, the General Medical Council, the Nursing and Midwifery Council and the Royal Colleges.

We carried out our announced inspection on the 11 and 12 October 2016, with a further announced visit on the 18 October 2016. We spoke with a range of staff in the clinic including a nurse, consultants, administrative and clerical staff, laser therapists, and the registered manager. We also spoke with staff individually as requested.

During our inspection we observed how people were being cared for, talked with carers and family members and reviewed patients' records of their care and treatment. We also spoke to a sample of previous patients over the telephone. We also reviewed comment cards the clinic had been handing out to patients in the weeks leading up to the inspection.

We inspected all areas of the clinic over three days including waiting rooms, treatment and consultation rooms and the operating theatre.

Summary of this inspection

Information about The Private Clinic Limited - Bristol

The Private Clinic Bristol is a small clinic that provides cosmetic surgery services to private patients. It has one operating theatre where day case procedures are undertaken. No overnight accommodation is provided by the clinic.

The clinic is registered to provide the regulated activities:

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

The clinic also has a regional manager and a clinical services manager who are based in Manchester and London, but visit on a weekly basis.

The clinic employs one full time registered nurse, two laser therapists and two clerical members of staff. There are two doctors carrying out regulated activities at the clinic who are self-employed and operate under practicing privileges for the Bristol branch of the Private Clinic and one doctor who holds group wide practicing privileges, who also carries out regulated activities at the Private Clinic Bristol. Other registered nurses who work at the clinic are from a nursing agency.

All operations at the clinic are carried out under local anaesthetic and sedation. Anaesthetists who work at the clinic are provided by a specialist anaesthetic agency.

The clinic did not carry out any regulated activities on children and young people under the age of 18.

The clinic did not hold a license for the storage of controlled drugs so did not hold any stock overnight on the premises.

The clinic provided a range of surgical and non-surgical treatments, including treatments such as hair transplants, acne laser treatments, Botox and other injectable fillers, which are not currently regulated by CQC.

Between July 2015 and June 2016, there were 116 visits to theatre for regulated activities. The clinic saw 2666 patient for all procedures including activities not currently regulated by the CQC.

Surgery

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

The Private Clinic Bristol is a small independent clinic which is a part of the larger organisation The Private Clinic Limited. They provide a selection of cosmetic surgery procedures and non-surgical cosmetic interventions. The clinic provides treatment for private self-funding patients. The Private Clinic Bristol is registered as an acute day clinic with no overnight beds. The clinic consists of one operating theatre, two treatment rooms and three consulting/treatment rooms.

During the year July 2015 to June 2016 the clinic saw 2666 patients for all procedures including activities not currently regulated by CQC, and 143 theatre visits for regulated activities. The most common procedures undertaken were Endovenous Laser Ablation and Vaser liposuction.

The clinic employed a registered manager, a registered nurse, two laser therapists and two clerical members of staff. Surgical procedures were carried out by two surgeons who worked under practising privileges alongside an anaesthetist provided by a specialist anaesthetic agency.

During our inspection we spoke with nine members of staff, nine patients and two relatives. We observed care and treatment and looked at 14 sets of care records. We reviewed information from various sources about the performance of the clinic prior to and following our inspection. We also received feedback via comment cards from patients.

Summary of findings

Our summary of our key findings from our inspection are as follows;

- Consent forms were not clear and did not clearly state which procedure patients were consenting for.
- Safety cannulas were not being used, and a sharps injury had been reported as an adverse incident.
- The service did not routinely carry out venous thromboembolism (VTE) risk assessments for all patients undergoing surgical procedures.
- Resuscitation equipment was not stored in a trolley with tamper evident tags.
- Medical gases were stored in a store room but did not have any warning signs on doors to the room.
- Patient records were not always complete or legible and surgeon's summary letters were not included in patient notes.
- Risks associated with procedures were not always recorded, or were illegible.
- Staff were not up to date with some training and records were not up to date.
- Psychological assessments were not recorded in patient notes.
- There were no prescription audits which checked the quality of the prescriptions filled out.
- The clinic monitored some clinical outcomes from surgical procedures including ultrasound assessments of varicose vein treatments.
- There was no audit of consent forms.
- One treatment room was visible from the road, meaning consultations could be viewed from outside.
- Clinical staff were unaware of translation or interpretation services.

Surgery

- Most staff were aware of the values for the clinic, however some were unaware of the vision.
- Risk registers were held centrally and were accessible, however, some staff were unsure how to access them.
- The clinic was not using coding for its surgical procedures.
- One doctor working under practising privileges at all clinic locations was not on the Voluntary General Medical Council specialist register, which was a condition of the providers granting of practising privileges.

However;

- Staff had a clear understanding of local safeguarding procedures which were clearly displayed.
- Safety data was collected centrally and was shared with clinic managers through a governance framework.
- All staff had received a minimum of basic life support training.
- There was a detailed infection prevention control audit which showed good compliance.
- Agency nurses and anaesthetic staff had thorough inductions, and provided evidence of their clinical practice to the clinic.
- The clinic followed National Institute for Clinical Excellence (NICE) guidance for varicose veins treatment.
- The clinic had received good patient feedback and had started collecting Friends and Family Test data.
- The clinic benchmarked patient satisfaction data against other clinics within the business.
- Staff had undertaken specialist training to help enhance the aftercare given to patients.
- There was a thorough process for granting practicing privileges for doctors working at the Private Clinic Bristol, and the clinic held evidence of competencies on site.
- Staff were compassionate in their approach to patient's needs.
- Patients could have multiple follow-up appointments and all patients were given a 24 hour emergency phone number.
- Staff treated anxious patients with kindness and compassion.

- Alternative treatment options were discussed with patients.
- Patients waited four to six weeks for their procedures.
- Operating lists had been adjusted to minimise delays following patient feedback.
- The clinic took account of patients' individual needs including dietary requirements.
- The clinic was a member of the Independent Healthcare Sector Complaints Adjudication Service (ISCAS) and the Centre for Effective Dispute Resolution (CEDR).
- Leaders were very visible and approachable.
- The registered manager had a virtual forum for help and advice from their peers in other clinics.
- Doctor's levels of indemnity insurance and skills were monitored both in clinic and centrally using a database.
- There was evidence of improvements made as a result of infection, prevention control audits.
- The clinic followed General Medical Council guidance on the marketing of cosmetic procedures.

Surgery

Are surgery services safe?

We found:

- Consent forms for some procedures were not clearly labelled and contained information about all possible treatments which was not always edited to reflect which treatment a patient was undergoing.
- Safety cannulas were not being used and had resulted in a needle stick injury.
- The service did not routinely carry out venous thromboembolism (VTE) risk assessments on all patients undergoing surgical procedures.
- Resuscitation equipment was not stored in a trolley with tamper evident tags.
- Medical gases were stored in a store room but did not have any warning signs on doors to the room.
- Patient records were not always complete and legible, and the target audit compliance of 100% had not been met.
- Surgeons' summary letters of consultations were not included in patient notes.
- There was inconsistent recording of the risks associated with each type of surgical procedure.
- Some staff were past some of their training refresher dates, and records were not kept up to date to reflect recent training that had been completed.
- There was no evidence of psychological assessments recorded in patient records.
- There was no evidence of prescription audits.

However;

- There was clear evidence of learning from clinical incidents, even those which occurred elsewhere in the business.
- Safety data was collected centrally by the provider to look for trends and was shared with clinic managers.
- Staff had a clear understanding of local safeguarding procedures.
- All staff had received a minimum of basic life support training.
- There was a detailed infection prevention control audit which showed good compliance, with evidence of improvements made as a result.
- The clinic used the same agency nurses and anaesthetic staff, and ensured they had thorough inductions.

Incidents

- The safety performance over time was good and senior staff told us they had a central oversight of safety data at their head office which was regularly communicated to staff through quarterly clinic meetings and monthly managing director meetings, however, we did not see any evidence of any comparisons of infections or incidents being made between the private clinic branches.
- Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them internally and externally. Five incidents had been reported to the end of 2015 and no incidents had been reported in 2016 at the time of our inspection. Of the incidents reported, one was graded as low harm, and the rest were no harm.
- The incident graded low harm was a needle stick injury from a cannula, caused when a patient moved suddenly.
- We saw that the clinic was not using safety cannulas for any of its procedures and we were told this was because the doctors did not like using them. Safety cannulas are modified intravenous cannulas which automatically sheath the needle when withdrawn from the cannula, and are recommended for use to minimise the risk of needle stick injuries to staff and patients in guidance issued by the Royal College of Nursing (RCN) and the National Patient Safety Agency (NPSA).
- Staff told us incidents were discussed verbally with the registered manager before being reported. The current incident reporting system used paper forms, but senior managers told us a new electronic system had been purchased and was scheduled to go live in two months.
- When things went wrong, thorough and robust reviews or investigations were always carried out. All relevant staff were involved in the investigations completed. An example of this was when a patient had told staff they had a chaperone to pick them up after their procedure, but in fact did not. Managers and staff reviewed the chaperoning policy and added a new step which involved recording the chaperones number and with the patient's consent, calling them in advance of the procedure to ensure they were available to collect the patient.
- When things went wrong, lessons were learned, and action was taken as a result of investigations. For example staff told us of an incident at another Private Clinic branch where a clinical waste bag had been put out with general waste by cleaning staff. The incident

Surgery

was discussed in all Private Clinic branches and lessons were shared to ensure action was taken to improve safety beyond the affected team or service. Staff told us they had changed their waste management policy as a result, and now emptied every clinical waste bin at the end of the day regardless of how full it was, and locked them in a secure bin.

- There had been no never events in the service during the twelve months prior to our inspection. Never events are incidents that are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation, which was introduced in November 2014. This regulation required the organisation to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds. Staff we spoke with were aware of this legislation and demonstrated good understanding of their responsibilities under this legislation. The Private Clinic had a serious incident policy which showed that this requirement would be considered as part of the investigation process, but no serious incidents had been reported between July 2015 and June 2016 which required them to follow this process.
- Staff at all levels were able to describe what the duty of candour involved and the actions required. Staff were aware of the organisations guidance regarding duty of candour and how to access this.
- Senior staff told us of an incident at another clinic where a patient had complained and was invited to a meeting with the senior managers and consultant to discuss the complaint.

Safety thermometer (or equivalent)

- The service did not collect or report information about avoidable patient harm such as for Venous thromboembolism (VTE) risk for all of its surgical patients undergoing liposuction. Instead, all patients received a medical assessment during their

pre-operative assessment to highlight any potential issues before surgery took place. However we saw that the medical assessment did not cover the same information as a VTE assessment.

- The National Institute for Clinical Excellence recommends VTE assessments (NICE guideline CG92) for patients undergoing surgery if they are going to have reduced mobility post procedure and they also have one of a number of pre-existing conditions including, heart disease, being aged over 60 or the use of hormone replacement therapy. In one set of notes we saw that a cardiac problem had been recorded at initial medical assessment, but there were no further details or any evidence of any investigation of this condition recorded in the notes or any documented VTE assessment.
- Of the 14 sets of patient records we looked at we saw two documented VTE assessments. These assessments were on patients undergoing venous surgical procedures, which was in line with clinic policy to screen all venous patients for deep vein thrombosis using Doppler ultrasound. However, in one of these sets of notes, we saw the results of this scan recorded on the back of another form.

Cleanliness, infection control and hygiene

- Reliable systems were in place to prevent and protect people from a healthcare associated infection and these systems were regularly monitored and improved when required.
- All clinical and non-clinical areas were clutter free, organised and visibly clean. Staff explained how standards of cleanliness and hygiene were maintained. For example, the clinical staff employed by the Private Clinic cleaned the clinical areas including the operating theatre. We saw a detailed cleaning checklist for the operating theatre which was complete and up to date. Staff told us they had plenty of time to clean, and that it was a top priority.
- We saw alcohol gel dispensers in all consulting rooms and patient waiting areas, and there were multiple hand washing stations and best practice hand washing guide posters on display.
- Staff explained deep cleans in theatre were carried out every six months, but could be requested more frequently if required. Staff told us they would do this if they had treated a patient with an infectious disease, although they could not give an example of where this had happened.

Surgery

- All non-clinical areas we visited, including consultation rooms, store rooms and patient waiting areas were visibly clean and we saw evidence that cleanliness and hygiene checks were regularly carried out and there was evidence of cleaning audits and re-audits when necessary. An external company provided cleaning services for all non-clinical areas, and we saw cleaning audits undertaken by the company and registered manager every two months. The most recent audits showed 90% compliance against the audit checklist. Actions from these audits were recorded by the cleaning company and manager and followed up on the next audit. An action was recorded around some of the higher level cleaning not being sufficient, which was fed back to cleaning staff by the cleaning manager and monitored by the clinic manager.
- Cleaning and sterilising of multi-use devices was carried out appropriately, and the clinic had a service level agreement with a large private hospital nearby to provide sterilisation services for the clinic's multi-use equipment, which we saw. The clinic held a small stock of sterile equipment, but said they could usually get additional or replacement equipment packs very quickly.
- Patients were not screened for Methicillin-resistant *Staphylococcus aureus* (MRSA) routinely unless they were identified as a risk during the medical assessment. In these cases, the patients were sent to a nearby larger private hospital for their screening. Risk factors staff looked out included whether patients had recently been an inpatient at another hospital.
- We saw healthcare workers decontaminated their hands immediately before and after every contact or episode of care. Staff we spoke with could describe good hand washing techniques and understood when to use disinfectant hand gel.
- The clinic carried out monthly hand hygiene audits which showed 100% compliance in May, June and July 2016, and all staff we saw were bare from the elbow, in line with clinic policy. These policies were available to staff in a policy file kept in the clinic office, and also on-line.
- Specialised personal protective equipment was available, and staff always wore personal protective equipment such as aprons and gloves when required.
- Patients who needed a vascular access device (a needle inserted into the hand for the giving of medicine) had their risk of infection minimised because the staff followed specified procedures for insertion and removal that complied with NICE quality standard 61. For example, cannulas were inserted using an aseptic technique and removed as soon as they were no longer needed.
- Surgical site infection rates for all cosmetic surgery were monitored, and no infections had been reported between July 2015 and June 2016.
- The service ensured systems; process and practice reflected best practice guidance and had a detailed document outlining clinical guidelines for theatre practice standards. This guidance had been developed using the Association for Perioperative Practice (AfPP) principles of safe Practice in the Perioperative Environment (2011). The theatre did not require equipment to filter air, as the procedures undertaken were minimally invasive.
- The clinic ran a monthly infection prevention control audit, which looked at a variety of things including the clinic's physical environment, hand hygiene compliance, waste disposal and sharps disposal. This audit showed 100% compliance with the audit checklist between September 2015 and March 2016, and July 2016 and August 2016. Data was not supplied for April, May or June 2016. Actions were recorded on the checklist which included an ongoing issue with the storage of stock on floors. The Registered manager and nurse in charge had addressed this by purchasing extra drawer units to ensure no excess stock was stored on the floors. Staff said this ensured thorough cleaning could take place at all times.

Environment and equipment

- Facilities and premises were designed in a way that kept people safe, and clinical facilities were designed in keeping with the department of health guidance. However, a recent audit performed by an external company had shown that a fire door in the recovery room did not close properly. The clinic had an action plan to repair this which had been completed at the time of our inspection.
- The clinic occupied the ground floor of a building and comprised of one theatre, two treatment rooms and three consultation rooms. There was also a large patient waiting room. Due to the minimally invasive procedures

Surgery

undertaken, the theatre and treatment rooms also doubled as recovery rooms, except when patients had received sedation, when one of the treatment rooms was used as a recovery room for the theatre.

- Equipment was regularly and adequately maintained to keep people safe. The system in operation in the hospital was electrical safety testing for all equipment and regular maintenance of specialist equipment. These systems were monitored effectively to ensure maintenance was completed. We checked several pieces of equipment, all of which were within their electrical safety test dates.
- Staff used equipment safely, and described the procedure for testing equipment the day before and on the day of surgical procedures. In many cases, due to the small size of the clinic, there was only one piece of each type of specialist equipment, such as the laser machine used for treating various veins. This meant that procedures would have to be cancelled if the equipment failed. However, staff said because they checked the equipment the day before patients' appointments, they could inform patients in advance if there was a problem. Checks of this equipment formed part of the daily clinical checklist performed by the nurse, which we saw was complete and up to date.
- There were safe systems for managing waste and as a result of a recent clinical incident at another clinic, the procedure for disposing of clinical waste had been changed. All staff we spoke to knew all clinical waste bins had to be emptied at the end of everyday regardless of whether they had been used or not. There was a locked clinical waste bin where all clinical waste was stored, and the registered manager told us they had been carrying out spot checks to make sure this was done.
- The clinic did not take any samples or specimens on site, and had a service level agreement with another larger private hospital where patients attended for clinical samples to be taken.
- Sharps bins were used appropriately and dated and signed when full to ensure timely disposal. We did not see any overfilled and all sharps bins were temporarily closed when not in use. These systems were reliably communicated to staff and monitored by the registered manager and nurse. All sharps bins awaiting disposal were stored in a secure 'dirty' room, and we saw signs displayed reminding staff of the different coloured lids system for the disposal of different hazardous materials, including human tissues and fluids and unused drugs.
- Resuscitation equipment was readily available; however, this equipment did not have a tamper evident tag. The equipment was stored in the operating theatre in a three drawer wheeled storage cart, and we saw documentation which showed the clinic had recently changed to checking the cart on a daily basis from the beginning of October 2016. This had previously been done weekly. All doors to the theatre had key coded locks which prevented unauthorised access. All equipment, single use items and emergency medicines we checked were in date. Staff told us they used the British Resuscitation Council guidance when determining what needed to be present on the trolley.
- Staff told us when new staff from specialist agencies came and worked in the clinic, the nurse in charge gave them specific training on the resuscitation equipment before any theatre lists started, however we did not see any records of this.
- Medical gas cylinders were not always stored appropriately in identified areas with adequate signage. This had been noted on a health and safety audit performed by an external company in May 2016. Spare oxygen cylinders were stored in the equipment store room, and the registered manager had called the manufacturer of the medical gases to gain assurances that this was safe, and had completed a risk assessment to reflect this. The room was locked and had barred windows; however we did not see any signs on the storage room door showing that medical gases were stored in the cupboard.
- The service monitored instruments, equipment and implants in compliance with the Medicines and Healthcare products Regulatory Agency (MHRA) requirements, and received regular emails from the MHRA about defective equipment. There was a process for providing feedback on product failure to the appropriate regulatory authority, and the clinic had designated forms for identifying and recording problems with equipment.

Medicines

- There were reliable systems for obtaining and storing medicines securely. The clinic did not hold a licence to store controlled drugs overnight and staff explained

Surgery

how they used denaturing kits to dispose of left over medicines at the end of each day. All other medicines were stored in locked cupboards and the nurse in charge held the keys to the cupboards.

- The clinic monitored minimum and maximum temperatures of the rooms where medicines were stored and we saw records of this which were complete and up to date. Staff could explain what to do if there had been a temperature spike, and explained how they would speak to their local pharmacist for advice. Staff demonstrated an understanding about the effects temperature fluctuations could have on the medicines they held stock of.
- The clinic held a number of prescriptions locked away in the controlled drugs cupboard. Staff explained these were filled out by the doctors for each patient before the patient attended for their procedure, and stored securely in the locked controlled drugs cupboard. Staff explained they had to do this in order to obtain medicines for surgical lists. The medicines which were ordered the day before a list and securely delivered on the morning of the list. The prescriptions stored in the controlled drugs cupboard were checked daily by the nurse to ensure none went missing, however this was not recorded anywhere. The clinic kept copies of all prescriptions written, however we did not see any audit of these prescriptions.
- The clinic had a service level agreement with a commercial medicines provider for their stock medicines, and another with a local pharmacy for the controlled medicines.
- Staff explained that they could approach the local pharmacy for advice and had a named pharmacist who they contacted.
- The processes for identifying out of date medication was effective and staff showed us they completed daily medicines stock rotation to identify out of date medicines, and recorded all disposals in the medicines record book. Medicines to take home were available to facilitate timely discharge of patients home.
- The systems for managing medicines were reliably communicated to staff. The clinic provided guidance to staff in a comprehensive medicines management policy and standard operating procedures. However, we did see two errors in the medicines record book where a medicine had not been countersigned and had been entered into the book twice for two different strengths of the same medication. We raised this with the

registered manager at the time of our inspection, who said an agency nurse had made the error. When we checked the record book the next day the signatures had been completed. Staff told us, agency staff had been reminded of the clinic policy following this incident, but it had not been reported as a safety incident.

- The systems for managing medicines were regularly audited for areas where medicines were stored and the clinic performed monthly medicines management audits. We saw the last 12 months audits which showed no issues. Staff told us actions were recorded at the end of each audit and followed up the next month.
- Allergies were clearly documented on prescriptions that we looked at; however there was no evidence of an audit being carried out to check that allergy documentation on prescriptions was being done consistently, and it was not included as part of the monthly patient notes audit.
- Patients were prescribed antibiotics in accordance with NICE quality standard 61. For example, patients were prescribed and administered a prophylactic dose of antibiotics during their procedure; however, we did not see any protocols or policies covering this.

Records

- Patient's individual care records were stored securely, and locked away in secure cupboards when not in use. All patient records were stored on site in an archive and were readily available to staff working in the clinic.
- Between July 2015 and June 2016, 100% of patient notes were available for patient appointments.
- Patient's individual care records were not always accurate, complete or legible. We reviewed 14 sets of patient records. We found the documentation of discussions with patients around risks associated with each procedure were not always recorded in patient notes, and we saw hand written medicines charts which were not legible and we could not read the units of the medicines administered. We also saw that surgeon's notes were sometimes unclear and made in various colours rather than all in black ink.
- The clinic carried out a monthly audit of patient notes and the clinic standard for compliance was set at 100%. This had not been met in May, June or July 2016, and showed varied compliance between July 2015 and March 2015. Data for April was not supplied. Issues identified in the audit included incomplete medical

Surgery

histories, missing costing sheet summaries, lack of patient identifiers on each page, intraoperative notes not signed by the surgeon and missing batch and expiry numbers for medicines used during procedures. We did not see any evidence of any action plans drawn up to address this, however, notes recorded on the monthly audit report stated individual clinicians would be spoken to and reminded of the company policy.

- Admission notes were not always legibly documented. The pre-assessment questionnaire used a tick box system, but additional details written on the assessment were not always clear or legible.
- We saw the surgeons completed detailed notes which they used to summarise the consultations in letters to patients, however these letters were not included in the patients' notes.
- There were systems for managing records and these were communicated to staff; however documentation audit data showed issues had been identified with agency nurses completing paperwork and doctors signing all patient note sheets. Actions were recorded on the monthly audit sheets and followed up in monthly staff meetings and recorded in the meeting minutes.
- Patient records showed evidence that individualised care plans were consistently completed, and showed post-operative advice tailored to each patient including details of compression garments and mobility advice.
- The service did not consistently ensure that appropriate pre op assessments were recorded. For example we saw standardised sheets for each surgical procedure where risks associated with the procedure were printed out on a tick box sheet. In one of the sets of patient notes we reviewed, this had not been completed. In another set of notes, a list of risk factors discussed with the patient had been written on the back of another form, but it was not legible and we could not determine which risks had been discussed with the patient.
- The service ensured that consultants operating records were integrated into the hospital record for the patient. All of the patient notes we looked at contained this information.

Safeguarding

- There were systems, processes and practices to keep people safe. Safeguarding systems and processes were communicated to staff. All staff were able to explain

these procedures. Information about who to contact if there was a safeguarding concern was clearly displayed on the wall behind the reception desk, and also in an information book in the patient waiting area.

- There were arrangements to safeguard adults and children from abuse that reflected the relevant legislation and local requirements. Staff understood their responsibilities and consistently adhered to safeguarding policies and procedures set out by the clinic. Staff explained they would discuss safeguarding concerns with the registered manager. There was a safeguarding lead for the clinic based at the head office, but staff explained they had a named person at the local authority whom they could also contact for further advice.
- All staff had been trained in safeguarding of adults and children, and had attended a training day in 2015 provided by an external company; however, training records showed that refresher training was not due until 2019.

Mandatory training

- Staff received regular mandatory training updates in safety systems, processes and practices. Data received from the clinic indicated that 100% of staff were up to date with their mandatory training requirements at the time of the inspection. However, we saw that many staff had gone past their refresher dates for epi pen training and defibrillator training and records had not been updated to reflect recent training for staff in basic life support, infection control and health and safety.
- Staff told us they covered a range of subjects which included three yearly manual handling updates, yearly fire safety updates and three yearly customer service training. Staff told us they felt training was of a good standard and relevant to their jobs. They also told us that having time to go on mandatory training was not an issue as they could arrange appointments around their training.

Assessing and responding to patient risk

- There was a group wide standardised approach to the detection of a deteriorating patient, and there was a clearly documented escalation response called a '999 policy'. There was no protocol for the transfer of people using services to NHS facilities in the event of complications from surgery; instead the clinic had a

Surgery

written policy for staff to call 999 for an emergency ambulance. All staff we spoke with were aware of this policy, and felt confident they knew what to do in an emergency.

- We spoke with an anaesthetist who told us they carried out a medical and physical examination of each patient undergoing sedation, which took place on the day of their surgery. Observations from this assessment were recorded on a handwritten form which included details of intraoperative observations, medicines administered and aftercare, and a copy was placed into the patient's notes after the procedure. We were told that an anaesthetist had picked up a fast heart beat as part of one medical assessment, and had referred the patient back to their GP for tests before surgery was performed.
- We saw a surgeon explain to a patient that they would not be able to undergo surgery whilst they were still smoking. The medical reason for this was discussed with the patient as well as what they needed to do to be able to undergo surgery.
- The service did not ensure that consultations took account of the Royal College of Surgeons recommended key aspects for cosmetic surgery including ensuring that any psychologically vulnerable patient was identified and referred for appropriate psychological assessment. We did not see any documentation recording these assessments and patients we spoke with could not recall being made aware of having a psychological assessment as part of their consultations. Senior managers told us if they did identify a psychologically vulnerable patient, they would refer them back to their GP for assessment.
- We did not see any evidence that at the Private Clinic Bristol, cosmetic surgeons took appropriate or relevant psychiatric history, however, we did see evidence of discussions held with people about body image before cosmetic surgery was carried out. Senior managers told us of a patient who had been identified in another clinic prior to surgery and described how the clinic had involved the GP and other specialist organisations in the assessment of the patient.
- The world health organisation (WHO) five steps to safer surgery checklist was not used to increase the safety of patients undergoing a procedure. The service used a procedure checklist which covered pre-operative, intra

operative and post-operative checks. We did not see any evidence that this had been audited, other than on a notes audit, which confirmed the presence of the documentation in the patient notes.

- Senior staff told us they were implementing the use of the WHO checklist from the next operating session following our inspection.
- There was an appropriate 24-hour emergency hotline for patients following discharge and the service ensured patients could contact suitably-qualified person if they experienced complications outside of normal working hours. The telephone service was manned by a team of nurses qualified to advise on the surgical procedures the clinic carried out. The nurses held contact details for the surgeons if any issues needed to be escalated.
- The clinic had processes and procedures in place if a patient required a return to theatre, however these were group wide policies and staff could not recall an instance where this had happened. Senior managers told us if a patient was to return to theatre, it was more likely to be related to an outcome of the surgery and treated as a separate visit to theatre rather than a return.
- The clinic did not use Modified Early Warning Scores (MEWS) to monitor their patients during or post procedure, instead all observations were recorded by the anaesthetist on a hand written form, which included pre, intra and post-operative observations, as well as medications administered. Nurses recorded their observations on printed templates, which were placed in the patient notes at the end of the procedure. The Clinic had an escalation policy where staff were instructed to call 999 in a medical emergency; however it was not clear how deteriorating patients would be identified or if there was a standard pathway for staff to follow.

Nursing staffing

- Staffing levels and skill mix were planned and reviewed so that people received safe care and treatment at all times. There was one full time registered nurse on duty at the clinic at all times, but on days where surgical procedures were carried out, another agency nurse was always present.
- During the period July 2015 to June 2016 the Private Clinic Bristol used agency staff between 4.5% and 13.5% of the time. Staff told us this was because agency nurses were brought in on surgical days to support the permanent nurse. The use of agency staff reflected the

Surgery

number of surgical days the clinic held, so fluctuated in line with demands for the services. If the permanent nurse was on annual leave then clinics would be planned around this or agency staff would be used.

- Between April 2016 and June 2016, agency nurses covered 16 shifts out of 253, which is 6%. This included shifts where the permanent nurse was present, and also shifts where they were absent.
- Agency staff received a comprehensive induction to the clinic setting and we saw a detailed induction package as well as a teaching folder which had been developed by the nurse in charge to aid new staff. Nursing staff and managers told us that the clinic tried to use the same agency nurses so they did not continually have new staff to train.
- There were adequate processes in place to keep patients safe at times of handover and shift changes. Every day was started with a team brief to discuss the procedures for the day ahead, including any potential challenges.

Medical staffing

- Staffing levels and skill mix were planned in advance depending on the procedures booked. All procedures involving sedation required an anaesthetist as well as the operating surgeon. These staffing levels were monitored and reviewed so that people received safe care and treatment at all times. The clinic had an electronic booking and diary system to track the procedures booked.
- Two consultant surgeons operated at the Private Clinic Bristol under practising privileges and another cosmetic doctor operated at all Private Clinic locations, including Bristol.
- Staff identified and responded appropriately to changing risks to people who were seen in the clinic, including during potential medical emergencies. Staff told us how one surgeon and anaesthetist had been quick to respond to a situation where a patient's airway had potential to be compromised and resolved it before that happened.
- The clinic did not use surgeons from any agency; however, anaesthetists were supplied for all procedures involving sedation, by a specialist anaesthetic agency. This made up 34.4 % of surgical procedures carried out

at the clinic between July 2015 and June 2016. These staff received a comprehensive induction to the service and we saw training files kept for each surgeon and anaesthetist documenting their induction.

- The clinic ensured the consultant surgeon and anaesthetist remained onsite until each patient was ready to be discharged from the service later that day.
- There was a 24 hour helpline provided by the provider and the nurses manning the line had the telephone numbers of the surgeon and anaesthetist if a patient rang with problems after the procedure.

Major incident awareness and training

- Potential risks such as disruption to staffing were taken into account when planning services, and managers told us as soon as they knew about a member of staff being unavailable, they would contact patients to avoid them making any unnecessary journeys to the clinic.
- The clinic had an annual fire safety audit undertaken, which had shown no concerns. There was a designated fire warden and staff also received annual fire training updates.
- The clinic did not have a backup power supply to ensure safety in cases of electrical failure. Staff told us they were considering this as they were looking into providing procedures involving general anaesthesia.

Are surgery services effective?

We found:

- The service followed National Institute for Clinical Excellence (NICE) guidance on the use of EVLA for the treatment of varicose veins.
- Staff had undertaken specialist training to help enhance the quality of aftercare delivered to patients.
- The clinic had a thorough application process for the granting of practicing privileges.
- Doctors provided detailed evidence of their clinical experience.

However;

- The clinic monitored some clinical outcomes from surgical procedures it offered.
- The clinic did not yet use any pre or post-operative questionnaires to collect patient reported outcomes, but were investigating ways to do this.

Surgery

- The clinic benchmarked patient satisfaction data against other clinics within the business.
- The quality or compliance with consent forms was not being audited or monitored.

Evidence-based care and treatment

- The clinic used relevant and current evidence-based best practice guidance and standards, to develop how services, care and treatment were delivered. For example, the use of Endovenous laser ablation (EVLA) was recommended as the treatment of choice for the removal of varicose veins by NICE interventional procedure guidance IPG52.
- Patients had their needs assessed and their care planned and delivered in line with evidence-based, guidance, standards and best practice. For example, patients told us as part of the surgeon's consultation, the outcomes of procedures were discussed with them so they clearly knew what to expect. A surgeon told us that if a patient had unrealistic expectations of the procedure, it would not be carried out.
- Staff showed an understanding of the rights of people subject to the Mental Health Act and had regard to the MHA Code of Practice. We saw mental capacity assessment forms; however, staff could not recall when they had needed to use one.
- Patients were supported to be as fit as possible for surgery, and pre-operative assessments were used to flag things such as smoking and obesity before the first surgeon's consultation.
- The clinic did not have a list of exclusion criteria for patients; however, doctors assessed each patient on an individual basis. For example, one doctor told us if a patient smoked they would not accept them. We also saw that consultations were carried out in line with the General Medical Council's 2016 guidance in relation to the outcomes of the procedure. Doctors told us if they felt the procedure would not give the desired benefit, they would not operate. Staff told us the rejection rate for patients wishing to undergo Vaser liposuction was 72%, and for EVLA was 43%, which they felt showed they would only perform procedures when the outcomes were achievable and realistic.
- We saw evidence that cosmetic preoperative assessments included discussions with people about

body image before surgery was carried out. Surgeons used an eight question grid to ask patients comment on how they felt about their body appearance in different situations.

- The service did not use the Royal College of Surgeons (RCS) audit tool to ensure that key aspects of the pre-operative consultation were carried out in compliance with the RCS professional standards for cosmetic surgery 2016 guidelines. Instead, Doctors and nurses recorded written notes of follow-up consultations which included discussions about patient satisfaction with their procedure. However, some of the notes we looked at were difficult to read.

Pain relief

- Patients' pain was managed by asking them if they had pain, which we saw documented in nursing notes. The clinic had not implemented the Faculty of Pain Medicines Core Standards for Pain Management 2015.
- Staff demonstrated a good understanding of methods available to them for management of patient's pain and we saw documentation covering pain relieving medicines prescribed by the surgeon for patients to take home with them.
- Patients we spoke with told us when they experienced physical pain, discomfort or emotional distress, staff responded in a compassionate, timely and appropriate way. One patient told us pain was not an issue as it was very well controlled by the staff.
- As part of the preparation for patients undergoing procedures involving local anaesthetic, the patient's weight was used to calculate the correct amount of local anaesthetic to use to minimise pain and discomfort during the procedure.

Nutrition and hydration

- Staff demonstrated a good understanding of the importance of assessing nutrition and hydration needs. Patients' nutrition and hydration needs were adequately met. For example, all patients had to have a small amount of food post procedure before they were deemed fit for discharge. As part of the nursing pre-operative assessment, staff made a note of food allergies and dietary requirements to ensure they had suitable food for each patient after their procedure.

Surgery

- Anaesthetists ensured patients' nausea and vomiting was managed during the procedure, and nursing staff continued this care post procedure and documented symptoms in the patients' records.

Patient outcomes

- Some information about the outcome of people's care and treatment was routinely collected and monitored. For example, the clinic collected patient satisfaction data, which was collected centrally at the head office and some benchmarking of this data across three clinics had been carried out. This data showed that the Bristol clinic had the highest levels of patient satisfaction post procedure when compared to two other similar sized clinics.
 - The services participated in local audits, and senior staff told us they had recently changed the content of their audit checklists and were planning to start some local benchmarking of the data with the other clinics in the organisation.
 - The clinic engaged with the Private Healthcare Information Network (PHIN) and data was submitted in accordance with legal requirements regulated by the Competition Markets Authority (CMA). Data had been collected centrally at the head office and submitted on behalf of all the clinics; however the registered manager was unaware of this, and did not know what had been submitted in relation to their clinic.
 - The service did not yet collect Patient Reported Outcome Measures (Q-PROMs) for all patients receiving liposuction. Senior managers told us they were planning to start this in the near future. Q-PROMs are more specific than generally measuring satisfaction and experience, and are procedure specific, validated and constructed to reduce bias.
- The learning needs of staff were clearly identified during staff annual appraisals and all staff received appropriate training to meet their learning needs. All staff were encouraged and given opportunities to develop. For example, the nurse in charge of the clinic had undertaken specific training to provide manual lymphatic drainage massage to patients as part of their post-operative care.
 - There were reliable arrangements in place for supporting and managing staff and there was a reliable system of staff supervision. Staff told us they often visited other clinics for clinical supervision sessions if they identified an area they needed to develop. Staff told us they kept written records of their clinical supervision sessions, which we saw and this was in keeping with the Private Clinic's clinical supervision policy.
 - The clinic ensured consultant surgeons only carried out surgery that they were skilled, competent and experienced to perform through a comprehensive application process at the start of their employment. As part of the system of granting or reviewing practising privileges, surgeon's wishing to operate at the Private Clinic Bristol had to submit original documentation which covered for example, identity, qualifications, GMC registration, insurance and revalidation status. Files containing copies of these documents were kept onsite at the clinic and were monitored centrally on a doctor database at head office. We reviewed these files which were complete and up to date.
 - Senior managers told us the doctor's database was monitored daily and flagged up when training, insurance or revalidation needed to be renewed. The system generated a letter for both the registered manager of the clinic(s) the doctor worked in and the doctor themselves. Registered managers were responsible for chasing this up with the doctors, and updating head office, however, most doctors responded directly to the letters. We looked at the database, and spoke to one of the cosmetic surgeons who confirmed they had received a reminder letter about their upcoming revalidation.
 - The clinic ensured that anaesthetists had relevant skills and expertise for the procedures being undertaken by regularly reviewing training records and CVs submitted by the anaesthetic agency. Staff told us this happened

Competent staff

- All staff had the right qualifications, skills, knowledge and experience to do their job when they started their employment, or when they took on new responsibilities. The clinic held a training record for all staff, including those staff working under practising privileges. Senior managers showed us they also held records for agency staff, such as the anaesthetists and regularly checked with the agency to ensure the anaesthetists were keeping up to date with their training and professional development.

Surgery

on an annual basis, but they were increasing this to twice a year. We reviewed the records held by the clinic for the anaesthetist, which included evidence of training and registration.

- There were arrangements in place to make sure that local healthcare providers were informed in cases where a staff member was suspended from duty. Senior managers told us they had oversight of decision alerts which were monitored centrally alongside the doctor's database. Decision alerts were generated automatically by the GMC if a doctor had been subject to a fitness to practice investigation or hearing. Senior managers told us they had never received any alerts for doctors working at the Private Clinic Bristol.
- The registered person ensured that surgeons who carried out cosmetic surgery underwent a multi-source feedback exercise during their revalidation cycle that included their cosmetic practice. For example, both surgeon and anaesthetist told us they supplied references from their other employers on an annual basis, which we saw as part of the personnel files kept at the clinic.
- Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice. Surgeons at the Private Clinic engaged in this revalidation process with the responsible medical officer, who communicated concerns directly with the registered managers of the clinics.
- Surgeons who carried out cosmetic surgery undertook relevant continuing professional development (CPD) activities including in the area of professional behaviours. For example, a surgeon told us they had submitted all of their CPD evidence via an electronic system as part of their revalidation process, which was made available to the Private Clinic Bristol to review, and we saw evidence of this in the clinic records.
- The service did not hold regular case reviews of complex cases, as most patients with complex medical histories were not accepted for procedures. However, senior staff did tell us of a complex case review which took place in another clinic which had involved the patient's GP and other specialist services. Staff told us learning from this case had been shared across the whole company and discussed in team meetings.
- The service had plans to fully comply with the Competition and Markets Authority's (CMA) requirements in relation to information about each surgeon's performance. However, this was being looked into at head office, and a number of external companies were being considered to help the Private Clinic Limited achieve this. The clinic had already complied fully with the CMA's requirement to submit data to PHIN.
- Surgeons who carried out cosmetic surgery had a lot of experience carrying out the cosmetic procedures they undertook at the Private Clinic, and had completed the amount recommended by the Royal College of Surgeons to be able to apply for voluntary specialist certification. One of the surgeons had been directly involved in the development of this certification scheme.
- The clinic had two doctors who operated under practising privileges at the Bristol Private Clinic, and one who operated under group practising privileges at all Private Clinic locations. Both doctors at the Private Clinic Bristol had General Medical Council (GMC) registration and specialist registration, but the other doctor did not have specialist registration. In order for doctors to be able to apply for voluntary RCS certification in their chosen speciality, they must first be on the specialist register. This is also a condition of the terms and conditions of the granting of practising privileges within the Private Clinic group.
- Nursing revalidation is the process by which registered nurses are required to demonstrate on a regular basis that they are up to date and fit to practice. The clinic supported nurses to complete this process through regular one to ones and annual appraisals, as well as an on-going programme of clinical supervision. Nurses we spoke with told us they were prepared for this process when it arose.

Multi-disciplinary working

- All necessary staff were involved in assessing, planning and delivering people's care and treatment which was delivered in a coordinated way. For example, the Private Clinic Bristol had a multi stage referral process, which began with a pre-operative medical history questionnaire carried out by a trained coordinator. After this, the patient went on to have an initial consultation with the surgeon.
- All staff worked together to assess and plan on-going care and treatment in a timely way. This included at

Surgery

referral and discharge. For example, all staff we spoke with were clear about their responsibilities at each stage of the patient's treatment and could describe how they contributed to the patient's overall pathway.

- Patient discharge from the clinic was always done at an appropriate time of day. A patient was only discharged when all the members of the team were happy the patient was fit to go home. Discharge only took place when on-going care was in place.
- All team members were aware of who had overall responsibility for each individual's care. For example, staff told us both surgeon and anaesthetist remained onsite until a patient was fit for discharge and they retained overall responsibility for the patient's care.
- The clinic asked if patients wished for their GPs to be informed about their procedures as part of the pre-operative assessment questionnaire. If patients did not wish for this to happen, the clinic did not inform the GP. However, senior managers told us if anything was discovered during the assessment, such as during ultrasound deep vein thrombosis screening for EVLA, they would inform the GP, although would discuss and explain the need to do this with the patient first.
- Access to medical consultants was available when needed (for surgical patients), by informal arrangement with a nearby larger private hospital.

Seven-day services

- The clinic offered patients a range of appointments Monday to Saturday, including evening appointments for consultations and follow-ups.

Access to information

- The information needed to deliver effective care and treatment was always available to staff in a timely and accessible way. For example, the Private Clinic Bristol held all of its patient records onsite, including those that had been archived.
- When patients came to the clinic for treatment, information from other health care organisations was not always available. Staff told us the pre-operative medical assessment was designed to capture as much medical history and information possible which was relevant to the treatment that was going to be carried out.
- The systems that managed information about patients supported staff to deliver effective care and treatment.

For example, all notes were prepared in advance of consultations and the clinic used a day drawer to store notes for the next day. This was secure and staff meeting minutes confirmed staff felt it was working well.

- Discharges were only communicated to GPs with the patient's consent and details of the treatment and care were only sent if the patient had given their permission. Details of the surgery, including details of any implant or injectable used, were sent to the patient but only sent to the GP if requested by the patient.
- There was a system to ensure that medical records generated by staff holding practising privileges were available to staff who may be required to provide care or treatment to the patient. At the end of the procedure, nursing staff combined all notes made by the surgeons and anaesthetists with the patient's care record. The registered manager and nurse carried out monthly audits of patient records which showed this was consistently being done, however, doctors' discharge letters were not integrated into the Private Clinic notes.
- When patients required additional tests, they were sent to another nearby independent hospital. Results from these tests were sent directly back to the Private Clinic Bristol, and patients were informed when they arrived back.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Most staff demonstrated understanding of consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005. The process for seeking consent was monitored by auditing the presence of signed consent forms in the patient records. The audit data showed this was being done, however, the audit did not look at the information being given to patients, or compliance with the consent process. We did not see any evidence that an audit of consent forms is or has been undertaken.
- Patients' mental capacity to consent to care or treatment was assessed by the surgeon at the initial consultation and this assessment was recorded in the patient notes on a designated form. However, we did not see any of these forms in any of the notes we looked at, and staff could not recall when one had last needed to be used.
- The service did not ensure that the consultant surgeon carrying out the cosmetic surgery always explained and ensured the patient understood the expected outcomes

Surgery

and risks before agreeing to go ahead with surgery. We looked at 14 sets of patients notes, and we saw incomplete risk checklist forms and saw that where risks had been documented by hand, this was not always legible, or recorded on official continuation sheets.

- The service ensured that there was a two week cooling off period between the patient agreeing to undergo cosmetic surgery and the surgery being performed in line with the Royal College of Surgeons Professional Standards for Cosmetic Surgery. We saw notes in patient records confirming this, and all follow up dates we saw were a minimum of 14 days after the initial enquiry. Staff told us doctors often requested a longer period and that no contact was made by the clinic during this time, however, staff said that if patients rang up they would speak to them if necessary.

Are surgery services caring?

We found:

- Staff understood the impact cosmetic surgery could have on patients and were compassionate in their approach to patient's needs.
- Staff interacted with patients in a friendly and professional way.
- Feedback collected from patients was almost all positive.
- The clinic collected Friends and Family Test data to reflect data collection methods in the NHS.
- Staff were aware of the anxiety patients felt before a procedure and responded with compassion.
- Alternative treatment options were often discussed with patients.

However;

- One treatment room was visible from the road which meant patients might be seen.

Compassionate care

- Staff understood and respected patient's personal needs. For example, we were asked to leave a consultation as the surgeon felt it was not appropriate due to the next patient's social and personal circumstances.

- Staff took the time to interact with people who used the service and those close to them in a respectful and considerate manner. We saw reception staff addressing patients and their relatives upon arrival and whilst waiting for their appointments.
- Staff introduced themselves to patients by name and ensured the patients understood who they were and what their job was.
- Staff took account of the patient's psychosocial aspects of care as well as the physical aspects. For example, surgeons told us they did not operate on patients if they felt they had unreasonable expectations of the procedure. The reasons for not performing a procedure were discussed with the patient and followed up with a letter. Surgeons said this was always difficult to manage, as patient reaction could not be anticipated, however, most patients understood the reasons for the decision.
- Staff made sure that people's privacy and dignity was respected, including during physical or intimate care. For example we saw blinds used to cover mirrors and screens used to help maintain patient privacy and dignity, however, we noticed that there was a two to three inch gap below the blinds of one of the examination rooms, which looked out onto the main road. Staff used a mobile screen to give patients privacy and dignity during their consultations, however, passers-by could still see into the examination room as the gap was at eyelevel to people on the outside street. Since our inspection, the clinic has stopped using this consultation room and have arranged for frosting to be added to the glass immediately after the inspection.
- Staff respected patient confidentiality at all times. We saw doors being shut during consultations and treatment ensuring that discussions were kept private at all times. We were told there was a private side room available which was used when patients did not want their conversations overheard by the waiting room.
- The Private Clinic Bristol had recently changed their system for collecting patient feedback to reflect the Friends and Family Test used within the NHS. Of the limited feedback responses received (four responses) during the month since changing to the new system 100% of people who used the service would recommend the service to friends and family.

Surgery

- The previous feedback collected from January 2016 to August 2016 showed 100% of patients felt very satisfied that their dignity was respected during their visit. No responses indicated that any of the patients were not satisfied with the treatment and care they received.
- As part of our inspection, we received 32 comment cards from patients. Of these 31 were positive, one was negative and one was neutral. Patients reported that staff gave, “the upmost care and sensitivity”, “were very professional and helpful” and “very understanding of my needs”.
- Comments on the negative response included feedback relating to poor communication from the clinic and a promised call back which did not occur.
- We spoke with four patients. One patient reported their experience was, “absolutely fantastic” and there was, “no way my care could have been improved”. Other patients reported they had received compassionate care by staff throughout their assessment and treatment.
- Following their procedure, patients told us that they understood the follow-up process and had the date of their next appointment. Patients could have unlimited follow-up appointments post procedure which were free of charge.
- The service ensured that staff advised people about all possible costs that would be incurred in a timely manner and checked that people understood this information. Patients we spoke to were aware of all the potential costs involved with their treatment and received copies of quotes after their first consultation. We also saw evidence of emails clarifying costs and where an error had been made, the lower cost was honoured.
- In cases where the patient was responsible for full or partial cost of care or treatment, appropriate and sensitive discussions took place about cost as part of the initial consultation, which we saw when we sat in on a patient’s initial consultation.

Understanding and involvement of patients and those close to them

- Staff always communicated with patients so that they understood their care, treatment and condition. Patients we spoke with told us staff supported them in their decisions surrounding their treatment and care and that they answered any concerns or questions they had.
- We saw two relatives of patients attend consultation appointments and saw they were fully involved in the consultation and given time to ask questions.
- Patients were spoken to in an unhurried manner and staff checked if information was understood. Staff said that they tailored appointment length to the individuals.
- Staff made sure patients and those close to them were able to find further information and ask questions about their care and treatment and directed patients to external websites.
- Patients told us that alternative treatment options were discussed and the potential risks and complications of treatment were fully explained to ensure they had sufficient knowledge to make an informed decision. Patients told us that surgeons explained what treatment was an option and why. This included risks, complications and possible side effects. Patients said they had time to consider the options and were not pressurised in to making a decision.

Emotional support

- Staff understood the impact that a person’s care, treatment or condition could have on their wellbeing and patients’ physical and psychological needs were regularly assessed and addressed. Including issues around anxiety. We were told of a consultation where a patient was exceptionally nervous prior to treatment. Staff took the patient to a private room and answered any questions or concerns the patient had. Staff worked with the patient and their relative where a joint decision was made for treatment to be postponed, for the patient to have more time to determine if treatment was the correct way forward for them.
- Patients told us staff were aware of their emotional needs and one patient said they had been sympathetic to their concerns and were good listeners.
- Patients were always empowered and supported to manage their own health, care and wellbeing and to maximise the effectiveness of their treatment. At consultation, surgeons said that if a patient smoked or had a high body mass index (BMI), they would not carry out surgery on them. Surgeons said they encouraged patients to go away and make changes to their lifestyle before they would be considered for surgery again.
- Staff did not always discuss treatment options with patients and surgeons said patients had often made

Surgery

their minds up about a procedure. However, patients and their relatives were encouraged to be part of the decision making process, and we saw relatives invited into consultations with the patients consent.

- Staff provided patients with information leaflets and written information to explain their condition and treatment plan which included aftercare, which patients said was thoroughly explained to them, and we saw this happen in a patient consultation.

Are surgery services responsive?

We found;

- Patients did not have to wait long to access their treatment or procedure.
- The clinic offered treatment and procedures which met the needs of their patients.
- Operating lists had been adjusted to minimise delays to patient appointments.
- The clinic provided food to patients which took account of their individual needs.
- The clinic allowed patients to use alternative exits to avoid populated areas.
- The clinic had a complaints process which included the use of independent external complaints organisations.
- However;
- Clinical staff were unaware of translation or interpretation services available.
- There was no evidence of psychological assessments for patients wishing to undergo cosmetic surgery.

Service planning and delivery to meet the needs of local people

- Information about the needs of the local population was used to inform how services were planned and delivered. For example, the clinic offered minimally invasive surgical procedures because patients recovered a lot faster and required less time off work. The services provided reflected the needs of the population served and provided flexibility, choice and continuity of care.
- Where patient's needs were not being met, this was identified and used to inform how services were planned and developed. For example, some patients had expressed concerns that the procedures were more invasive than they had thought, so the information given to patients had been reviewed and improved.

- The facilities and premises were appropriate for the services that were planned and delivered. For example, there was a well-equipped operating theatre and multiple private consultation rooms, including a room patients could use to speak with the receptionist away from the main waiting area.
- Information was provided to patients in accessible formats before treatment. This included contact details, a map and directions to the clinic, the consultants name, a brief CV and information about any tests or preparation required before the treatment or procedure.
- The clinic had tailored its opening hours to ensure people could access their services outside of work and school hours. This included a late opening on Tuesday and being open on a Saturday.

Meeting people's individual needs

- The clinic was situated on ground level and systems were in place to ensure people with limited mobility could access the clinic. Staff reported that via the telephone booking service they would be made aware of any patient with specific needs that was due to attend. This enabled them to ensure that all the necessary adjustments were made prior to their arrival.
- The clinic ensured that support was available for patients with complex needs such as deafness or visual impairment. Staff told us about occasions when reasonable adjustments were made so that disabled people could access and use the services on an equal basis to others. For example, a deaf patient had attended for an appointment and the clinic staff adapted their consultation to allow the patient to see their mouths at all times so they could lip read. Managers also told us there were sign language interpreters available if they needed them however, clinical staff were not aware of this.
- The clinic was able to adapt its main entrance to allow wheelchair users to access the clinic by using a temporary ramp. Staff said patients could also be picked up outside the front door to minimise any stress associated with being picked up after their procedure or treatment. Staff also told us some patients preferred to use the back entrance to their clinic to avoid the main road, busy traffic and populated areas. Staff said some patients did not like to be seen leaving a cosmetic clinic, which is why they offered an alternative exit.

Surgery

- Senior managers told us translation services were readily available if required through an external company; however, clinical staff were not aware of this service.
- The clinic did not have arrangements in place to ensure psychiatric support was available where necessary. Senior managers told us if a surgeon had concerns about the mental health of a patient, they would contact the patient's GP. We did not see any evidence of a formal referral process in any policies or documents we looked at. General Medical Council (GMC) guidance states that doctors must consider the psychological needs of the patient and refer them to an experienced colleague if the care they need is outside their expertise.
- Patients were given adequate choice of menu items to meet their personal and cultural preferences. Staff told us patients were required to eat a little food as part of their discharge assessment, so staff ensured they had food suitable for each patient, based on their dietary requirements or personal preference.
- Patients told us they received letters from the surgeon summarising their surgery and they were aware these could be sent to their GP if they wished.
- Patients told us they knew who to contact if they were worried about their condition or treatment after they left hospital and told us they were given a 24 hour phone number to speak to a qualified nurse if they had any problems or concerns.
- Information regarding safeguarding from abuse was displayed where patients would see it, in a discreet information folder, and also on the wall of the waiting room.
- convenience. Ultrasound screening for deep vein thrombosis for patients wishing to undergo Endovenous Laser Ablation (EVLA) was carried out as part of the initial surgeon's consultation.
- Once a patient had decided to go ahead with the surgery, the clinic reported an average of 4-6 weeks wait for the procedure to take place. During this time, a second consultation was arranged, and sometimes a third. Senior managers told us they were led by when patients wanted their surgery performed.
- Staff told us if they experienced in rise in demand for procedures, they approached the surgeons to see if they would hold an extra consultation evening or operating list.
- Patients were often able to access care and treatment at a time to suit them and patients were always kept informed about delays to their treatment or care. For example, staff told us if a theatre list was running behind, patients would be contacted ahead of their appointment time, to enable them to delay their journey. When this had happened in the past the clinic decided to extend the operating time to allow longer for each procedure and minimise the risk of delays to other patients. If patients had already arrived or their treatment, staff informed them of the delays in one of the private consulting rooms. During our inspection we saw reception staff keeping patients informed of delays and offering drinks.
- Patients told us that the appointments system was easy to use, and they were offered a choice of appointments.
- Care and treatment was only cancelled or delayed when absolutely necessary. Patients told us that cancellations of treatment were explained to them, and they were supported to access treatment again as soon as possible. Between July 2015 and June 2016, the Private Clinic Bristol cancelled seven appointments out of 2666 including appointments for consultations and treatments not currently regulated by CQC. Of those four appointments were for consultations or treatment regulated by CQC.
- Between July 2015 and June 2016, the clinic held 2666 appointments for all treatments and procedures, including those not currently regulated by CQC. 36 patients did not attend for their procedure or treatment, which is 1.3%.
- The service did not manage the provision of un-planned surgery, such as unexpected returns to theatre, because all patients were day case patients, and the clinic had

Access and flow

- Patients always had timely access to an initial assessment which was usually arranged over the phone in the Private Clinic's central call centre. Face to face assessments took place in person at a time and date of the patient's choosing, usually within one to two days of the initial phone call.
- The clinic reported a waiting time of one to two weeks for first medical consultation following initial assessment.
- Patients did not wait a long time for diagnostic services, which were provided by another larger private hospital nearby. The clinic reported that patients were able to attend for diagnostic tests, including blood tests at their

Surgery

no overnight beds. A senior manager told us that if a patient required a return visit to theatre, it would be counted as a new visit to theatre, as it was more likely to be linked to the outcome of the procedure rather than a complication. However, the clinic had no records of any cases where this had happened.

Learning from complaints and concerns

- Patients told us that they knew how to make a complaint or raise a concern. Patients told us they felt confident to speak up about concerns and were given information about the process as part of their pre-operative information.
- Patients who had raised a concern were treated with compassion, and staff told us it would in no way affect the patient if they chose to come back to the clinic in the future.
- We saw that written information about the complaints process was included in the information sent out to patients prior to their consultations.
- Between April 2015 and August 2016 the clinic received 10 complaints in relation to all treatments and procedures carried out, including those currently not regulated by CQC. Of those complaints, four were upheld, five were not and one was waiting on the final results of the procedure. There had been one complaint in relation to a regulated activity.
- The clinic investigated all complaints it received, including via anonymous reviews on internet sites. Senior managers said that where possible, if a patient could be identified from a review, they would try and contact them to resolve their complaint.
- Managers told us most complaints were resolved informally at clinic level, but where investigations needed to be conducted, the registered manager did this at clinic level with involvement from head office if necessary.
- The clinic had signed up to the Independent Sector Complaints Adjudication Service (ISCAS), and was also a member of the Centre for Effective Dispute Resolution (CEDR), which acted as an independent body to review complaints if patients were not happy with the outcome from an investigation.

- Most staff were aware of the values for the clinic, however some staff were unaware of the vision.
- Risk registers were held centrally and were accessible, however, some staff were unsure how to access them.
- Audit schedules did not include any quality indicators.
- The clinic was not using a coding system which allowed continuity across different clinics and hospitals carrying out cosmetic surgery.

However;

- Leaders were very visible and approachable.
- The registered manager was able to access a virtual forum where they could go for help and advice.
- There were thorough processes for monitoring doctor's levels of indemnity insurance.
- There was evidence of improvements made as a result of infection, prevention control audits.
- The clinic followed General Medical Council guidance on the marketing of cosmetic procedures.

Vision and strategy for this service

- The Provider had adopted a set of values which placed quality and safety as the top priority; which staff were aware of.
- The service had a vision centred on business growth and patient satisfaction, which included on-going collection and analysis of Friends and Family Test data, as well as the collection of patient reported outcome measures (PROMS).
- The service was not making arrangements that ensured surgical cosmetic procedures were coded as recommended by the Royal College of Surgeons (SNOMED_CT- a system of coding which allows organisations to use the same coding for procedures to provide continuity across different clinics and hospitals carrying out cosmetic surgery). However, senior managers said the Private Clinic Limited had set up a series of committees at other locations to discuss issues such as health and safety, patient experience and outcome measures. Coding was going to be discussed within these committees, however, some staff did not know these committees had been set up, or what their purpose was.

Are surgery services well-led?

We found:

Governance, risk management and quality measurement

Surgery

- There was an effective governance framework to support the delivery of the strategy. Senior managers told us of quarterly clinic meetings and we saw evidence of learning from incidents being shared across the whole group.
- Working arrangements with partners and third party providers were managed effectively. For example we saw several service level agreements covering cleaning, sterile services and pharmacy support which were in date, and staff could explain what was done by each service. These agreements were monitored and reviewed on an annual basis by the senior management team.
- The governance framework and management systems were regularly reviewed and improved. We could see from recent audit data that the checklists for data collection had become more comprehensive since May 2016, when a new senior manager for theatres had been employed at the head office.
- There was a comprehensive assurance system. Service performance measures such as infection prevention control data and medicines management data were reported to head office and monitored by senior managers.
- There was a systematic programme of clinical and internal audit in the clinic, and the data from these audits was used to monitor quality and there were systems to identify where action should be taken. For example we saw actions recorded on the monthly infection prevention and control audit about a lack of storage. Staff told us they had asked to purchase some freestanding plastic storage units for excess stock, which was agreed by the business. However, audits of patient records checked for the presence of documentation but did not look at the quality of the documentation.
- There were arrangements for identifying, recording and managing risks, issues and mitigating actions. The clinic did not have its own risk register, but the registered manager fed risk assessments into head office where risks were identified and placed on the register if they met a certain threshold. However, the registered manager of the clinic was unsure how to access the register and it was not clear how they found out what was on the register. Some of the risks recorded identified concerns around the absence of monitoring consent to treatment. Mitigating actions included a project to review the compliance with current consent forms.
- Staff at the Private Clinic Bristol also identified a risk around the size of the current premises and said that if the business continued to grow as it had over the past three years, they may need to consider larger premises.
- There was a clinical governance group responsible for reviewing cosmetic surgical procedures which met on a monthly basis. Staff told us discussions had taken place around the PHIN information submission as well as on-going improvement to audits, including the implementation of the WHO checklist by the new theatre manager. We saw evidence of these discussions recorded within the meeting minutes.
- The clinic manager ensured surgeons carrying out cosmetic surgery had an appropriate level of valid professional indemnity insurance in place and we saw copies of insurance certificates held on file at the clinic. This insurance was also monitored at head office and if it was due to lapse, letters were sent to both the registered manager of the clinic and also the doctor.
- The roles and responsibilities of the Medical Advisory Committee (MAC) were clearly set out and available. The Responsible Officer who had recently been appointed, and was based at the London Headquarters chaired the MAC. The registered manager told us the regional manager and clinical services manager attended every MAC meeting and fed back advice and guidance at the quarterly clinic manager's meetings which were held a week after. We saw minutes from both the MAC and subsequent clinic managers meetings which confirmed that information and messages from the MAC were being discussed.
- The clinic made sure doctors involved in cosmetic surgery in the independent sector, informed their appraiser of this in their annual appraisal and maintained accurate information about their personal performance in line with national guidance on appraisals for doctors. We saw that the files kept for each doctor contained evidence of appraisals and declarations of work undertaken elsewhere. Senior managers told us they asked for evidence of appraisals from doctors on an annual basis, and a newly appointed registered officer in head office coordinated this.

Leadership of service

- Leaders of the service told us they had the skills, knowledge and experience that they needed to do their jobs, and they understood the challenges to good quality care and were able to identify the actions

Surgery

needed to address these challenges. Senior managers told us there had been a lot of challenges over the last year with the recommendation from the Keogh report in relation to the reporting of cosmetic surgery outcomes, but they felt they had engaged fully with the process. Senior managers also told us they understood the need for the changes and were planning on-going work to continue implementing the recommendations across the whole organisation.

- Leaders were visible and approachable, and the regional and clinical services managers visited most locations on a weekly basis. The registered manager told us they also had a virtual forum where they could go for help and advice from their peers in other clinics.
- Staff said that leaders were always visible and approachable and both a regional and local level, and felt they could go to them with questions and for support.
- Staff were aware of the whistleblowing policy, and could describe how they would raise a concern.
- Leaders ensured that employees involved in invasive procedures were given adequate time and support to be educated in good safety practice. They were also given time to train together as teams and to understand the human factors that underpin the delivery of ever safer patient care. Nursing staff told us they frequently went to other clinics to observe and share practice with their colleagues.

Culture within the service

- The culture of the service centred on the needs and experience of patients and staff told us patient satisfaction was the main measure of how well the business was performing. One surgeon told us they were happy to carry out additional surgical interventions if patients were not happy with the overall outcome of their surgery. They felt it was the least they could do and it was what they would expect of the service if they were using it.
- There was a good emphasis on promoting the safety and wellbeing of staff and staff told us they felt respected and valued. Staff told us they felt a shared responsibility to deliver good quality care and felt that the company invested in them through approving extra specialist training.

- The service had responded well to the requirements related to Duty of Candour legislation and all staff we spoke with could explain their responsibilities, and told us it was now covered in their training updates.
- The service ensured the provider only carried out marketing that was honest and responsible and that complied with the guidance contained within the Committee on Advertising Practice's (CAP). Managers told us they did not offer any financial incentives or discounts on procedures, and followed the General Medical Council guidance on marketing of cosmetic procedures.
- There was a system in place to ensure people using the services were provided with a statement that included the terms and conditions of the services being provided to the person and the amount and method of payment of fees. Terms and conditions of payment were set out on the back of the quotation form and patients told us they had this fully explained to them, however, we did see from the monthly notes audit that this information had been missing from some patient records.
- The service ensured they complied with the Competitions and Marketing Authority (CMA) order about the prohibition of inducing a referring clinician to refer private patients to, or treat private patients at, the facilities. No financial incentives were offered to surgeons to get them to practise at the private Clinic.

Public and staff engagement

- The clinic listened to the views and experiences of the patients in order to shape and improve the culture and the care in the service. For example, after patients expressed some concerns over the invasiveness of the procedures not being what they expected, work was done to improve patient information and allow ample time for questions during consultations.
- The clinic used simple patient surveys to capture overall patient satisfaction with their treatment, which showed 82% of respondents were satisfied with their procedure or treatment (including activities not currently rated by CQC). However, the clinic also used a more detailed feedback questionnaire to capture more data about patient experiences, which used five questions and had space for patients to comment freely.
- The service made sure people considering or deciding to undergo cosmetic surgery were provided with the right information to help them make the best decision about their choice of procedure and surgeon. For

Surgery

example, staff were aware of the newly launched Royal College of Surgeons information pages and said they also told patient to read their reviews on an independent site.

Innovation, improvement and sustainability

- Staff were focused on continually improving the quality of care and actively sought new training opportunities to do this, which included observing care in other clinics.
- The service had arrangements in place to encourage, record and monitor RCS Certification by surgeons who carried out cosmetic surgery, and one of the surgeons working at the Private Clinic Bristol had been involved in developing the certification scheme.

Outstanding practice and areas for improvement

Outstanding practice

- Nursing staff had identified and been trained in a type of massage which helped enhance patient aftercare.
- The registered managers had a virtual forum where they could go for help and advice from their peers in other clinics.

Areas for improvement

Action the provider **MUST** take to improve

- Ensure all patient care records and notes are complete, legible and contain all appropriate assessments and relevant medical history, including risks associated with procedures.
- Ensure consent forms clearly explain the procedures patients are consenting for.
- Provide adequate safety signage for rooms where medical gases are stored.
- Ensure observations and medications are recorded in a standardised and legible way, which covers pre, intra and post-operative aspects of patient care.

Action the provider **SHOULD** take to improve

- Consider using safety cannulas for all patients requiring intravenous medication.
- Consider VTE assessments for all patients undergoing surgical procedures in line with best practice guidance.
- Record evidence of psychological assessments in patient records for all patients undergoing surgery for cosmetic reasons.

- Consider making arrangements to ensure psychiatric support is available to patients if and where necessary.
- There should be consideration for sharing safety data which is collected centrally with the registered managers at the locations such as The Private Clinic Bristol.
- Consider replacing the resuscitation trolley with one which can be sealed with tamper evident tags.
- Ensure all staff are up to date with all mandatory training.
- Monitor the information contained in patient consent forms and ensure it is accurate and appropriate.
- Monitor the consent process and ensure it is being followed, and audit and document this.
- Consider using Modified Early Warning Scores (MEWS) to help identify deteriorating patients.
- Consider including doctors' summary letters in patient records.
- Consider ensuring all medical notes are recorded in black ink.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>Regulation 17- Good governance</p> <p>17 (2) (c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of care and testament provided to the service user and of decisions taken in relation to the care and treatment provided.</p> <p>Patient records were not always complete.</p> <p>Discussions of risks associated with procedures were not always documented in the patient's notes.</p> <p>Surgeon's summary letters were not included in patient notes.</p> <p>Handwritten observation and medication charts were not legible.</p>
Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 11 HSCA (RA) Regulations 2014 Need for consent</p> <p>Regulation 11 – Need for consent</p>

This section is primarily information for the provider

Requirement notices

11 (1) Care and treatment of service user must only be provided with the consent of the relevant person.

Consent forms did not make it clear which procedure patients were being consenting for.

Consent forms were not labelled as consent forms, and it was not clear if patients knew they were signing a consent form.

Regulated activity

Treatment of disease, disorder or injury

Regulation

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

Regulation 12 – Safe care and treatment

12 (2) (d) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to

d) Ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way.

There were no warning notices alerting staff to the presence of flammable materials on the door to the store room where the oxygen cylinders were stored