Queen Anne Street Medical Centre

Quality Report

Queen Anne Street Medical Centre
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Date of inspection visit: 1 and 7 September 2016
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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location

Summary of findings

Letter from the Chief Inspector of Hospitals

We undertook an unannounced focused inspection at the Queen Anne Street Medical Centre in response to concerns raised regarding the surgical services and the governance arrangements. The concerns related to cross infection issues, medicine management and the lack of leadership in the surgery department.

We inspected on the 1 September 2016, and undertook a further unannounced inspection on 7 September 2016.

During our inspection, we reviewed surgical services, which included the operating theatre and recovery area. We spoke with surgery staff and members of the senior staff, including those responsible for monitoring the quality of service provision and overall governance.

This report covers the areas we inspected with regards to the specific concerns raised. As this was an unannounced focused inspection we have not considered all of the key lines of enquiry. The service will be undergoing a full comprehensive inspection in February 2017.

Our key findings were as follows:

- Staff, including the safeguarding lead were not trained to the recommended level in safeguarding vulnerable adults and children. Safeguarding vulnerable individuals was not included as part of mandatory safety training.
- The safeguarding policy was outdated and did not refer to the most recent guidelines. Information with respect to female genital mutilation, child sexual exploitation, and child slavery was not included.
- There were no full pre-assessment records kept at the centre. Staff were unaware of the pre-assessment checks taken prior to patient's treatment. As such, we were unable to see evidence of risk assessments having been undertaken,
- No in-depth audits of surgical site infections, hand hygiene, or World Health Organisation (WHO) safer surgery checklists were completed.
- Leadership of the theatre department lacked direction. Staff told us they did not feel confident to raise issues or report incidents to the manager.
- The service did not have a duty of candour policy, and although some staff knew it meant being open and honest, they were unaware of the finer details of the regulation.

However:

- The centre had provided an action plan for safeguarding and pre-assessment checks, after we raised concerns.
- The plans included safeguarding training for all staff, which was expected to start in September 2016. This would include a safeguarding lead trained to level three.
- The company assured us they would be asking patients to complete a comprehensive pre-assessment check prior to treatment and details be kept in the patient records.

- Medicine management was kept in good order by the pharmacy department and staff had received good training.
- Staff had received a good level of resuscitation training from the centre.
- Equipment had been regularly serviced and stickers were placed on equipment to show they had been checked.
- The governance team held regular meetings to keep up-to-date on risks, Key Performance Indicators (KPI), and incidents.
- Incidents were discussed at the Medical Advisory Council (MAC) meetings.
- Learning from incidents was shared to each department manager and they cascaded information to staff.
- Staff were trained to the appropriate level of competence to fulfil their duties within their role.
- The senior team managed revalidation and training well, with meetings to discuss practising privileges of each consultant surgeon.

Summary of findings

- The centre used an early warning score (EWS) system, to determine if patients needed further medical assistance. Escalation process involved transferring patients to another independent hospital or calling emergency services for life threatening cases.
- Staff wore the appropriate personal protective equipment when treating patients.
- The centre had a service level agreement with an NHS hospital for the decontamination of all instruments.
- Patient records were stored safely in lockable cupboards and were in line with the Data Protection Act.
- Patients were able to participate in a 30-day follow up questionnaire. The centre used this questionnaire as a tool to measure infection rates.
- We were told the provider engaged with the Private Healthcare Information Network (PHIN) so that data could be submitted in accordance with legal requirements regulated by the Competition Markets Authority (CMA).
- We were told the service was not yet collecting data for Patient Reported Outcome Measures (Q-PROMS) for relevant cosmetic procedures performed at the location.
- A Total Quality Management (TQM) patient satisfaction survey was managed internally. The TQM for theatres from January 2016 to August 2016 showed patient satisfaction was consistently above 95%.

During our inspection, we did not observe any areas of outstanding practice.

However, there were areas of practice where the service needed to make improvements.

Importantly the service should:

- Make sure staff are trained to the appropriate safeguarding level and establish a safeguarding system within the centre, which includes mandatory training and an appropriately trained safeguarding lead.
- Update their safeguarding policy to reflect intercollegiate guidelines.
- Devise a system whereby comprehensive patient pre-assessment information can be accessed in patient records.
- The WHO surgical safety checklist needs to be led in a more robust and efficient manner, so it is clear and not disjointed.
- Improve leadership and communication within the theatre department team, so staff are fully engaged and feel confident to report issues and raise concerns.
- Theatre team meetings should be documented with clear agenda and actions.
- Involve and expect all staff regardless of their job role,to report clinical incidents.
- Consider how the theatre staffs knowledge and understanding of the duty of candour can be improved.
- Make sure staff keep the theatre fire exit clear at all times. It should not be blocked with large equipment.
- Consider clearly identifying storage areas within theatre, and where staff need access to the hand washing facilities, this access is not obstructed.
- Monitor staff compliance with regard to single use items of equipment.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

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Summary of this inspection

Background to Queen Anne Street Medical Centre

Queen Anne Street Medical Centre (QAMC) is a private independent acute care hospital, which was established in 2005. It is located in central London, and is easily accessible via public transport. QAMC provides specialist medical care offering a range of services from cosmetic surgery, clinical trials and cancer care.

Cosmetic surgery treatments include, breast enlargement, reduction, and uplift. They also provide eye surgery, liposuction and nose surgery.

Our inspection team

Our inspection team was led by: Inspection Manager, three inspectors and a specialist advisor who was a registered theatre nurse.

Why we carried out this inspection

We carried out this inspection in response to concerning information received by the commission. The matters raised with us related to practices in the operating theatre department and the overall leadership and governance.

How we carried out this inspection

We visited the Queen Anne Street Medical Centre based in London, where we spoke to the medical director, governance lead, theatre manager and four theatre staff, as well as one receptionist, and administrative staff. We viewed six sets of patient records.

We visited theatre, recovery bays, and patient rooms.In addition, we viewed documentation provided to us.

Information about Queen Anne Street Medical Centre

The surgery services comprise of one theatre, a two-stage recovery area with two bays and two further patient rooms. The number of patients who have received surgery treatment from January 2016 to August 2016 was 198.

We carried out an unannounced focused inspection with respect to the surgical services and governance arrangements on 1 September 2016, and a further unannounced inspection took place on 7 September 2016.

We spoke with 10 staff members and viewed six patient records. We were unable to speak with patients as they were not conscious during our inspection and no surgery took place on our return visit.

Surgery

Safe	
Effective	
Responsive	
Well-led	

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- In-depth audits of compliance with hand hygiene, or World Health Organisation (WHO) safer surgery checklists and other safety records were not routinely completed.
- Leadership of the theatre department lacked direction. Staff told us they did not feel confident to raise issues or report incidents to the manager.
- The service did not have a duty of candour policy, and although some staff knew it meant being open and honest, they were unaware of the finer details of the regulation.

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Are surgery services safe?

By safe we mean that people are protected from abuse and avoidable harm

Overall, we found improvements were required for the service to provide safe care because:

- Staff were not trained in safeguarding and the safeguarding policy was not in line with national guidelines.
- Theatre staff were not confident that all incidents were reported by their line manager and did not always receive feedback on reported incidents.
- Nursing staff were not aware of duty of candour and had not received training with regard to this.
- Staff told us they had to re-use non-invasive single items of stock and no action was taken when their concerns about this were raised to their line manager.

However:

- Staff were aware of how to report incidents and the escalation process.
- Where incidents had been reported they were investigated well by the senior management team, with clear actions taken and lessons learned.
- Staff wore the appropriate theatre attire and adhered to cross infection guidelines.
- Staff were aware of the process and procedures to follow when dealing with controlled drugs.
- Staff completed patient records and stored them safely.
- Staff were up-to-date with their mandatory training.

Incidents

- We were told by a member of staff the incident reporting process was paper based, and included the completion of a form, which was then scanned and sent to the line manager.
- We were shown the IT system 'help desk', which enabled staff to access standard operating procedures and the incident reporting programme.
- We were shown the IT dashboard for recording the number of incidents by type, which had occurred in the past year. It should be noted the data included information pertaining to the surgical service as well as the other separate services provided from the centre. The figures showed there had been 10 clinical incidents,

one clinical near miss and six general incidents. There had not been any serious incidents or never events. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

- We asked staff how information from incidents, particularly learning from these was shared with staff. In response, we were told there was a reliance on line managers to share such information.
- Theatre staff told us incidents were reported by informing the theatre manager and the manager would report the incident using the appropriate process. However, those staff told us, they were not always confident the theatre manager reported incidents. For example, staff reported the repeated use of a single use non-invasive item of stock (blue slide sheets). Staff had not received feedback on the reported incident and no further action had been taken to stop the sheets from being repeatedly used.
- Staff told us they did not always receive feedback from reported incidents. The theatre manager said feedback was given through staff meetings. We asked to see minutes of these meetings but were told they were not recorded. Therefore we were unable to verify the content of staff meetings.
- The Medical Director told us they did not expect the Health Care Assistants (HCA) to report clinical incidents. This meant there was a potential to miss opportunities within the organisation to capture as much information on incidents as possible. All staff in the theatre environment, regardless of their job role, should be able to report any type of incidents, and should expect to have this investigated and acted upon.
- We were told mortality and morbidity was discussed in the Medical Advisory Committee (MAC) meetings, although we could not see evidence of this in minutes provided to us. The monthly governance committee meetings were said to include discussion of any incidents, clinical, general, or occupational. The minutes of meeting we reviewed showed there were no incidents to discuss.
- The Medical Advisory Committee (MAC) minutes also included a review of clinical incidents. However, the minutes of 29 June 2016 indicated there were multiple incidents, which were all reviewed by the chair, who concluded processes taken were satisfactory and no further actions were required. The minutes did not detail what the incidents were, and as a result, we were not able to assess the thoroughness of the review procedures.
- The MAC meeting minutes of 1 March 2016 showed there were two clinical incidents. One relating to patient blood pressure dropping post-surgery. The other incident related to balance discrepancies in the controlled drug book. Both incidents had an incident record number and had been investigated. Information included what actions needed to be taken, the dates for the actions to be completed and the staff members involved.
- We viewed a clinical near miss report regarding a needle that was found in a bin by the housekeeper. The report was detailed and demonstrated a root cause analysis process was followed. The report showed clear actions taken and instructions given to staff. A risk assessment was also undertaken and a score given to highlight how serious the risk was. The incident and follow up actions were mentioned in their health and safety meeting a month later. This showed a clear incident pathway was followed by the organisation. Staff were able to relay the incident to us and the subsequent actions taken.

Duty Of Candour

- Duty of candour is a legal duty to inform and apologise to patients if there have been mistakes in their care that may have led to significant harm. There was no policy on the duty of candour and most staff had no understanding of it. A few staff said it meant being open and transparent but did know the finer details.
- Staff told us they had not received any training or informal discussions on the duty of candour.

Safety thermometer

- This service, unlike NHS trusts, is not required to use the national safety thermometer for measuring, monitoring, and analysing common causes of harm to patients, such as falls, new pressure ulcers, catheter and urinary tract infections and venous-thromboembolism (VTE).
- As there were no VTE checks completed at the centre and no documented evidence in patient records, we are unable to determine if the appropriate patient safety checks had been undertaken. Theatre staff we spoke with told us they did not know whether a patient they

treated had received the assessment beforehand. Therefore staff would not be aware in advance of any potential or actual risks to the patients they were providing care for.

Cleanliness, infection control and hygiene

- Infection control training was part of induction and mandatory training. All staff we spoke with had completed the training in May 2016, and we saw the records to support this. A bank nurse was scheduled to take the training in September 2016.
- Most of the theatre environment was visibly clean and tidy and hand gel was available in every room, which included recovery, theatre, and patient pre-operative rooms. Hand washing facilities were provided.
- In accordance with regulatory guidance, personal protective equipment was available in all areas and we saw staff using gloves at the appropriate times. However, there were occasions when two members of staff were observed not removing their gloves when exiting the theatre environment. This posed a risk of possible cross infection contamination, if those staff then touched other work surfaces, equipment, or other individuals.
- Staff wore the appropriate scrub garments and had their hair tied back. Staff working inside the operating theatre wore theatre caps and masks during treatment.
- The 'bare below the elbows' policy was observed by most staff. However, at the start of the inspection, we observed two members of staff wearing jewellery. The staff members had started treatment with patients in theatre and recovery. Later when we revisited the same area, the staff members had removed the jewellery.
- We saw a certificate of theatre deep clean was displayed in the staff room. The last deep clean had been 11 July 2016.
- There was a theatre cleaning schedule kept in a logbook in the recovery room, which had been dated and signed by staff.
- We observed staff cleaning the theatre environment after the patient had received their treatment.
- During the inspection, we noticed there was no cleaning schedule for the patient bathroom. The theatre manager told us the list was usually displayed on the door or inside the room for people to see and explained the cleaner must have taken it with them.
- Although the bathroom looked visibly clean and tidy, we were unable to establish when it had last been cleaned and checked by staff.
- We spoke with the Infection Prevention Control (IPC) lead. They told us for theatres, they were responsible for training staff how to wash their hands.
- When asked what IPC audits and checks were completed for theatre the IPC lead was unable to tell us. The service did not undertake any hand hygiene audit checks and the IPC audits we viewed confirmed this. Theatre staff we spoke with told us no audits were undertaken for hand hygiene. Therefore there was a risk that staff, including consultants may not have been adhering to best practice guidelines regarding hand hygiene but this would not have been known.
- A theatre audit of 23 May 2016 included elements of infection control and cleanliness. This only detailed what staff should be doing rather than monitoring and measuring safe infection control practices. There was no data to see if improvements or actions were needed as the audit was too general.
- An independent infection control company undertook a six monthly audit of the centre, including theatres and pre-admission areas. They measured areas and gave a final compliance score. For July 2016 the compliance score for the whole centre was 94.6%.
- The company measured the environment and equipment. They gave suggestions to areas that were not compliant. For example, in the patient recovery areas they noted the washable curtains had no labels to indicate when they had last been cleaned. We noted during our inspection curtains labels were in place, with the dates when they had last been checked.
- Infection control committee meetings were held monthly. Minutes that we viewed of 27 June 2016, showed topics discussed included serious incidents reported, theatre air testing, legionella testing, 30-day follow up questionnaires and current infection rate. The theatre manager attended the meetings.
- Many people carry meticillin-resistant Staphylococcus Aureus (MRSA) on their skin without showing any symptoms. By screening (performing a simple swab test) before an operation, tests can determine who is carrying the germ and treatment can be provided before the patient is admitted to hospital.
- The organisation did not screen new admissions for MRSA. The medical director took the decision not to screen patients in 2010. In 2013, they reassessed their

decision with the same conclusion. The director provided discussion papers to substantiate their decision. This information had showed there was no evidence that pre-operative MRSA screening had any effect on subsequent surgical infection rates.

- We were told the private and voluntary hospitals (PVH) performance indicators data submitted to the CQC on a quarterly basis showed infection rates at QASMC to be nearly zero for the previous 10 years. We reviewed this and noted submission of surgical site infections to the PVH related to hip and knee procedures only, neither of which were undertaken at this location.
- We saw other PVH data included the submission of results related to blood cultures for MRSA and MSSA only. We noted data was missing for quarters two and three of 2015/16. Therefore we did not know if any such bacteraemias had occurred.
- Staff we spoke with told us they had to re-use non-invasive single use items of stock. For example, the lateral patient transfer device, (blue slide sheets), were re-used by staff, and lower limb 'flowtron' pressure pads. Staff told us they had escalated their concerns to the theatre manager but no action had been taken. Re-using single use items poses a risk of transmitting bacteria and possible infection arising.
- Staff said they did not report the matter as an incident, as they did not feel confident the theatre manager would escalate it through the appropriate process. Instead, staff placed absorbable bed pad sheets on top of the blue sheets with a view to prevent cross infection.
- When asked why items of equipment were re-used, staff indicated this was a cost saving measure. This was strongly refuted by the provider. Further, we did observe during the inspection a good stock supply of lateral patient transfer device sheets.
- We saw clinical waste was managed safely, and sharps bins were labelled correctly, and were not too full. Staff were able to tell us the appropriate arrangements were in place for specialist waste to be collected.
- We viewed the service level agreement the centre had with an NHS hospital for the decontamination of all instruments. This service enabled the safe management and provision of sterilised instruments for surgical procedures.

Environment and equipment

- The surgery department was based on the ground floor. There were two patient, pre-assessment rooms with patient beds, a two bay recovery area, and an operating theatre.
- There were no separate male and female second stage recovery areas but a curtain was drawn to provide sufficient privacy.
- During our inspection, we saw the fire exit in the theatre side room was blocked with a trolley. Staff explained it had been placed there while the floor was being cleaned in-between surgical activity. However, later during the inspection and on our return on 7 September 2016, the trolley had not been removed. We noted the trolley would be easily manoeuvred in the event of staff needing to access the fire exit.
- Another side room, which had facilities for staff to wash their hands, was completely stocked full of equipment and prevented staff from using the facilities. There was conflicting information provided to us with regard to this room. The manager explained the area was not usually used for storage, and they were in-between moving the equipment. Other staff told us the room was always full of stock and was unusable.
- Nurses told us equipment stock ordering was done by placing their orders on an informal list in the office. Ordering was done through purchase order daily or weekly and signed off by finance. We did not see any stock lists in theatre to assess what should have been available to staff.
- Theatre staff were unable to tell us if a consultant bought their own equipment with them or the correct processes staff followed if this happened. However, we were provided with information that demonstrated those consultants under practicing privileges had to fully complete an 'application for admitting rights' form. This form provided details of what equipment consultants were planning to bring to the centre and the evidence of servicing and calibration of such equipment.
- The equipment we viewed had service stickers attached to identify when the equipment had last been serviced and when the next service was due. One Bair Hugger (a patient warming device) in the recovery area did not have a service sticker attached.
- Clinical waste was disposed of correctly and staff were able to tell us the appropriate arrangements for specialist waste to be collected.

- We viewed the resuscitation trolley, which was fully stocked and daily checks had been made and recorded.
- Of the 10 oxygen cylinders stored in the theatre walk-through, six were on level red. The theatre manager said arrangements were in place to order more cylinders and deliveries usually arrived very quickly. In the recovery area, one cylinder was on the red level; however, a staff member changed this cylinder during our inspection. Staff we spoke with said there had never been a particular occasion when there had been a shortage of oxygen.
- Advanced airway equipment was available inside the theatre and was easily accessible by staff.
- The whistle-blower had raised a concern regarding the lack of supportive bed rails for patients. All patient beds we inspected during our visit had the appropriate bed rails in position.
- Staff were able to access a wheelchair for patients. This was based by the lift within the centre and was easily accessible to staff.
- Prior to the inspection, we received information relating to the diathermy machine being switched into three different extension leads, which would be a safety concern. We did not observe this practice during our inspection, and none of the staff we spoke with corroborated the pre-inspection information raised with us.

Medicines

- The centre had their own accountable officer for medicines. A pharmacy department and pharmacists were present within the centre and were responsible for medicine reconciliation.
- We spoke with the pharmacist who told us they did a three monthly check on all controlled drugs (CD) and this was audited for quality assurance. We saw the pharmacist checks logged inside the CD cupboard within theatres.
- We viewed the controlled drugs audit for theatres dated February 2016 and May 2016. The audit findings detailed mistakes made, for example, record keeping for Fentanyl showed specific dates staff had entered details incorrectly. The audit gave corrective actions and preventative actions and the person responsible to take actions, with specific target dates for completion. The audit also clarified mistakes would be discussed in the Medical Advisory Committee (MAC) meetings and training for CD management would be given by the pharmacist. The MAC minutes of March 2016, confirmed medicine discrepancies were discussed. Staff we spoke with in theatres were able to confirm they had received training from the pharmacist.
- The pharmacist also checked the CD cupboard and ordered stock when necessary.
- The CD cupboard was locked and access was through a key held by the theatre manager.
- The surgeon and anaesthetist were responsible for prescribing patient medication and the pharmacist did a clinical check before dispensing.
- A temperature checking system was followed for refrigerated medicines. We saw the temperature was recorded on a daily basis. Staff were able to use other fridge facilities within the centre if the fridge storage system was not working accurately. We did not see any auditing of these checks.
- Prior to the inspection concerns had been raised regarding the shared use of cefuroxime. However, single use dosage had been introduced to the centre, and this was still evident during the inspection.
- The pharmacist told us they held regular training sessions for staff in safe medicine management.
- Medicine management audits and early warning scores audits were carried out to identify if all procedures and process were being followed by staff, and whether the correct information was being recorded. Medicine management audits focused on whether staff had recorded the administration and management of controlled drugs correctly and followed the correct guidance. Audits of March 2016 and May 2016 identified mistakes made and actions taken to rectify those mistakes. For example, a heading for morphine injection, page 59 dated 11 March 2016, 'time needs to be clarified', was one entry. Corrective action taken and the responsible person was listed on the audit.

Records

- Records were paper based and stored in lockable filing cabinets.
- The patient records we viewed did not contain any pre-assessment information about the patient, and therefore nursing staff did not have any essential information available. Such information would cover for example; previous medical and surgical history,

medicines, and allergies. There was no information to indicate risk assessments had been undertaken. Such risks would include venous thromboembolism (VTE) assessments or cardiac matters for example.
- We viewed six patient records for individuals who had received a surgical procedure between the dates of August 2016 up to the date of our visit. The records showed the information collected after the patient had arrived at the centre. These included pre-operative checks, consent, recovery observational, and anaesthetist recordings were in place. A few records had consultant input.
- We found one consent form was illegible and therefore we could not identify what procedure the patient had consented for. One patient file contained no signature on the intra-operative care notes.
- A records management audit was completed in March 2016. The audit concentrated on the safe storage of records rather than the content of records to see if staff were completing important patient information correctly. The audit showed compliance of the storage of patient records and how they could be identified and located.

Safeguarding

- The company had a safeguarding policy, which had not been updated to reflect the current guidelines, for example, with respect to female genital mutilations (FGM), sexual exploitation, and child slavery.
- Staff had not received any safeguarding vulnerable adults or children's training, and were not trained to the recommended levels.
- The safeguarding lead was not trained to level three in safeguarding vulnerable children and did not understand all staff were required to be trained to an appropriate safeguarding level. Therefore safeguarding training was not included in mandatory training.
- Staff had awareness, when asked what safeguarding meant and said they would report any matters to the appropriate manager.
- We asked the company for an action plan to address our safeguarding concerns. They had subsequently set up a plan to ensure staff would be trained in safeguarding. This included training all clinical staff to level two by 7 October 2016 through an e-learning system.
- The information provided within the action plan indicated a deputy-safeguarding officer was to be recruited and trained to safeguard level three.
- The provider informed us they would initiate actions to update their safeguarding policy, to include separate policies for children/young adult and adults with effect from 15 September 2016.
- We have since received the training attendance records for safeguarding levels two and three and the staff who have successfully completed the training. All theatre staff have received and completed training including the safeguarding lead who has completed level three training.
- The centre have now updated their safeguarding policies which reflect current intercollegiate guidelines.

Mandatory training

- We were told topics covered for mandatory training included, fire safety, and security, health and safety, control of substances hazardous to health (COSHH), medicines management and infection control.
- We viewed the mandatory training tracker for theatres. The bank nurse required training for all topics, and this had been scheduled for early September 2016. The deputy theatre manager had three topics to complete, and the theatre practitioner had two. It should be noted the deputy manager was new to the centre. Other contracted staff were up to date with their mandatory training.
- Training took the form of e-learning modules and courses. Resuscitation training was completed within the centre. Theatre staff were immediate life support trained. The RMO was advanced life support (ALS) trained, and could be contacted via a bleep system.
- We viewed the staff certificates for mandatory training for the theatre nurses, which were kept in the theatre office.

Assessing and responding to patient risk

- At our initial visit, we found pre-assessment checks were not recorded in the centres patient records and as such, staff told us they were not sure of the checks patients had undertaken prior to treatment. The surgeon had their own notes they brought with them. This meant staff were not aware, beforehand of the patient's condition, including any pre-existing matters, which may have posed a risk.
- Although the centre confirmed the appropriate pre-assessment checks were being made by the

consultant there was no documentary evidence to show this. However, we did see pre-operative checks made when patients came to centre, which included taking their blood pressure.

- Staff told us they sometimes received a telephone call from the patient's consultant to inform them if a patient had an allergy, for example to latex products.
- We requested and received an action plan outlining the way in which the service would respond to our concerns about the patient records, and risk assessments. At our second visit, we found they had devised a comprehensive pre-assessment form that was to be used with the patient booking form and patients would be asked to complete this prior to treatment. This form included a risk assessment evaluation, which would be reviewed by the medical director or surgery staff prior to surgery. All consultant surgeons would be informed of this action and would start to use the form with immediate effect.
- The National Patient Safety Agency recommended in 2010 that The World Health Organisation (WHO) 'five steps to safer surgery' checklist should be followed and used for every patient undergoing surgical procedure in the NHS. The WHO checklist could be adapted for use in other services, with the focus on safety checks before, during, and after surgery. The service was using an adapted version using three steps. This was not audited to check for compliance.
- During our inspection, we observed the WHO checklist being used for a patient. We found the 'time out' check was disjointed with no real leader taking control. We did not observe a briefing or debriefing stage. However, after further discussion with staff they were able to tell us the consultant discussed all treatments at the beginning of the day and issues arising from procedures would be discussed at the end of the session. We did not see any evidence of this recorded.
- The service used an early warning score (EWS) system for their patients. If escalation was required, the EWS score was assessed with the Resident Medical Officer (RMO) and medical director, and a decision was made as to whether the patient was sent to another private hospital.
- The medical director had practising privileges, and an arrangement with another private hospital to accept their patients, and the centre paid them for further treatment, if necessary. The centre called 999 for life threatening incidents. Over the last ten years, they had had three of each type of escalation.
- The centre did not see high risk patients and their patients had a physical classification anaesthetic risk score of 1 or 2. This meant patients undergoing surgery were generally low risk. High risk patients with significant morbidity may also be treated at QASMC, for example for ophthalmic surgery under local anaesthetic. Whilst these may be high risk patients by definition, the procedure would be classified as low risk.
- Post-surgery, patients were seen by a nurse, trained in recovery. They assessed the patient's vital signs, pain, and general comfort. The records we viewed showed observations were made routinely and recorded using the EWS system.
- Within the centres management of medical emergencies policy, processes were in place to manage sepsis, using the sepsis six protocol. This is a recognised approach to identifying and responding to patients who show signs of infection.

Nursing staffing

- In addition to the theatre manager there was a deputy theatre manager, a registered nurse a scrub nurse and a health care assistant (HCA). A registered bank nurse was frequently used at least once a week.
- At the time of our inspection, theatres had a vacancy for another full time scrub nurse.
- Staffing was arranged according to clinical activity.
- Agency staff worked in theatres when required. During our inspection, an agency nurse was used for theatres. When we asked for details of the agency nurse's registration and certificates of competency, the theatre manager was unable to tell us. Only later when they had contacted the agency could they provide the relevant information.
- Prior to our inspection, information received suggested staff were often called away from the surgery department to work in other areas of the centre, leaving theatres short of staff. During our inspection, a staff member confirmed this often happened.

Surgical staffing

- Surgical consultants and anaesthetist had practising privileges to work within the centre. There were three consultant surgeons working from the centre. Suitable

checks were carried out to enable medical staff to practice at the centre: including for example, their professional registration, qualifications, insurance, disclosure and barring, and revalidation.
- Arrangements for out of hours care for the patient was made between the consultant and patient directly.
- The Resident Medical Officer (RMO) was always in site but, only saw patients if requested by staff. They did not do routine checks on patients.

Are surgery services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Overall we found some improvements were needed to ensure the effectiveness of the service because:

- The centre was reliant on patients completing the 30-day patient follow up review to monitor surgery site infection rates and other quality outcomes. The patient response rate for January 2016 to August 2016 was 54.45%.
- Theatre team meetings were held but not recorded.
- Staff had not received training in the Mental Capacity Act (2005), and lacked an understanding of this.
- Pre-assessment information was not available to staff before patients treatment.
- Auditing within theatres was undertaken but did not include compliance with the WHO safety checklist and VTE assessments. The theatre manager was unable to tell us what audits took place within the theatre department.

However:

- Audits were conducted throughout the centre on a regular basis and actions were taken on findings which required improvement.
- Patients were offered the appropriate pain relief at a suitable time.
- All staff were trained to the required level to fulfil the requirements of their job role. Staff had the appropriate certification and checks before they started work within the centre.
- Management told us they engaged with the Private Healthcare Information Network (PHIN) so that data could be submitted in accordance with legal requirements regulated by the Competition Markets Authority (CMA).
- A residential medical officer was on site and available when the consultant and anaesthetist were not available.

Evidence-based care and treatment

- Patients treatment and care was delivered care in line with the relevant National Institute for Health and Care Excellence (NICE) and Royal College guidelines, such as the Royal College of Anaesthetists and the Academy of Medical Royal Colleges.
- There was access to policies and procedures to guide and inform clinical staff.
- An internal theatre audit was conducted in May 2016, which found the centre was compliant with CQC requirements. The audit covered areas such as, ensuring staff had read all local policies, and standard operating procedure, auditing the theatre environment to ensure it was fit for purpose, and equipment checks.
- We saw from the resuscitation committee minutes of March 2016, EWS audits were undertaken and the compliance score was 70%. The minutes showed discussion took place on areas of concern such as temperature monitoring not being recorded and written up accurately. Actions included the theatre manager checking two patient files at the end of each day to review compliance and feedback results to the senior management.
- The resuscitation committee minutes of June 2016 confirmed EWS audits would be carried out every three months. Records we viewed during our inspection demonstrated EWS scores were recorded for every patient.
- We saw actions taken in response to audit findings. For example, no sign was present on a waste bin in a patient room. A responsible person was given the task to ensure the action was followed through and a specific date to complete the action.
- A records management audit was conducted in March 2016, which focused on the safekeeping of patient records. There was no auditing of the actual completion of patients medical records, which would include such things as the WHO safety checklist and VTE assessments.

Surgery

- At the time of our inspection, the deputy theatre manager was reviewing all risk assessments within theatre.
- Staff we observed generally adhered to local policies. Staff we spoke with had read local policies kept in the surgery department and standard operating procedures.
- We were told the Quality Assurance department had responsibility for programme of audit, although departmental managers had responsibility for undertaking and closing off audits. We reviewed the audit dashboard, which showed all but two audits were still in progress.

Pain relief

- Pain relief was prescribed by the anaesthetist or consultant surgeon and was recorded on patient's medication records.
- We saw pain scores were used to determine the patient's level of pain. Staff told us they would contact the anaesthetist, consultant, or RMO to review the patient if they needed more assistance.

Nutrition and hydration

- There was a kitchenette within the centre, whereby food and drink was offered to patients before they were discharged.

Patient outcomes

- Surgery undertaken at the location was elective in nature, and was not classified as complex in nature. There were no emergency facilities.
- Patients were able to participate in a 30-day follow up questionnaire. The centre used this questionnaire as a tool to measure infection rates and other quality outcomes. Patients were asked questions regarding their procedure, for instance, had they any complications after the operation, had their wound healed fully, did they have an infection after their procedure, had they a need to contact their GP.
- The 30-day follow up information provided to us showed, for the month of July 2016, 20 patients were seen. Twelve patients responded, indicating a 60% response rate. For the month of June 2016, the response rate was 42.2%. So far, since January 2016 to July 2016, 191 patients consented to complete the form and 104 returned the form, totalling a 54.45% return. Therefore, the centre was reliant on patients completing and returning the form to measure their surgical infection rate and other measures of quality outcomes.
- No local audits were undertaken in theatres, such as checks on compliance with the completion of the WHO safety checklist or the completion of VTE assessments. The theatre manager was unable to tell us what audits were carried out.
- The pharmacist and quality assurance manager completed a medicine management audit for theatres on 10 May 2016, to assess the compliance of management of controlled drugs (CD) in theatre. The audit covered record keeping of the CD book. Mistakes made were listed, for example, overwriting in the book and fed back to the relevant staff member. Actions included ensuring all staff received CD training from the pharmacist.
- A theatre audit of 23 May 2016 was very broad in scope. The audit centred on topics such as infection control and cleanliness, safety and suitability of premises, equipment, complaints, records, and assessing the quality of service provision.
- We were told by the provider the service was not yet collecting data for Patient Reported Outcome Measures (Q-PROMS) for relevant cosmetic procedures performed at the location. Completion of PROMs, pre- and post-operatively, allows for a patient's own measurement of their health and health-related quality of life, and how this has been changed by the surgical intervention.
- We were told by the provider they engaged with the Private Healthcare Information Network (PHIN) so that data could be submitted in accordance with legal requirements regulated by the Competition Markets Authority (CMA). Staff told us the service had met three of the four required elements and the area as yet to meet related to the six month follow up of patients.
- The private and voluntary (PVH) performance indicators for the reporting period showed there had been no reported mortality or morbidity. There were no unplanned transfers or unplanned returns to theatre. There was one unplanned readmission within 29 days and no serious injuries reported.

Competent staff

- The registered manager, who was a doctor, undertook appraisals of admitting consultants.

Surgery

- Surgeons and anaesthetists working at the location were required to have approved practising privileges. We were shown the database used to monitor required information in support of such approval. This included General Medical Council membership number, evidence of revalidation, a performance review, and certification of qualifications and experience.
- We saw the information was up to date and a designated member of staff had responsibility for monitoring and requesting updated information at timely intervals.
- Offer letters of practising privileges contained detailed information of the terms and conditions, as well as responsibilities.
- Information was shown to us to demonstrate where consultants, their qualifications, brought in first assistants and skills were checked as part of practising at the hospital.
- Revalidation meetings were held to discuss each consultant surgeon and anaesthetist in terms of their appraisals, revalidation and caused for concern. We viewed meeting minutes of 29 June 2016. Discussion took place regarding individual consultants, current investigations, complaints, concerns and actions taken.
- Nursing staff we spoke with told us they understood the revalidation process and felt they would be supported by the organisation. We did not see any evidence during the inspection of supportive systems in place to assist nurses through the process.
- The centre held the appropriate qualifications and certificates for their nursing staff.
- At the time of our inspection, a health care assistant (HCA) was still in training and being supported by staff within theatre.
- Staff were immediate life support trained. The centre had a good life support training system, and staff had bleeps so they were able to contact an advanced life support person from within the centre building.
- There was no designated anaesthetic nurse. The theatre manager was anaesthetist trained and was present through the patient's treatment.
- A staff member due their appraisal told us they were frustrated at the lack of arrangements within theatre. They had attempted to arrange their meeting but the manager had not taken action.

Multidisciplinary working

- Theatre staff team meetings were held but not documented or recorded; therefore, we were unable to see what discussions took place during these meetings. We were not told how often the meetings were held. Consultants did not attend the meetings.
- Staff were aware who had overall responsibility for each individual patients care.
- An RMO was available within the premises, and was present when the consultant and anaesthetist were not on site.
- We were told by staff the discharge arrangements were made between the consultant and patient. Staff told us the centre did not provide any discharge information to the patient, such as information leaflets, as this was provided by the consultant. The patient was given the direct number of the consultant to call if they had out of hour concerns.
- Following the inspection, the provider told us that discharge arrangements for the patients involved the RMO, medical director and theatre staff together with the consultant surgeon.

Seven-day services

- We were told surgery was not provided at weekends.
- Consultants with practising privileges were responsible for the treatment and care of the patients having surgery. Whilst they did not remain on-site until the patients were discharged home, an RMO remained on-site until all patients had been discharged.
- Out of hours, the registered manager and RMO also provided cover via on-call arrangements.

Access to information

- Access to information was disjointed. Staff did not have access to pre-assessment information and discharge guidance and advice was between the patient and consultant.
- The centre was not involved with arrangements of discharge communicated to the patients GP. This was done between the consultant and patient.
- We were told the patient was the responsibility of the consultant and therefore most information on patients care was between the patient and them. Staff had access to the patients contact details but detailed pre-assessment information was not provided prior to treatment.

- Staff had access to the centres policies and Standard Operating Procedures (SOP) and these were kept in folders within the theatre department. Policies were in date and there was one SOP in the process of being updated.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patient consent was taken on the day of treatment. Forms we viewed showed risks were listed and contained patient signatures. However, one consent form we viewed was illegible. We were unable to tell what treatment had been done.
- Staff were clear about their responsibilities in relation to gaining consent from people although they were unsure of the mental capacity act and how this would be applied in practice.
- Staff had not received training for the mental capacity act.

Are surgery services responsive?

By responsive, we mean that services are organised so that they meet people's needs.

Overall we found there was a responsive service, because:

- The service provided treatment options in response to self-funder or privately insured patients.
- Discharge arrangements were made between the consultant and patient.
- Patient satisfaction was consistently above 95%, although the response rate between January 2016 and August 2016 was 37.82%.
- The centre had received two complaints in the previous year.

Service planning and delivery to meet the needs of local people

- Patients using the service were self-funded or have private medical insurance. No NHS work was provided at the location, and clinical commissioning groups were not involved in planning or agreeing services.

Access and flow

- Patients were booked for treatment via contact between the consultant surgeon's office and the centre. Patients completed a booking form and suitable appointment times were arranged to meet the patient and consultants diary.
- Discharge arrangements, including follow up were made between the patient and consultant. Patients contacted the consultant directly for out of hour's enquiries.
- The centre had no involvement with the patients GP. Communication was made directly from the consultant to the patients GP.
- The centre kept details of patient cancellations. Details we viewed showed since January 2016 there were 16 cancellations. Of those 16 patients, nine were re-booked with the centre. The consultant surgeons made all cancellations, and all alternative arrangements were made between the consultant and patient.
- One consultant surgeon brought their own chaperone nurse during patient treatment. The nurse would stay with the patient throughout their pathway of care from initial post-operative assessment to discharge. As patients could be seen at another location for initial consultation, the nurse chaperoned the patient to provide a consistent communication link between patient and the consultant.

Learning from complaints and concerns

- A Total Quality Management (TQM) patient satisfaction survey was managed internally.
- We viewed the TQM for theatres from January 2016 to August 2016. Patient satisfaction was consistently above 95%.
- The total of patients attended between January 2016 and August were 193. Surveys completed was 73, meaning the response rate was 37.82% with an average satisfaction rating of 98.32%
- Patients were asked questions on their admission, stay at the centre, medical care, consultant surgeon care, nurse's care, and discharge information. Patients were also encouraged to make suggestions for improvement.
- We were told there had been two complaints only in the previous year. Complaints were handled in line with their management of complaints policy. Both complaints had been closed within the month from being communicated to staff. Staff we spoke with told us they would attempt to rectify any complaints with patients as soon as possible to avoided escalation.

Surgery

Are surgery services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Overall, we found some improvements were needed to ensure a well-led service, because:

- The executive team had not recognised their responsibilities for establishing appropriate safeguarding practices.
- There was a lack of direct local leadership within theatre. Team minutes were not documented and specific surgery audits were not undertaken. Staff were not confident to report incidents and raise concerns.

However:

- The governance arrangements were well managed and the structure was clear. Each director had an area to govern.
- Governance meetings were managed well with risks, incidents and key performance indicators (KPI) discussed with actions to take.
- The Quality Assurance team reported directly to governance.
- Systems were in place to ensure staff who had practising privileges had indemnity insurance.
- Each department was responsible for managing and identifying their risks.

Governance, risk management and quality measurement

- The director and medical director headed the governance structure. There was a governance lead, health and safety lead, and quality assurance manager. An external director who was also the legal advisor led the governance committee. This consisted of seven external directors, each leading a service, for example, infection control and medical resuscitation
- We were told by the governance lead, as the service was a small independent hospital the governance committee had two independent chairs, one for resuscitation, and one for infection prevention and control. This provided necessary expertise and reduced conflict of interest. The independent chair sat on each committee, and a lawyer chaired the governance committee. Minutes of governance meeting confirmed an independent chairperson sat in and contributed towards these meetings.
- Staff told us the governance arrangements included an integrated governance team meeting, which took place at monthly intervals. The medical director, business manager and external leads attended this meeting. Departments provided information in the form of key performance indicators (KPI), which were discussed. Minutes from the governance meeting of 25 August 2016 demonstrated KPI's were discussed. Other subjects discussed included the corporate risk register and directorate risk register, incident reporting and compliance dashboard.
- We were told the Medical Advisory Committee (MAC) met quarterly, and had a remit to review clinical practice and clinical incidents.
- A senior managers meeting was held at two week intervals. Their meetings included a review of KPI, with a particular focus on 'red-line' items. Action plans linked to the latter, and were said to be reviewed and checked for their robustness. We saw from the minutes of the meetings held in July 2016 and August 2016, no red line items needed to be discussed.
- Staff told us 'week ahead' meetings had been implemented two months prior to our visit. These meetings provided an opportunity to review any issues from the previous week but to consider activity for the week ahead, any issues, staffing, and the allocation of the resuscitation bleep rota.
- The quality assurance team had a direct reporting line into governance.
- We were told the service had developed a governance dashboard, which had collected all the external reporting information.
- A formalised system was in use to ensure staff working under practising privileges had indemnity insurance. We were shown the database, which held this information. The system enabled identification of expiry dates and alerts to be sent to relevant individuals.
- We viewed the risk policy and saw departmental managers were responsible for identifying risks, which then contributed to the central risk register. We viewed the health and safety meeting minutes of 11 May 2016 and saw a review of risk registers were discussed during the meeting with action points given for each topic discussed. The corporate risk register was also

discussed at the governance committee meetings of July 2016 and August 2016. We did not see evidence of risks being discussed at theatre departmental meetings, as these meetings were not recorded.

Leadership of service

- We were told the provider engaged with the Private Healthcare Information Network (PHIN) so that data could be submitted in accordance with legal requirements regulated by the Competition Markets Authority (CMA). Staff told us the service had met three of the four required elements and the area yet to meet related to the six month follow up.
- Theatre was led by a theatre manager and a deputy. Theatre staff who spoke with us told us they worked well as a team. However, they expressed a lack of confidence with the leadership of theatre. For example, with regard to responding to incidents. Further, they told us they were not confident to discuss concerns with their manager.

Culture within the service

- Staff reported a culture of collaborative working, with staff from other service areas, such as clinical trials providing support or help to the surgical area.
- Theatre staff who spoke with us told us they felt there was a lack of confident leadership within theatres and were unable to express their opinions to senior management.

Innovation, improvement and sustainability

- Staff told us the flatter organisational structure meant it was easier to be innovative and suggest ideas. Business opportunities or other changes were said to be captured in the governance meetings. Staff were also encouraged to suggest ideas to their respective department managers.
- Staff told us the performance evaluations provided the opportunity to undertake projects.
- Theatre staff we spoke with did not feel they had a voice within the company to make improvements as they felt they were not listened to locally.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- Make sure staff are trained to the appropriate safeguarding level and establish a safeguarding system within the centre, which includes mandatory training and an appropriately trained safeguarding lead.
- Update their safeguarding policy to reflect intercollegiate guidelines.
- Devise a system whereby comprehensive patient pre-assessment information can be accessed in patient records.
- The WHO surgical safety checklist needs to be led in a more robust and efficient manner, so it is clear and not disjointed.
- Improve leadership and communication within the theatre department team, so staff are fully engaged and feel confident to report issues and raise concerns.
- Theatre team meetings should be documented with clear agenda and actions.
- Involve and expect all staff regardless of their job role, to report clinical incidents.
- Consider how the theatre staffs knowledge and understanding of the duty of candour can be improved.
- Make sure staff keep the theatre fire exit clear at all times. It should not be blocked with large equipment.
- Consider clearly identifying storage areas within theatre, and where staff need access to the hand washing facilities, this access is not obstructed.
- Monitor staff compliance with regard to single use items of stock