The Cadogan Clinic

Quality Report

120 Sloane Square
London
SW1X 9BW
Tel: 0207 901 8500
Website: www.cadoganclinic.com

Date of inspection visit: 2 October 2020
Date of publication: 08/12/2020

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

Ratings

Overall rating for this location

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

Summary of findings

Letter from the Chief Inspector of Hospitals

The Cadogan Clinic is operated by Personal Health Service Limited. Facilities include three operating theatres, a two-bedded recovery area, consulting rooms and diagnostic facilities.

The hospital provides cosmetic surgery, outpatients and diagnostic imaging. The hospital also provides some services for children and young people including consultation services and minor procedures under local anaesthetic.

We inspected cosmetic surgery using our focussed inspection methodology. We carried out an announced inspection on 02 October 2020. As this was a focused inspection, we did not rate the service.

During this inspection, we focused on the concerns raised at the last inspection, as well as the provider's pre-operative and post-operative processes. We undertook this inspection due to two separate incidents, both of which related to the provider's pre-operative and post-operative processes.

We found the following areas of good practice:

- Standards of cleanliness and hygiene were well maintained. Staff kept equipment and the premises visibly clean.
- The design, maintenance and use of equipment kept people safe.
- Roles and protocols were clear in the event of a patient deteriorating.
- There was a pathway for the psychological screening and assessment of patients, including the referral for further psychological assessment, where needed.
- The service had enough staff with the right qualifications, skills and experience to keep patients safe. The service made sure staff were competent to assess the psychological needs of patients.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patient consent.

However, we also found the following issues that the service provider needs to improve:

- We were not assured that all aspects of The World Health Organisation's Five Steps to Safer Surgery checklist were consistently completed.
- The provider's safeguarding children policy did not reference up-to-date national guidance.
- The provider's MRSA policy had not been fully implemented.
- The assessment of venous thromboembolism was poorly documented.
- We were not assured that service risks were always effectively identified.

Since the inspection, the provider has worked to implement the changes identified within this report. This work continues and will be reviewed when the service is next inspected.

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

Dr Nigel Acheson
Deputy Chief Inspector of Hospitals (London and the South)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery		Cosmetic surgery was the main activity of the hospital. As this was a focused inspection, we did not rate the service.

Summary of findings

Contents

The Cadogan Clinic

Services we looked at:
Surgery

Summary of this inspection

Background to The Cadogan Clinic

The Cadogan Clinic is operated by Personal Health Service Limited. The hospital opened in 2008. It is a private hospital in Chelsea, London. The hospital primarily serves the communities of London, but accepts patient referrals from outside this area.

The main service provided by the hospital is cosmetic surgery. The hospital also offers cosmetic procedures such as dermal fillers and laser hair removal. These services are not within our scope of regulation and therefore were not inspected as part of this inspection.

The current registered manager has been in post since 2016.

Our inspection team

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

Information about The Cadogan Clinic

The hospital is registered to provide the following regulated activities:

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

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

We last inspected The Cadogan Clinic in December 2016. At that time, CQC regulated cosmetic surgery services but did not have the legal duty to rate them, therefore The Cadogan Clinic did not receive a rating. At our last inspection, we highlighted good practice and issues that the service needed to improve. We also took regulatory action. At our last inspection, we found the following breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

Regulation 12 (safe care and treatment) - care and treatment was not provided in a safe way for service users because;

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

Regulation 17 (good governance) - systems and processes were not established and operated effectively because;

1. A large number of policies referenced out of date guidance and consequently did not reflect current requirements.
2. The consent policy did not reflect current legislation for consent of children under 16 years old.
3. The medical screening questionnaire did not reflect the MRSA guidance.
4. There was extremely low compliance with the WHO safety checklist and the '5 steps to safer surgery' were not embedded.
5. The clinic stated that Association for Perioperative Practice (AfPP) guidance was followed to determine theatre staffing however records showed that this regularly fell below this guidance.

Summary of this inspection

Regulation 18 (staffing) - there were not sufficient numbers of suitably qualified, competent skilled and experienced persons deployed because;

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

Following our inspection in December 2016, the provider sent CQC an action plan which detailed how they were going to meet each regulation they had breached.

During this inspection, we visited the hospital's three theatres and the recovery area. We spoke with nine members of staff including registered nurses, medical staff, operating department practitioners, and senior managers. We spoke with one patient. We reviewed five sets of patient records.

Activity

- From September 2019 to August 2020, the hospital undertook 807 general anaesthetic and sedation cases. The three most common procedures were liposuction (169), rhinoplasty (108) and breast augmentation (106).
- From September 2019 to August 2020, the hospital reported 15,867 outpatient attendances.

As of September 2020, 61 plastic surgeons, 58 anaesthetists, 10 dermatologists, two vascular surgeons and two podiatrists worked at the hospital under practising privileges. The Cadogan Clinic employed seven registered nurses, two operating department practitioners and three health care assistants, as well as 28 administrative and clerical staff members. The accountable officer for controlled drugs was the registered manager.

Services provided at the hospital under service level agreement:

- Emergency and critical care transfers
- Oxygen and medical gases
- Cleaning services
- Sterilisation services
- Laundry
- Maintenance of medical equipment
- General pathology
- Histopathology
- Confidential waste
- Clinical waste
- IT services
- Fire equipment
- Intruder alarm
- Cryotherapy
- Medical courier

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

This inspection focused on specific areas of safety including safeguarding, infection control, equipment, staffing levels and assessing and responding to patient risk. We did not rate the safe domain. We found the following areas of good practice:

- Standards of cleanliness and hygiene were well maintained. Staff kept equipment and the premises visibly clean.
- The design, maintenance and use of equipment kept people safe.
- Roles and protocols were clear in the event of a patient deteriorating.
- There was a pathway for the psychological screening and assessment of patients, including the referral for further psychological assessment, where needed.
- The service had enough staff with the right qualifications, skills and experience to keep patients safe.

However, we also found:

- We were not assured that all aspects of The World Health Organisation's Five Steps to Safer Surgery checklist were consistently completed.
- The provider's safeguarding children policy did not reference up-to-date national guidance.
- The provider's MRSA policy had not been fully implemented.
- The assessment of venous thromboembolism was poorly documented.

Are services effective?

This inspection focused on specific areas of effectiveness, specifically competent staff and consent. We did not rate the effective domain. We found:

- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patient consent.
- The service made sure staff were competent to assess the psychological needs of patients.

Are services caring?

On this inspection we did not inspect the caring domain.

Are services responsive?

On this inspection we did not inspect the responsive domain.

Summary of this inspection

Are services well-led?

This inspection focused on specific areas of leadership, specifically managing risks, issues and performance. We did not rate the well-led domain. We found:

- Although there were processes for managing performance and risks, we were not assured that service risks were always effectively identified.

Surgery

Safe	
Effective	
Well-led	

Are surgery services safe?

Safeguarding

The provider's safeguarding children policy did not reference up-to-date national guidance.

The hospital had two safeguarding policies, one for safeguarding vulnerable adults and another for safeguarding children. At our last inspection in December 2016, we found the provider had not referenced up-to-date guidance in either policy. During this inspection, we found that despite being reviewed in 2018, the safeguarding children policy still did not reference two key guidance documents - the intercollegiate document 'Safeguarding children and young people: roles and competences for healthcare staff' published by the Royal College of Paediatrics and Child Health in 2014, and the government document 'Working together to safeguard Children' which was last updated in 2018. It was also unclear from the document which member of staff had reviewed the most recent version of the policy as the 'approve by' section had not been completed.

Following an incident, the provider had updated their policy for the treatment of patients under the age of 18. Within the policy, surgeons were instructed to request proof of age for any patient 'whose appearance indicated they may be 21 years old or under'. This change in policy reduced the risk of staff unknowingly operating on a patient under the age of 18. Any procedure on a patient under 18 years old was subject to a full assessment of the risks and benefits, including the health and psychosocial consequences, as well as support from the patient's parents, GP and/or psychologist.

Cleanliness, infection control and hygiene

Standards of cleanliness and hygiene were well maintained. Staff kept equipment and the premises visibly clean. However, the provider's MRSA policy had not been fully implemented.

All areas visited were visibly clean and tidy. Signed cleaning schedules were in place and staff cleaned the departments daily.

Personal protective equipment (PPE), such as gloves and aprons, were accessible for staff in all clinical areas. Wearing PPE reduces the risk of cross-infection when providing care. We saw staff using PPE appropriately. PPE was also used by all non-clinical staff, in order to reduce the risk of transmitting Covid-19.

Hand sanitiser points were widely available to encourage good hand hygiene practice, and we saw staff washing their hands before and after contact with patients. This was in line with National Institute for Health and Care Excellence (NICE) Quality Standard 61, which states that staff should decontaminate their hands immediately before and after every episode of direct care.

At our last inspection in December 2016, we reviewed the provider's policy for Methicillin-resistant Staphylococcus aureus (MRSA), a common healthcare-associated infection. The policy stated that, through the pre-operative questionnaire, all patients would be asked three questions in order to identify patients at risk of MRSA. However, when we reviewed the provider's pre-operative questionnaire, we found that the questionnaire only contained one of the three questions. It was therefore unclear how patients at risk of MRSA would be consistently identified and tested.

During this inspection, we reviewed the provider's most recent MRSA policy (dated August 2018) and five sets of patient records. We found the provider had still not fully implemented its MRSA policy; the pre-operative questionnaire contained two of the three questions listed in the policy. We raised our concerns with the registered manager who told us the additional question would be added to the pre-operative questionnaire the next working day. However, as this action was taken following our inspection, we were unable to assess staff compliance with this change.

Environment and equipment

Surgery

The design, maintenance and use of equipment kept people safe.

At our last inspection in December 2016, the hospital had only one capnography machine in the recovery area, which was broken. A capnography machine is used to monitor the amount of carbon dioxide (CO2) in a patient's exhaled air. During this inspection, we found the hospital had upgraded their monitoring equipment and now had two machines that monitored capnography. We tested both machines and found them to be in working order.

Assessing and responding to patient risk

Roles and protocols were clear in the event of a patient deteriorating. There was a pathway for the psychological screening and assessment of patients, including the referral for further psychological assessment, where needed. However, the assessment of venous thromboembolism was poorly documented. We were also not assured that all aspects of The World Health Organisation's Five Steps to Safer Surgery checklist were consistently completed.

The World Health Organisation's (WHO) Five Steps to Safer Surgery is a surgical safety checklist, made up of five steps: briefing, sign-in, timeout, sign-out and debriefing. The checklist is designed to be completed for all surgical procedures, in order to reduce the risk of patient complication and mortality. As part of this inspection, we observed four surgical procedures.

For general anaesthetic procedures, compliance with the WHO's surgical safety checklist had improved since our last inspection. Staff told us they were completing a briefing, sign-in, timeout and sign-out consistently and the audits we reviewed confirmed this. However, we found staff were still not completing the checklist's fifth step, the staff debrief. From speaking with staff, it was unclear why the fifth step of the checklist was not completed. It was also not included as part of the theatre's quarterly WHO audit. The fifth step of the checklist provides staff the opportunity to discuss what went well and what they could improve on.

For local anaesthetic procedures, such as skin biopsies, we found staff were not completing the WHO's surgical safety checklist nor a modified version of the checklist. Again, when speaking with staff, it was not clear why staff did not complete this. By not completing the WHO's surgical safety checklist for minor procedures, the service was putting patient safety at risk. We raised our concerns with the registered manager during the inspection. Following the inspection, the registered manager told us that they had developed a modified version of the WHO's surgical safety checklist for local anaesthetic procedures. They also told us that, for general anaesthetic procedures, they had added the fifth step to the digital checklist record and to the audit document. However, as this action took place following our inspection, we were unable to assess staff compliance with these new processes.

The hospital had an admission policy, setting out the agreed criteria for the selection and admission of patients. This ensured patients were only accepted for treatment if the hospital could safely meet their needs. Prior to admission, patients were required to complete a pre-operative medical questionnaire. The questionnaire was then reviewed by an ambulatory nurse and an anaesthetist, and any concerns that required further investigation flagged to the surgeon and theatre manager.

Patients were also psychologically screened and assessed for their suitability for surgery in two stages. The first stage required all patients to complete a pre-operative psychological screening questionnaire, designed to assess unrealistic expectations, inappropriate motivations for surgery, underlying psychological disorders and any other wider risk factors (such as psychological vulnerability). The second stage involved an in-consultation assessment of the patient by the surgeon. All surgeons were required to provide evidence of their assessment and document this in their consultation notes, and make a referral to a clinical psychologist when necessary. We were told by the registered manager that, since July 2020, the medical director checked every patient record to ensure the patient's psychological history had been documented. This two-stage process was clearly set out in the provider's patient psychological screening and assessment policy and complied with national guidance from the General Medical Council and the Royal College of Surgeons of England.

At our last inspection in December 2016, we found all patients received a venous thromboembolism (VTE) risk assessment prior to surgery. This complied with guidance published by the National Institute for Health and Care Excellence (NICE) which states that all surgical patients should have their risk of VTE and bleeding assessed using a national tool, as soon as possible after admission.

However, since our last inspection, the provider had changed their VTE assessment processes, against NICE guidance, and no longer completed a risk assessment for each patient. Instead, all patients undergoing local anaesthetic were required to wear thromboembolism-deterrent (TED) stockings during both their procedure and post-operative recovery, and all patients undergoing general anaesthetic were required to wear a boot designed to prevent deep vein thrombosis. Again, this was during both their procedure and post-operative recovery. For some patients deemed at-risk of VTE, they received anticoagulant medicines prior to their procedure. Although we were told that the decision to give patients anticoagulant medicines was made by the anaesthetist, this decision was not documented in the patient's record. It was therefore unclear in the records how the anaesthetist came to the decision of administering anticoagulant medicines. We raised our findings with the registered manager who told us VTE risk assessments would be re-added to the day case procedure pack the next working day.

Staff used the national early warning score (NEWS) to assess patient deterioration and escalated appropriately. The NEWS is a tool, used by staff, to quickly determine the degree of patient illness, based upon key vital signs and patient observation.

At our last inspection in December 2016, we found that roles were unclear in the event of a cardiac arrest. During this inspection, we found that the process had improved. Roles were now delegated in the event of a cardiac arrest and staff told us they completed regular scenario training. Two staff were delegated each day to ensure there was always somebody available to respond in an emergency. The provider had protocols for the transfer of a patient in the event of complications from surgery or deterioration. The hospital had service level agreements in place with a number of private ambulance providers, as well as a service level agreement with a local private hospital with critical care facilities.

Nursing and support staffing

The service had enough staff with the right qualifications, skills and experience to keep patients safe.

Since our last inspection, staffing levels had improved. Theatre staffing now complied with the Association for Perioperative Practice (AfPP) guidelines, with each theatre staffed by at least two scrub practitioners, one circulating practitioner and an operating department practitioner. In the recovery area, staffing had also improved. Following an operation, two staff would remain in the recovery area with the patient, until the patient could maintain their own airway. This now complied with guidelines published by the Association of Anaesthetists of Great Britain and Ireland.

Are surgery services effective?

Competent staff

The service made sure staff were competent to assess the psychological needs of patients.

Practising privileges is a system which independent organisations use to allow a person to practice in their service. Consultants worked at the hospital under practising privileges and, as a result, were not required to complete the hospital's training programme. Instead, consultants were required to provide annual evidence to the hospital's medical advisory committee that they had completed ongoing training, appraisals and competencies at their main place of work.

As part of our inspection, we asked the provider for evidence that their consultant surgeons had received adequate training in assessing psychological needs. The registered manager confirmed that all surgeons completed psychological training as part of their consultant training. This was completed at the consultant's main place of work.

In addition, in March 2020, some of the provider's medical staff, including the medical director and the surgical director, attended a psychology training course, ran by the British Association of Aesthetic Plastic Surgeons. For those consultants who could not attend the course, the provider circulated the training presentation slides and held a virtual session to discuss the contents of the course.

Consent

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patient consent.

Staff made sure patients consented to treatment based on all the information available. We were told by staff that the surgeon carrying out the cosmetic surgery was responsible

for explaining the expected outcomes and the risks prior to surgery. The patient records we reviewed supported this. Prior to admission, patients also received an information pack, designed to prepare patients for their day case procedure. The information pack included information on various factors that can affect their surgery outcome including preoperative fasting and flying.

Staff clearly recorded consent in patient records. We reviewed five patient records and found consent was clearly documented in each record, with each consent form signed by both the patient and the operating surgeon. We also saw patients had signed a Covid-19 consent form. The provider had introduced Covid-19 consent forms in order to record that patients understood the additional risks of having surgery during the pandemic. We observed theatre staff confirming patient consent to procedures and confirming the patient's details before surgery was carried out.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. The hospital's consent policy referenced a two-week cooling off period between the patient's consultation and surgery, in line with the Royal College of Surgeons' Professional Standards for Cosmetic Surgery national standards. The consent policy also stated that in exceptional circumstances, the cooling off period may be waived, for example if a patient was in pain and required urgent surgery.

Are surgery services well-led?

Managing risks, issues and performance

Although there were processes for managing performance and risks, we were not assured that service risks were always effectively identified.

The provider had two risk registers, one for corporate risks and one for clinical risks. Each risk was given a rating, based on the potential consequence of the risk and the likelihood that the risk would happen. Risks were also given a responsible individual and an action plan, in order to mitigate the risk. Risks included the supply chain of certain medicines and procuring high quality personal protective equipment for staff. Risks were reviewed at the provider's monthly board meeting, demonstrating active management of risks.

However, we were not assured that risks to the service were always effectively identified and managed. Some concerns we identified during our inspection, for example those related to The World Health Organisation's Five Steps to Safer Surgery checklist, had not been identified by the service as risks. This meant there were no mitigations in place to reduce the risk.

There was a programme of clinical audit across the service, which meant senior staff could monitor compliance with safety standards. Where audits had been carried out, there was evidence that service leads had used the results to implement improvements and changes to the service. For example, following an infection prevention and control audit, we saw actions had been identified and acted upon.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure all aspects of The World Health Organisation's Five Steps to Safer Surgery checklist are consistently completed.
- The provider must ensure safeguarding policies are regularly reviewed and reference up-to-date national guidance.

Action the provider SHOULD take to improve

- The provider should ensure the assessment of venous thromboembolism is clearly documented in the patient's notes.
- The provider should ensure its MRSA policy is fully implemented.
- The provider should ensure service risks are effectively identified and documented on the risk register.

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	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment