Signature Medical Limited

Signature Clinic - Central London

Inspection report

Unit 11
73 St Charles Square
London
W10 6EJ
Tel:

Date of inspection visit: August 15 2023
Date of publication: 21/12/2023

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Good
Are services responsive to people's needs?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Overall summary

This was the first time we rated this service. We rated it as inadequate because:

- Over the last 12 months the service did not have enough suitably qualified staff to care for patients and keep them safe.
- There was poor adherence to infection prevention controls.
- The service did not manage medicines well and we were not assured that staff were following the services policies when administering medicines to patients.
- The service did not keep good patient records, all hand-written notes in patient care records that were reviewed were illegible.
- We saw a lack of clinical incidents and we could not be assured how well clinical incidents were recorded. We were not assured that lessons could be learnt from them.
- Managers did not monitor the effectiveness of the service or made sure staff were competent. Staff did not have access to key information. Pain relief was offered to patients when they needed it, however medications were often handed out by unqualified staff. Staff did not advise patients on how to lead healthier lives.
- Negative feedback was discouraged, and patients were ill-informed about the complaints procedure.
- Leaders did not support staff to develop their skills.
- Staff did not understand the service's vision and values, or how to apply them in their work.
- Governance processes were not robust, and we found incomplete key lines of communication between the senior leadership team and junior staff. There was a lack of formal recording in meeting minutes to cascade information. Not all risks identified on the inspection were known to the provider.
- The service did not engage well with patients or staff to plan and manage services.

However:

- For the majority of patients staff treated them with compassion and kindness. They provided emotional support to patients, families and carers, whilst they were at the clinic. The aftercare team supported patients well post operatively.
- Staff worked well together for the benefit of patients.
- Staff felt respected, supported and valued by members of senior leadership team.
- The service provided refreshments for patient and friends and family.
- After-care was available seven days a week.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Inadequate 	This was the first time we rated this service. We rated it as inadequate because: • Over the last 12 months the service did not have enough suitably qualified staff to care for patients and keep them safe. • Safeguarding knowledge was limited and was not understood by all staff, the policy and training was not up to date. • There was poor adherence to infection prevention controls. • The service did not manage medicines well and we were not assured that staff were following the services policies when administering medicines to patients. • The service did not keep good patient records, all hand-written notes in patient care records that were reviewed were illegible. • We saw a lack of clinical incidents and we could not be assured how well clinical incidents were recorded. We were not assured that lessons could be learnt from them. • Managers did not monitor the effectiveness of the service or made sure staff were competent. Staff did not have access to key information. Pain relief was offered to patients when they needed it, however medications were often handed out by unqualified staff. Staff did not advise patients on how to lead healthier lives. • Negative feedback was discouraged, and patients were ill-informed about the complaints procedure. • Leaders did not support staff to develop their skills. • Staff did not understand the service's vision and values, or how to apply them in their work. • Governance processes were not robust, and we found incomplete key lines of communication between the senior leadership team and junior staff. There was a lack of formal recording in meeting minutes to cascade information. Not all risks identified on the inspection were known to the provider.

Summary of findings

- The service did not engage well with patients or staff to plan and manage services.

However:

- For the majority of patients staff treated them with compassion and kindness. They provided emotional support to patients, families and carers, whilst they were at the clinic. The aftercare team supported patients well post operatively.
- Staff worked well together for the benefit of patients.
- Staff felt respected, supported and valued by members of senior leadership team.
- The service provided refreshments for patient and friends and family.
- After-care was available seven days a week.

Summary of findings

Contents

Summary of this inspection

Background to Signature Clinic - Central London

Signature Clinic – Central London is operated by Signature Medical Limited. The service offers a range of cosmetic surgery treatments for adults over 18 years old. The service provided a range of other cosmetic procedures that are out of scope for regulation.

The main service provided by this hospital was cosmetic surgery, the provider is registered for the regulated activities: Surgical procedures and Treatment of Disease, Disorder, or Injury.

100% of patients were self-paying patients.

The cosmetic surgery services are provided from the clinic location in West London, London. The provider had two theatres available. The service provided day case surgeries and did not have facilities for overnight stays.

There was a total of 1744 procedures carried out between August 2022 and July 2023. The top three procedures were upper blepharoplasty, lower blepharoplasty and gynaecology surgeries.

Following the inspection, we served the provider a Warning Notice under Section 29 of the Health and Social Care Act 2008. The Warning Notice told the provider they were in breach of Regulations 12 Safe Care and Treatment and Regulations 17 Good Governance and gave the provider a timescale to make improvements to achieve compliance. The principles we use when rating providers requires CQC to reflect enforcement actions in our ratings. The warning notice identified concerns in the safe and well-led domains. This means that the warning notice we served had limited the rating for safe and well-led to inadequate. The provider was also served with two requirement notices, details of these notices can be found at the end of this report.

How we carried out this inspection

We carried out an unannounced inspection of the service on 15 August 2023. We inspected this service using our comprehensive inspection methodology, which was carried out after receiving information of concern.

The inspection was carried out by 2 CQC hospital inspectors, and a specialist advisor. We visited the service and looked at all the facilities on site including four consultant rooms and two theatres. During the inspection we spoke with 8 patients and approximately 10 members of staff including the registered manager. We reviewed 7 patient records.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

Summary of this inspection

- The provider must have systems in place to assess the risk of infection and to prevent, detect and control the spread of infection (Regulation 12(2)(h)).
- The service must ensure that decontamination procedures are complete, and staff are fully trained to complete the decontamination processes and understand the importance of each step. (Regulation 12(2)(e))
- The service must ensure patient records are robust accurate and complete. Including ensuring that handwritten notes are legible and ensuring medical staff print their name in the appropriate place. (Regulation 12(1)(2)(a)(b)).
- The service must ensure proper and safe management of medicines. Patient specific directions and prescriptions for medicines must be clearly documented in the patient's records. Medicines dispensed for patient's to take away must be appropriately labelled, prepared and handed out by appropriately trained and competent staff. (Regulation 12(2)(g)).
- The service must ensure that complaints processes must be accessible to patients and operate effective systems for responding to complaints and proportional action must be taken in response to any failure identified. (Regulation 16 (1)(2)).
- The service must ensure security systems are in place to prevent unauthorised access to theatres. (Regulation 17(2)(b)).
- The provider must ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed in the service and that they receive appropriate support, training, professional development, supervision and training as necessary to enable them to carry out the duties they are employed to perform and be enabled where appropriate to obtain further qualifications appropriate to the work they perform. (Regulation 17(1))
- The service must have systems in place to protect confidential patient data. (Regulation 17(2)(c)).
- The service must implement robust governance process to be able to monitor the quality of their work, make improvements and drive changes. (Regulation 17(2)(a)).
- The service must ensure all patients have a two-week cooling off period before surgery. Any amendments made to the treatment plan on the day of the surgery is not in line with the two-week cooling off period. (Regulation 11(1)).
- The service must ensure that information and guidance on how to make a complaint is available and accessible to all patients. (Regulation 16(1)(2)).

Action the service SHOULD take to improve:

- The service should ensure full medical histories should be undertaken by a medical professional to ascertain suitability for surgery or any contraindications. (Regulation 12).
- The service should ensure that all staff are knowledgeable in all aspects of safeguarding. (Regulation 13).
- The service should ensure that only authorised personnel are able to gain access to theatres. (Regulation 17)
- The service should ensure that they are compliant with Health Building Note 00/10. (Regulation 12).
- The service should ensure that policies are aligned to the ways of working and embed them into practice. (Regulation 17).
- The service should ensure that the camera used to take before and after pictures of surgical areas was left overnight at reception. The photos did not have any identifiable information of the patient, but photos were of patients faces and bodies. (Regulation 17).
- The service should ensure that they send communication to patients GP when patient have consented for the clinic to do so. (Regulation 12).
- The service should ensure that all patients have access to a professional interpreter. (Regulation 12).
- The service should consider providing information to promote healthy lifestyles.
- The service should ensure that all medical staff have been signed off as competent and have completed their competency check list. (Regulation 17).

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Inadequate	Inadequate	Good	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Good	Inadequate	Inadequate	Inadequate

Inadequate

Surgery

Safe	Inadequate
Effective	Inadequate
Caring	Good
Responsive	Inadequate
Well-led	Inadequate

Is the service safe?

Inadequate

This was the first time we rated this service. We rated it as inadequate.

Mandatory training

The service provided mandatory training in key skills to all staff, but local managers did not have oversight of staff training records.

Staff received their mandatory training. The Human Resources (HR) manager was responsible for staff training.

The mandatory training included some face-to-face training such as basic life support and safeguarding training. Online training modules included infection control, challenging behaviour, manual handling, health and safety, food safety, resuscitation, and data protection act, control of substances hazardous to health, sharps awareness.

Mandatory training was overseen by the Head of Operations. 98.75% of training had been completed by Health Care Assistants (HCAs) and 91.04% of training had been completed by medical staff. The service set a training compliance of 95%.

The service did not have facilities for staff to complete their mandatory training at the location but relied on staff having access to their own facilities to complete their training at home. The one computer in the service was in the reception and used for checking patients in. Staff told us that training was completed outside of their working hours and staff would usually complete this training at home. Staff were compensated for the time spent at home working.

Safeguarding

Not all staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse but not all staff understood what was meant by safeguarding.

The training for safeguarding was face to face and included scenario-based training that gave examples of abuse. The clinic manager was not aware of female genital mutilation (FGM) but was aware of modern slavery as a form of abuse from the training scenarios. The safeguarding policy did not make reference to FGM or modern slavery. The provider submitted a standalone FGM policy dated 01 May 2023 after the inspection.

Inadequate

Surgery

HCA staff received training for adults and child safeguarding level two. Managers received training for adult and child safeguarding level three. The service had access to a safeguarding lead outside the provider that had received level four training safeguarding in adults and children.

We were not assured that the all staff at the service knew who the safeguarding lead was. Staff we spoke with thought the Director of Clinical Services was the lead, but the policy listed the Registered Manager (RM) as the lead. On the day of the inspection the Director of Clinical Services was knowledgeable and could give recent examples of safeguarding cases that they had delt with it, in another organisation in which they also worked.

Not all staff understood what was meant by the term safeguarding. Despite having a clear safeguarding flowchart in the staff kitchen, we were not assured that all staff knew how to identify adults and children at risk of, or suffering, significant harm and how to work with other agencies to protect them.

The service only treated patients above the age of 18, patients date of birth was recorded upon their initial consultation.

Cleanliness, infection control and hygiene

The service did not control infection risk well. The service used systems to identify and prevent surgical site infections. Staff used personnel protective equipment. Not all staff used control measures to protect patients, themselves, and others from infection. They did not keep the equipment and the premises visibly clean.

Dust was observed in high and low areas in the theatres.

The service did not have suitable furnishings that could be kept clean and well-maintained. We observed a wooden bed where patients could rest post operatively before going home. Best practice is to have the bedframe in a suitable material that can be fully disinfected between patients. We saw this bed being used twice during our inspection activity. Post inspection a newly appointed infection prevention and control nurse risked assessed the bed and found it to be impervious, break free and able to be cleaned between patients.

We were not provided with evidence that staff cleaned equipment after patient contact. There was no indication of when a piece of equipment was last cleaned. We observed bed linen left on the bed once a patient had vacated the room, this was reported to the Director of Clinical Services and to the Head of Operations. We checked the bed linen before we left the premises and noted that it still had not been changed. We could not be assured that the bed linen was routinely changed between patients.

There was a lack of hand towel dispensers near multiple sinks, including in the decontamination room and kitchen sink. This was rectified in one of the unused clinic rooms, where patients were not seen, when this was raised. Transmission of bacteria is more likely to occur from wet skin than from dry skin, the proper drying of hands after washing should be an essential component of hand hygiene procedures.

The service used a combination of single use instruments and instruments that required to be sterilised.

We found the service to be non-compliant with HTM 01-01 Management of Decontamination of Surgical Instruments as there was no magnifying glass available to check the integrity of the instruments once decontaminated.

In the decontamination room we found one washer disinfector was out of action. Senior staff we spoke with were aware of this and had plans in place to replace this piece of equipment, but we were not provided with supporting evidence for this. Following the inspection, the provider informed us that the equipment has been replaced, although they did not send evidence of this. The decontamination room was very hot and required improved ventilation.

We questioned staff on the importance of PPE in the decontamination room but staff were unable to show an understanding of the risks associated with the splashing of contaminated water. We could not be assured that the decontamination process was effective due to the lack of training and also due to the lack of incomplete equipment to complete the full process.

The service did not currently have an Infection Prevention Control (IPC) nurse at the service. They told, us they were looking to hire one for the month of September 2023, but provided no supporting evidence of this. We were notified after the inspection that an IPC nurse commenced employment at the service 30 August 2023. Cleaning notes were handwritten and transferred onto an electronic form. There was no current cleaning schedule, but this was in the process of being developed and we were provided with limited supporting evidence for this.

We looked at infection prevention control audits. We saw that there were no specific items to check, and staff had limited space to indicate actions taken. The IPC audit consisted of a tick box exercise where staff would tick a box indicating if generic items listed was incomplete, partially complete, or complete. Staff told us that they were informed via mobile messaging when the next audit was due for completion, this was often monthly.

We observed the cupboard used to store Control of Substances Hazardous to Health items was not always locked.

We observed a 22 litre sharps bin fully compliant with Health Technical Memoranda 07-01 in theatre one. However, the service did not have a pharmacy bin to dispose of pharmaceutical waste safely.

Staff had access to enough personal protective equipment (PPE).

We observed compliant sinks and requisites in line with Health Building Note 00-09. There were eight sinks in total at the service and each tap was run every morning in compliance with Health Technical Memoranda 04-01 safe water in healthcare.

Staff worked effectively to prevent, identify and treat surgical site infections. There were 20 surgical site infections in the reporting period of August 2022 and July 2023 out of 1744 surgeries. This amounts to an annual infection rate of 1.4%. The service had not reported any cases of Methicillin- resistant Staphylococcus aureus (MRSA), Clostridium difficile (C.Diff) or Escherichia coli (E. Coli).

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not keep people safe.

The design of the environment allowed patients to gain unauthorised access to theatre one. Staff would direct patients to the back of the clinic behind a close door to use the washroom facilities. Patients were unescorted and had easy access to the unlocked theatres.

The service was non-compliant with parts of Health Building Note 00/10. We observed gaps in the flooring in the theatres and in the clinic room which meant that sufficient cleaning could not be achieved in these areas.

Inadequate

Surgery

The service had an asset inventory for all equipment to keep track of service dates. We saw that all equipment had their last service in June 2023.

Most of the equipment observed at the service had in date electrical test certificates. However, we found one piece of equipment that had an out-of-date electrical test certificate that had expired in May 2023. This was a stack-adapter used in theatre. This piece of equipment was not included in the asset inventory list.

We looked at the resuscitation trolley and saw the Automated External Defibrillator (AED) was due for a weekly check in line with national guidelines. The last check documented was for 26 July 2023 which meant that we could not be assured that checks were consistent. We were informed that there had been no patients present at service due to staff training the week after the 26 July 2023. However, when we arrived on site on 15 August the AED had still not been checked. Items we looked at the on the resuscitation trolley were found to be in date.

Patient call bells were not available inside patient toilets.

We observed orange waste bins fully compliant with Health Technical Memoranda 07-01, Safe management and disposal of healthcare waste.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient to remove or minimise risk. The service had recently introduced a policy for patients at risk of deterioration. The service made sure patients knew who to contact to discuss complications or concerns.

Staff used a nationally recognised tool to identify deteriorating patients and escalate them appropriately. We observed staff using the National Early Warning Scores 2 (NEWS2) to assess for deteriorating patients. We observed vital signs of the patients were recorded pre and post operatively in patient records.

Staff knew about and dealt with any specific risk issues. Patients had a Venous Thromboembolism (VTE) risk assessment, a water-low risk assessment which calculated the risk of pressure ulcers developing and a pregnancy status documented in their records. Patients were also fitted with Thrombo-Embolic Deterrent stockings prior to their procedure if their surgery was scheduled for over an hour. These stockings were similar to compression stockings to help reduce potential swelling in the feet and ankles.

Patients with poor mental health were required to have clearance from their GP before proceeding with their cosmetic procedure. Patients were also screened for body dysmorphia by their surgeons.

The service had a patient selection criteria policy. The policy was detailed and listed medical conditions a patient could have and methods of supporting the patient's conditions during surgery. The patient selection criteria policy listed conditions that were not suitable for cosmetic surgery at this clinic.

All medical staff were trained in basic life support in line with the Academy of Medical Royal Colleges when minimal sedation was being given. Staff had access to a fully compliant defibrillator and an automated external defibrillator.

We looked at the resuscitation policy which made reference to an on-call service when the clinic was closed. We were notified on the day of the inspection that there was a limited on-call service available. The policy was reviewed in May 2023 but did not reflect the current ways of working at the service.

Inadequate

Surgery

Patient records recorded social history including smoking status, alcohol consumption, anxiety, depression, herbal medication, recreational drug misuse and pregnancy status. If was down to the surgeon's discretion whether to go ahead with the procedure if there were any concerns regarding the social history of the patient.

We were not assured that a full medical history was taken for every patient. We looked at patient records that documented no medical history, however we saw one patient was taking medication for high blood pressure and another patient taking medication for low thyroid disease. The medication names had been documented but not the medical condition of the patient. The section for medical history was left blank or incomplete.

We witnessed staff checking and confirming a patient's name and address before going in for their procedure. Discrepancies in addresses could be amended straight away.

Before surgery the patient's details were recorded on a white board with the patient's known allergies. The surgeon confirmed known allergy status with their patient and with the staff.

Highly infectious diseases were not screened for, known diseases were discussed during the initial consultation. The registered manager (RM) told us that if patients had a known infectious disease patients were often seen first on the surgical list or last. Extra time was allocated to allow for a deep clean post operatively.

We observed surgery and saw medical staff following the World Health Organisation (WHO) Surgical Safety Checklist. We also observed good practice and adherence to the count and check process.

We observed regular swab, suture and blade counts in theatre by a health care assistant, which was then updated to the white board.

We observed staff moving around the decontamination room correctly from the dirty to the clean side to minimise risk of contamination.

Staff knew to call 999 in case of an emergency. The service had developed a recognition of deteriorating patient and transfer policy in response to the CQC inspection carried out in their Manchester branch. This policy had been implemented in August 2023.

All procedures were carried out under local anaesthesia at the service. The service was required to have an assistant with appropriate training to monitor patients for signs and symptoms of toxicity in line with Association of Anaesthetists of Great Britain for liposuction procedures. We were informed that agency scrub nurses were used in the month of August and before then the service had only hired HCA staff. There was a total of 110 liposuctions carried out in the reporting period of August 2022 and July 2023 with insufficient qualified staffing numbers.

Control of Substances Hazardous to Health (COSHH) cupboard in the decontamination room was found to be locked.

Nurse staffing

The service relied on agency staff to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and gave agency staff an induction.

Inadequate

Surgery

The service did not have enough qualified nursing and support staff to keep patients safe at all times. The service employed 10 HCAs and from August 2023 used two regular agency nurses. The service was looking at recruiting two full time scrub nurses in September 2023 and had already completed the human resources processes to hire these two staff members.

The service built their staff rota around scheduled surgeries. Managers relied on the use of agency staff and requested staff familiar with the service. The service had not employed a registered nurse and was therefore required to use agency staff to ensure they had the correct skill mix within theatres.

One agency nurse we spoke with had 12 years of experience as a scrub nurse. The service did not use bank staff.

Managers informed us that agency nurses were inducted into the service for half a day.

We observed that HCA staff were being used as scrub nurses as their names were listed on a staff notice board as scrub nurses, for the month of August. We also saw HCA staff listed as scrub nurses on patient records. The service did not currently employee scrub nurses and we did not see efficient HCA competencies.

Staff told us that in case of sick leave surgery would have to be rescheduled but this was rare as the service was always able to request agency staff.

The service had a staff turnover rate of 14% in the reporting period between August 2022 and July 2023.

The service had a sickness rate of less than 1%.

There was currently one vacancy position for a scrub nurse but the service was hiring two scrub nurses to account for annual leave and sick leave.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service employed four surgeons and one surgeon was under practicing privileges, two of these surgeons were on the GMC Specialists register for plastic surgery.

Medical staff were required to complete a comprehensive induction document as part of their practicing privileges which was required to be completed on or before their first day. We did not see evidence of any completed checklists.

The service held revalidation dates, indemnity insurance, insurance expiration, general medical council pins, general dental council pins, surgical logbooks, practicing privileges, medical degrees, designated body, and latest appraisal certificates for each surgeon. Medical staff had their appraisals conducted yearly by an external company and practicing privileges were reviewed annually. During the inspection we were shown evidence of these checks for three employed surgeons.

The providers website listed in detail the qualifications, skills, and experience of each surgeon.

Inadequate

Surgery

Records

Staff kept records of patients' care and treatment, but records were not clear, stored securely or easily available to all staff providing care.

Patient records were a hybrid of physical paper notes and electronic patient records. Paper notes were scanned in the patients' files and destroyed appropriately. We were not assured that patient records were stored securely. We observed electronic patient records could be accessed without a password prompt on the RM laptop, the password had been automatically automated and could therefore be accessed by anyone who had access to the laptop.

Initial consultations were completed electronically by the aftercare team based in Glasgow on the patient record system. We reviewed patient records and found documentation on surgical and non-surgical treatments discussed, examples of risks, results and aftercare.

We were informed that the surgeon did not have access to the consultation notes when reviewing the patient face to face. We saw that in some cases these notes contained information such as excessive bleeding during a previous medical procedure. The RM told us that the surgeon would look at the notes at the start of the day, we could not be assured that this was the most effective way to minimise risks for each patient, as some surgeons saw up to 12 patients a day.

Handwritten medical notes from the procedure, by the medical team were mostly illegible. We reviewed a sample of patient records with the RM who struggled to read the information recorded and could not interpretate the writing. We saw post operative advice was documented on patients notes. Specific risks of the procedure were pre-populated, additional handwritten notes underneath were not legible.

Sections of the patient records that required the surgeon to print their name was left blank and incomplete.

Patient photos were taken on a camera and uploaded to their electronic medical record. We saw that the camera used to take photos was left at reception and staff confirmed that the camera was left out overnight and not locked away. We were informed post inspection that the camera was password protected. We raised this as a concern with the provider and the registered manager confirmed that the camera would be locked away overnight moving forward.

Medicines

The service did not fully use systems and processes to safely prescribe, administer, record and store medicines.

As the service did not have a Home Office Controlled Drugs license, consultants self-supplied controlled drugs, which were stored in their lockers. This was in line with good practice. Medicines included Diazepam 5mg, Diazepam 10mg, Codeine, and Aspirin.

We spoke to a surgeon about a controlled drug in their possession that was an emergency medicine. They explained they were unsure why they had it and that medicines were purchased through the services.

Patients were offered medicines if they were anxious. We were concerned that the doses that were offered did not reflect the doses that were recommended in the British National Formulary (Conscious sedation for procedures and in conjunction with local anaesthesia).

Whilst the patient's records contained details of dispensed medicines including the name, strength and dose. It was not clear who had prescribed these medicines for the patient.

Inadequate

Surgery

We reviewed the medicine management policy which stated that non-clinical and administrative staff were not allowed to handle medicines. A patient told us on the day of the inspection that they were given antibiotics, a cream and direction of use by one of the HCA's. Three further patients we spoke to, confirmed they had also received their medicines from an HCA. The service's own policy stated that the medicines should only be administered and supplied by a registered health care professional such as the Nursing and midwifery council, General medical council or the Health and care professions council. There was no evidence provided that HCA staff had completed any appropriate training to administer or supply medication to patients.

The medicine management policy stated that medication should have the patient's name and the date of the supply. The policy stated that medications should also have the British National Formulary (BNF) cautionary labels. We saw that prescription only medications had prelabelled doses. We were told by the clinic manager that no other information was written on the label.

We found in the medicine management policy that the surgeon should hold the medicine key. We observed on the day that the keys were being held by an agency member of staff. This meant that there was no clear oversight or management of the medications held on site. Following the inspection, the provider informed us the policy had been updated, however no evidence had been provided.

We looked a partially complete training logbook for an HCA staff member. We found that HCAs were preparing aftercare bags for each surgery ensuring all bags contained antibiotics and gauze. Surgeons were expected to sign off and approve medications. But the responsibility to make sure the patient had the appropriate aftercare bag with medications was down to the HCA.

Therefore, we were provided with numerous evidence that the provider failed to follow their own policy as well as national medication guidelines.

We looked at the medical documentation audit which was a tick box exercise. There was no space for notes or actions taken and there were no identifiers to indicate what had been checked.

The service had automated temperature alerts to ensure optimum ranges of temperatures were set for the clinic. When the temperature was above the optimum range the air conditioning unit was automatically switched on.

There was a service level agreement in place with a third party for medical waste.

We were not provided with evidence of patient group directions for staff supplying medicines to patients.

Incidents

We did not see documented patient safety incidents. We did not see any recorded incidents of when things went wrong requiring a duty of candour.

We were not assured that all staff could raise concerns and report incidents and near misses in line with the service's policy. Some staff knew what incidents to report and how to report them. Other staff we spoke to were unsure of what the incident process was or how to report it. The service had a duty of candour policy that staff were aware of. Training on the duty of candour was delivered one week before the inspection.

Some staff could recall a recent serious incident regarding hazardous waste and how it was resolved. The Director of Clinical Services could not recall the last incident recorded however, they had only been in the role for two weeks.

Inadequate

Surgery

Incidents were captured on paper forms. There were four incidents reported in the reporting period between August 2022 and July 2023. Incidents were not labelled by severity. But actions taken were recorded for each incident. None of the incidents involved a patient and all incidents were non-clinical, and business related.

Surgical Site Infection (SSI) rates were monitored monthly and per surgeon. We saw in the month of April, May and June 2023 the service reported 1%, 3% and 1% respectively of SSI. This was inline and better than the national average of between 2% - 4%. SSI were not reported as incidents.

There were no never events reported in the last 12 months.

Is the service effective?

Inadequate

This was the first time we rated this service. We rated it as inadequate.

Evidence-based care and treatment

The service provided care and treatment which was not always based on national guidance and evidence-based practice. Policies and procedures were not readily available for staff.

The service had a range of polices related to different clinical activities. The policies that we reviewed had been complied by the registered manager. However, we saw that policies did not always reference how the care provided was according to the best practice and national guidance. For example, the safeguarding policy failed to include information on FGM despite providing female genitalia surgery, nor did the policy make reference to the services' FGM policy. The service had not used relevant legislation to underpin training or competence in providing care as set out in the Adult Safeguarding: Roles and Competencies for Health Care Staff, Fist edition: August 2018, Intercollegiate Document.

We were told that medical staff were signed up to receive updates to national guidelines from agencies such as The National Institute for Health and Care Excellence (NICE) and Medicines and Healthcare products Regulatory Agency (MHRA). However, we were not assured that the service updated their policies regularly to reflect appropriate guidance.

Drug alerts were sent to the clinic managers but only those that were relevant to the service. We asked the clinic manager about The National Institute for Health and Care Excellence (NICE) guidelines but they were not aware of these guidelines.

If changes in guidance was applicable to the service it was disseminated via email to the clinic manager. We were not assured that updates were received in a timely manner due to the clinical manger having limited access to their work email as there was only one computer at the service. We asked the director of clinical services about the contingences in place if the clinic manager was out of office, they responded that they would delegate this responsibility to whoever was indicated on the out of office email. All other employed staff members were HCAs. We were not assured that information could be effectively relayed in this way and was not assured that the responsibility should fall upon an HCA. We were not assured that updates in clinical practices would be reflected in written policies and procedures.

There were no notice boards in the service to display changes in guidance or methods to inform staff that changes had been made. Following the inspection, the provider informed us that a governance newsletter was now sent to staff to give them updates.

Inadequate

Surgery

Policies were available electronically, but access to a computer was limited so we were not assured that staff could access all the information they required in a timely manner.

We were not assured that staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance, as we observed practice that did not follow the providers own policies.

There was currently no audit schedule in place.

Nutrition and hydration

Patients were not required to be nil by mouth before a localised anaesthesia.

The service carried out procedures using local anaesthesia and patients were not required to be nil by mouth before their procedures. The waiting area provided patients with hot and cold beverages and also biscuits. Patients were told to avoid coffee pre and post operatively.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.

Pain scores were measured on a scale of 1-10. We saw in patient notes that pain was only recorded on discharge. Some patients we spoke with had experienced very little pain post operatively.

Staff did not receive training on assessing pain.

Surgeons would prescribe paracetamol, diazepam or co-codamol post-surgery to help manage pain. One patient we spoke with said that they were not supplied with enough medication for their pain. In this case the patient was required to buy off the counter medication to help manage their pain.

Patients were sent home with a care pack containing their medication and other medical consumables to help manage their pain. Some patients we spoke with were required to top up their pain relief medication from a chemist.

Patient outcomes

Staff did not monitor the effectiveness of care and treatment.

Patients received a follow up phone call by the after-care team based in Glasgow, one day after their surgery, again at seven days post-surgery and then after one month. Any concerns raised by patients through the after-care team were reported to the registered manager. We were told that If patients required revision surgery they were seen at their initial clinic.

Due to the number of the concerns that were raised with CQC, we were not assured that the service was managing expectations as best as they could. We were also not assured that surgeons were being made accountable for patient outcomes. There were 20 surgical revisions reported from June 2022 to July 2023. This revision rate was estimated at 1.1%.

Surgical site infections were managed by the team based in Glasgow.

No other performance data was collected.

Inadequate

Surgery

Competent staff

The service did not always make sure that staff were competent for their roles. Managers held supervision meetings with staff to provide support and development.

Employed nursing staff were not qualified or had the right skills and knowledge to meet the needs of patients.

The clinic manager provided training to HCA staff and signed off a log book to demonstrate competencies. These competencies included taking the patient's blood pressure, pulse, temperature, oxygen saturation, drain removal, stich removal and wound dressing. The clinic manager was not medically trained and had limited clinical based knowledge and skills, and therefore did not have the correct qualifications or skills to assess these competencies. We were told after the inspection that the Clinic manager had underwent training with the Medical Director to be able to sign of HCA medical competencies however, we were not shown any evidence of this.

The Head of Operations was responsible for all staff and had oversight of staff training records, appraisals and staff credentials.

HCA staff were fully vetted before employment. Employment checks were thorough and included an up-to-date curriculum vitae's, compliance forms, confidentiality agreements, two references, three identification checks, health declaration forms, vaccination histories, and occupational health certificates. The service recorded Disclosure and Barring Service (DBS) membership numbers, disclosure number, date of issue, expiry dates and convictions. For staff that required a visa to work, additional checks included, police clearance, passport, right to work, current address and four previous addresses. During the inspection we were shown evidence of these checks for three staff members.

We were told by the Head of Operations that the clinic manager supported staff to develop through monthly, constructive appraisals. Staff were up to date with their monthly appraisals and staff told us that they had enjoyed this conversation with the clinic manager. However, we were told by the clinic manager that they did not have access to staff appraisals or staff records. Therefore, we were unassured that the staff appraisal processes were effective and if staff were confusing the appraisal process with their one-to-one meeting.

Senior managers did not always identify any staff training needs and did not give them the time and opportunity to develop their skills and knowledge. Managers did not always make sure staff received any specialist training for their role. The HCA staff in charge of the decontamination process did not have training in the decontamination process nor had they been on a course to educate the importance of each decontamination step. Staff we spoke with confirmed that they had not completed any competencies to assess their competence in decontamination. The registered manager told us that staff competencies and decontamination courses would be arranged for the two staff in the decontamination room. After the inspection we were told that the clinic manager had undergone the appropriate training and had trained the HCA staff in the decontamination process. However, the evidence produced post inspection was limited. We were sent an invoice quotation from the training provider addressed to a location in Manchester and we did not see any training certificates.

The reception desk was manned by an HCA who had training in administrative roles and theatre support.

Staff did have the opportunity to discuss training needs with their local line manager and were supported to develop their skills and knowledge. We looked at completed one-to-one meeting form and saw staff had requested additional support in the turnover processes involving pre and post operative aftercare.

Inadequate

Surgery

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

The whole surgical team worked well to ensure that the patient was relaxed and comfortable throughout their procedure.

We observed good non-verbal and verbal communication between all staff in theatre.

There were current multidisciplinary team meetings that were regular, recorded, and had a set agenda in the form of clinical governance meetings.

Patient records contained contact details of their GPs and patients were required to consent for information to be shared with their GP. The registered manager informed us that the service did not routinely send letters to patients GPs even when the patient had consented for the clinic to do so.

Seven-day services

Patients could contact the service seven days a week for advice and support after their surgery.

The service was opened Monday to Friday from 7am until 7pm or until the last patient exits the building. The first patient of the day was called in from 9am. We were told that weekend procedures were available and was provided with the surgery list for the month of August which showed procedures being carried out on both a Saturday and a Sunday. We saw procedures were booked in from 8am till 8pm on the weekend. The aftercare team was available for patients from 8am to 7pm, 7 days a week.

Health promotion

Staff did not give patients practical support and advice to lead healthier lives.

The service did not have relevant information promoting healthy lifestyles and support at the clinic. Staff did not document practical support and advice for patients to lead healthier lives in patient records.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not always support patients to make informed decisions about their care and treatment. They did not follow national guidance to ensure that patients gave consent and adhere to the 14 day cooling off period.

On the day of the inspection we observed staff reassuring patients but not applying pressure to go ahead with surgery. We observed the surgeon explaining the full risks of the surgery before allowing the patient to sign the consent form. The consent explanation took 20 minutes and was very thorough. A patient we spoke with on the day of the inspection stated that risks were well explained to them. However, this was in contrast to the information we received when we spoke to patients who had contacted the CQC. We were told that the consent process was rushed and that there was a lot of forms to sign and that this was often unexplained.

We looked at a blank consent form and saw that patients were required to consent for photographs to be taken before and after their surgery. There was also a separate consent for patients to consent for their images to be used as marketing purposes. In the five patient records reviewed off site we saw all records had completed consent forms. Specific risks of the procedures were listed and were prepopulated, additional risks were hand written. Six patients we spoke with post inspection told us that they had received a copy of their consent form. Two patients we spoke to were unsure if they had received a copy of their consent form.

Inadequate

Surgery

Staff did not always gain consent from patients for their care and treatment in line with legislation and guidance. Staff did not make sure patients consented to treatment based on all the information available. We were not assured that all patients were given a two-week cooling off period as the surgeon had told two CQC inspectors that treatment plans could be adapted on the day of the procedure. This included removing parts of the surgery already consented to and adding on parts to the surgery with ill formed consent. We reviewed the consent policy and observed no reference to the two-week cooling off period as recommended by the Professional Standards for Cosmetic Surgery and the General Medical Council. The service had a mandatory seven day cooling off period. The service did not undertake consent audits.

Training for consent was recently added to the list of mandatory training modules.

Is the service caring?

Good

This was the first time we rated caring. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients we spoke with on the day of inspection said staff treated them well and with kindness.

We observed staff putting patients at ease before their procedures and actively try to meet their needs where possible to support them.

Patients we spoke to spoke highly of the care received by all staff. Patients praised the aftercare team and the level of support that they had provided.

Even when surgeries had not gone as planned surgeons and staff were described as caring, lovely and kind.

Emotional support

Staff provided emotional support to some patients, families and carers to minimise their distress.

Patients were allowed to request music of their choice to be played during their procedure to help relax them. We observed patients thoroughly enjoying the music. We observed the surgeon communicating with the patient throughout the procedure to ensure that the patient was reassured and relaxed as can be.

We spoke to a friend of a patient waiting for their friend in surgery, they were kept well informed of delays and was regularly updated on their status.

Staff did not give all patients and those close to them help, emotional support and advice when they needed it. Patients who had left a negative review on a review website did not receive support from the service.

Inadequate

Surgery

Understanding and involvement of patients and those close to them

Staff supported some patients, families and carers to understand their surgery and make decisions about their care and treatment.

Upon speaking to patients, we found mixed reviews about the service. Some patients were extremely happy with their results and had recommended close friends and families to use the service. Whereas other patients were very unhappy with their results and struggled to find support.

Some patients reported that their surgery and the level of pain experienced was underestimated. Patients reported that surgeries were much more painful than anticipated.

Some patients thought that the service had sold them the idea of perfection, when in actual fact a revision surgery was required to achieve the look, they had wanted.

The service did not take into account individual needs of patients and their preferences on how they would like to be treated. Two patients we spoke to felt like they were on a conveyor belt and was rushed in and out of the service. However, one patient we spoke with felt more than happy to be in and out very quickly and appreciated how quick the procedure was.

On the day of the inspection, we observed communications between the surgeon and the patient and noted that the surgeon was very informative and allowed time for questions. We spoke to a patient on 15 August 2023 who stated that staff were really lovely and made them feel at ease. On initial consultation patients were asked to share pictures and describe their symptoms.

On the day of the inspection patients told us that there was a month gap between their online consultation and their surgery date. They describe the communication as positive and that the service was upfront about costs and were given accurate quotes.

The service did not currently collate patient satisfaction surveys. The service gathered feedback through online reviews and through the aftercare team. The aftercare team collected feedback at numerous times post operatively and this was shared with the corresponding surgeon.

Patients we spoke with told us that the clinic was upfront about the costs of treatment and prices were clearly displayed on their website.

The surgeon had rejected and refused to perform surgery on patients when they thought the patient would not benefit.

Patients living with dementia were not seen at this service and the service did not require dementia training or a dementia champion.

The service did not have any facilities to support patients living with mental health.

Inadequate

Surgery

Is the service responsive?

Inadequate

This was the first time we rated this service. We rated it as inadequate.

Meeting people's individual needs

The service was able to facilitate some individual needs and preferences of patients. Staff made reasonable adjustments to help patients access services. There was a system for referring patients for psychological assessment before starting treatment, if necessary.

The service had two theatres and 24 patients could have a procedure each working day.

The service did not offer an overnight stay and all cases were booked in as day case surgeries.

The service had easy access for patients who require the use of a wheelchair. There was a ramp and large entrance to the side of the building and there was a large wheelchair friendly washroom facility on the ground floor. Patients who had mobility issues had easy access to theatre one on the ground floor.

The service was limited in carrying out surgery for patients that were medically obese due to the lack of equipment available to help transfer patients onto the surgical couch. Patients requiring surgery required to be mobile and be able to self-transfer onto the surgical couch. The surgical couch had an upper weight limited of 200kg. We reviewed the services patient selection criteria policy that stated that patients would not be suitable for surgery if they had a Body Mass Index (BMI) over 40. The policy did not reflect a patients mobility for any surgery provided by the clinic.

Psychiatrist services were not available at the service however patients were referred back to their GP if their consultant thought that this was necessary.

Staff at the service was multilinguistic speaking several languages between them including the surgeon. Staff told us that when there was a language barrier, they would ask the patient to bring somebody in to translate for them. NHS England guidance stipulates that a professional interpreter should always be offered, rather than using family or friends to interpretate. The service did not have a service level agreement with a translation company.

The service was unable to meet the communication requirements for someone using British Sign Language.

Patient information leaflets were in English, and we did not see any leaflets in any other languages. When we asked the manager why patient information was only in English, they said that they have never been asked for patient information in another language.

We observed a patient with diabetes being asked about their glucose level on the day of the surgery.

Patients and family and friends had unlimited access to hot and cold beverages in the waiting room as well as light snacks.

Inadequate

Surgery

Patients were given the number of the aftercare team and was told to contact them regarding any concerns post operatively. Patients were asked to provide photographic evidence if there were any medical concerns, and these were passed onto a doctor for review in the headquarters in Glasgow. The after-care team was available for patients from 8am to 11pm, 7 days a week. Patients were advised to go to their local accident and emergency department if they experienced any concerns after 11pm. There was currently no 24/7 on call services provided by consultants.

One patient we spoke with was offered revision surgery with the same surgeon. Even though they described their surgeon as kind they preferred not to go ahead with the revision surgery due to the lack of face to face after care with their surgeon post operatively. The provider told us post inspection that patients were able to choose how their post operative review took place either in person or by video call. Revision surgeries were offered free of charge.

Access and flow

People could access the service when they needed it.

Patients had online consultations with a surgeon and met the surgeon performing their surgery on the day of their surgery. Most patients stated that they did not have a continuity of care with their surgeon.

Appointment times were booked for longer than required and with gaps in between appointments to allow for a time to catch up or for the surgeon to take a break.

Managers and staff worked to make sure patients did not stay longer than they needed to. Patients said that any delays on the day of their surgery was communicated well to them. We spoke to a patient's friend who had been waiting in the reception who had been well informed of their friends delay in theatres.

Patients were called in 30 minutes before their appointment time. Staff at the reception desk was able to call headquarters in Glasgow to enquire about patients who did not attend their appointments. These patients were then asked if they wanted to reschedule or cancel their appointment. If a patient arrived 30 minutes late of their appointment time more often these patients would not be able to have their surgery that day and they would be rebooked in at another time.

When patients cancelled their surgery was a three to four week wait until surgery could be rescheduled. The waiting time was still the same if the clinic cancelled the surgery. There was currently an 8-12 week waiting list for new patients.

Patients were called by the aftercare team one day post procedure, and again on day seven. Several other follow up appointments were booked in throughout the first year post operatively with the patient.

Patients we spoke with had mixed reviews about their after care. Some patients reported receiving thorough advice of what was required whilst other patients felt that their concerns were not being listen too.

The service did not record did not attend (DNA) rates and said that this was a rarity as patients paid for their procedure before the day of surgery.

Learning from complaints and concerns

The complaints policy and procedure were not accessible to patients. The service did not have a system for referring unresolved complaints for independent review. Patients we spoke with felt that they were encouraged to leave positive reviews about the service on an external website and told us that they were threatened with legal action if they left negative comments and reviews.

Inadequate

Surgery

The service did not display information on how to raise a concern or complaint in patient areas or on their website. We requested the complaints policy post inspection, we observed that the policy was written, with the intended reader to be the patient. We were not sure how patients would be able to view this policy. The service did not allow for patients to make anonymous complaints. Patients we spoke with did not know how to make a complaint if they wanted to, were not aware of the complaint processes or of the complaints policy.

The Director of Clinical Services told us that all complaints were escalated to the aftercare team in Glasgow, there was no mention of medical input by surgeons. This was in contrary with the complaints policy that stated that a medical practitioner would look at the complaint, passed on to either the surgeon who completed the surgery or the registered manager. Following the inspection, the provider told us: The after-care team manage the administrative process associated with complaints. Members of the team, including the surgeon were asked to provide written statements, this process was facilitated by an administrator under the direction of the Medical Director

The registered manager was able to give examples of learning from complaints, changes made including planning gaps between surgeries to allow time to catch up on appointment times. The service also improved communications with patients and notified them of on the day delays to surgeries. The service was not signed up with an independent third party to review if patients were dissatisfied with the outcome of their complaint.

Patients were invited to leave reviews on the internet through a Quick Response (QR) code to provide feedback on an external, independent review internet website. The registered manager told us that the service received positive reviews that included having a small team with friendly staff. Negative reviews were also received and had themes around delays in treatment and patients being unhappy with their results.

CQC received four enquiries regarding the complaints, concerns and the feedback process. One patient informed us that when they had raised a concern with the provider they were contacted by the provider's solicitor and told that they would be sued for harassment if they attempted to contact Signature Clinic again. Two patients informed CQC that after leaving a negative review on the internet the providers solicitors had also been in touch with them and they were being sued for defamation. One patient wrote into the CQC to inform us that they were unhappy with their procedure but were too frightened to inform the service, as they were afraid of legal action against them.

Patients told us that they felt there was a lack of investigations carried out due to their feedback and we were shown evidence that that surgeons viewed feedback as a direct criticism of their work and not as constructive feedback. Patients we spoke with had spoken to other patients with similar reviews and procedures as theirs and reported being unhappy with their results. These surgeries included eyelid surgery known as blepharoplasty, face lifts and female intimate surgeries We were not assured that people leaving negative feedback were signposted to the service's complaints procedure so their concerns could be considered.

The RM told us that once a patient had left a negative review on the internet, they were contacted by the service's solicitors to remove parts of the review that seemed defamatory against the service. In some cases, patients were asked to avoid all communication with the service once they had left a review. If patients refused to take down their review the service enlisted their solicitor to start legal proceedings against them. Limited medical support was offered to the patient once a negative review was posted.

Is the service well-led?

Inadequate

Surgery

Inadequate

This was the first time we rated this service. We rated it as inadequate.

Leadership

Some leaders did not have the support and abilities to run the service. Leaders did not understand or manage the priorities and issues the service faced. They were not always visible, but they were approachable for patients and staff. They did not support staff to develop their skills for senior.

There was a registered manager and a clinic manager locally at the service.

The registered manager was a former GP and was the medical director and chair of Signature Medical Limited. The company's senior leadership structure also included a chief operating officer, chief medical officer and a marketing and sales director that reported to the chief executive officer. The finance director, the head of legal and the operations director reported to the medical director. Their time was split across the various locations throughout the United Kingdom and together the senior leadership team had oversight across all the different locations.

Each clinic manager could contact one another and the RM thorough a mobile messaging group.

The service did not have a contingency in place for when the clinic manager was not available. The clinic manager was newly appointed to the London clinic and was a manager in training. We were not assured that the clinic manager had the right support to be able to fulfil their role and their responsibilities. This was due to the limited presence of the senior leadership team. We were not assured that the clinic manager was appropriately trained to assess compliance in patient safety related clinical competencies. There was of a lack of support for the clinic manager and no assurance of effective training for their role was provided. Post inspection we were told that the clinic manager had received one to one training with the medical director to enable them to sign of competencies but we were not provided with the supporting evidence of this training.

We were told by senior staff that the clinic manager was in charge of completing staff appraisals, however they did not have access to staff appraisals, staff training records, or staff records. Staff appraisals we saw resembled monthly one-to-ones. Post inspection we were informed that the clinic manager conducted monthly one-to-ones and the Human Resources (HR) manager managed the annual appraisals.

Staff we spoke with spoke highly of working at the service and of their managers. Staff were complimentary of the clinic manager and told us that they had built a good professional relationship their manager.

Vision and Strategy

The service had a vision for what it wanted to achieve but it did not have a strategy to turn it into action, The vision and strategy were focused on how the company was portrayed whilst at the same time offering 'treatments in a fuss free manner that provided excellent value for money'.

Staff told us that they were not aware of the company's vision, mission or values. We did not see this displayed in the clinic or on the providers website. Post inspection the service told us that all staff had received a formal induction which included a session related to the companies mission, vision, and values.

Inadequate

Surgery

Both the Registered Manager and the Director of Clinical Services told us two different visions and for Signature Clinic.

We looked at a document called strategy which highlighted the vision mission and values and also the corporate structure. The document was incomplete and was missing the business strategy and the operational strategy.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, but did not provide opportunities for career development. The service did not have an open culture where patients and their families could raise concerns without fear.

Staff we spoke with on the day of the inspection stated that they enjoyed working at the service and found their clinic manager very supportive. Staff spoke highly of their peers and expressed a fondness of one another.

Staff were provided with diversity and equality training. We did not see career development plans in place for staff or opportunities to progress and learn.

The service had a whistle blower policy implemented at the beginning of 2022. We reviewed the whistleblowing policy and saw the RM was the whistleblowing officer. We received one whistle-blower enquiry in the reporting period between August 2022 and July 2023.

Two patients who had got in touch with the CQC informed us that they were scared to speak up as they were scared of getting sued.

Governance

Leaders did not operate effective governance processes. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet. There was limited evidence that staff discussed and learnt from the performance of the service.

The clinic manager had implemented a daily huddle a few days before the inspection and was not following an agenda for this cascade of information. However, the clinic manager did do a morning and afternoon debrief for all staff with a set agenda that included discussing the days surgical lists. This was not recorded.

We reviewed monthly management meeting minutes with the director, operations director and the chief medical officer. There was a set agenda of items to discuss and each location was discussed independently.

Governance meetings had a set agenda and were attended by the chief executive officer (CEO) director of clinical services and the registered manager. The meeting was not minuted or shared with other senior staff of the organisation.

There was no evidence of local team meetings relaying useful and important information to staff. We were shown a template of a structured team meeting with an agenda that the service was hoping to use in the future.

We reviewed policies on site and post inspection, these policies included the resuscitation policy, the complaints policy and the medicine management policy. We found evidence that the medicine management policy was not being followed on the day of the inspection. Even though policies reflected some national guidelines and some best practices we could not be assured that all policies were read, understood and were embedded in practice.

Inadequate

Surgery

There were not enough useful audits conducted to ensure the effectiveness of the service, quality of care or patient outcomes. We were not assured that results of the audits that were conducted were actioned in a timely manner and how the information collected in the audit was valuable to the service. Audits we looked at were incomplete and did not capture information of use. There were no action plans or areas of improvement identified from any audit.

There were unclear chains of command if the clinic manager was not present. There were no suitably qualified staff members employed by the service to cover the clinic managers daily duties and there were not enough suitably qualified staff in a theatre.

We found some confusion regarding the appraisal processes for HCA staff. We were shown evidence of the appraisal process during our inspection and were told that they took place every month. We were then sent a one-to-one form post inspection which mirrored what we were shown on inspection as the appraisal process. Appraisals are often an annual process, and we could not be assured that the provider was conducting them correctly.

Management of risk, issues and performance

Leaders and teams did not have access to systems to manage performance effectively. Identified risks had not been actioned to reduce their impact. There were no plans in place to cope with unexpected events.

We were not assured that risk management was a high priority. Senior staff were not aware of what was on the risk register for Signature Clinic Central London.

The provider had a corporate risk register and a local risk register. We looked at the local risk registered which covered all the locations in the UK including Glasgow and Wales. A control had been put in to minimise the risk, but mitigations were not in place. There was one other risk on the risk register for the London clinic which had been closed. The register indicated the owner of each risk and had time scales for completion and monitoring.

The theatre doors remained unlocked during procedures and the public were able to gain access to the theatres and the equipment at all times.

On the day of the inspection, we saw the back door to the service left opened and unattended. The door to the COSHH room had been left open at the same time and there was a risk that unauthorised personnel could access the products in the COSHH room or walk into the theatre.

We observed patients being told to go to the back of the clinic, behind a door, to use the washroom facilities. Patients were not escorted to the washroom and had easy access to theatre one, the decontamination room and the stairs leading up to the second theatre and the kitchen. We reported this to staff on the day of the inspection and they suggested that patients should be escorted to the toilets. Senior staff were not aware of this security risk nor had it been documented on their risk register.

We looked at audits and found incomplete audit cycles. It was not evident from audits that action had been taken to address issues found. We looked at the current infection prevention control audit which was a tick box exercise. The audits did not list specific items to check and was generic to the service. The audit was simple and there was limited room for comments or for actions taken. When risks had been identified there had been no oversight of actions, update of records or who was responsible. In one audit a light was reported to not work properly, in this particular audit there was space to document issues to resolve but the broken light was not documented. We asked staff if this had now been fixed, escalated or reported to more senior staff. Staff we spoke to were unsure.

Inadequate

Surgery

There was a lack of record keeping or logs for tasks that needed action. We were unsure how immediate risks would be rectified and escalated and how urgent tasks would be prioritised.

Surgeons had access to patient notes and medical records, not all records viewed were complete which meant that patient risks could not be identified, or actions put in place to reduce harm to the patient.

We were sent a fire risk assessment that had made recommendations for an annual review. The last assessment was conducted in February 2022, and a further risk assessment had not been carried out. The review highlighted nine areas of high concern where there was a likely risk of fire occurring and moderate risk of harm to occupants. There were 23 areas of concern with medium risk, five areas with low concerns and two advisory areas of concern. The risk rating was high overall. There were sections of the report that required a signature once risks had been mitigated but this was incomplete. There was also a check list to populate once actions had been completed but this was also incomplete. Some actions required immediate attention one to three months after the report.

Information Management

The service did not collected data. The information systems were integrated but were not secure.

All staff had access to one computer situated at the front desk. There was also a laptop available for use. All staff shared a log in for that one computer which meant that there was a lack of traceability of what information was looked at, removed, altered or added and by who. This included for computer usage and searches. This was raised on the day of the inspection. We also found that electronic patient records could be easily accessed on the registered managers laptop as the electronic record system was automatically signed in and the password was automated. We raised this with the registered manager and we were told that they had just been accessing a file seconds before we had looked at the laptop. We were not assured that patients data was being appropriately protected at all times.

Engagement

Leaders and staff did not actively and openly engage with patients and other staff.

There were no staff surveys conducted to engage with staff. The head of operations based in Glasgow told us that they regularly spoke with staff face to face at the London clinic. We were told that if issues were raised they were resolved with the clinic manager. We were told that there had been no issues to feedback on but we were unsure of the line of communication this would have followed.

Staff newsletters were sent out once a month.

The service had a Freedom To Speak Up Guardian (FTSUG) who is a named individual staff can gain support from when they raise concerns. Training had been arranged on 7 August 2023 for the staff at the clinic.

The service did not have a mechanism in place where patients could leave anonymous feedback.

There was a lack of facilities and opportunities to engage with staff at the service. There were no staff notice boards, limited access to emails and senior staff moved between various locations withing the UK. We were informed post inspection that there was a monthly newsletter sent out to all staff and that a governance newsletter had been initiated in September 2023.

The website advertised a range of procedures available at signature clinic but did not break this down by location, so it was unclear for patients which locations provided which surgeries.

Inadequate

Surgery

Learning, continuous improvement and innovation

New patient record systems and incident reporting systems were being introduced to the service in the near future.

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 11 HSCA (RA) Regulations 2014 Need for consent The provider did not ensure: • Documentation on consent forms were legible. • Patients were given adequate time to reflect the changes made to their surgical procedure.

Regulated activity	Regulation
Surgical procedures	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The provider did not: • Take appropriate action to failure identified by a complaint.

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 Treatment of disease, disorder or injury	S29 Warning Notice 1. The Care Quality Commission conducted an inspection at the location stated in this notice on 15 August 2023 and found you had failed to ensure care and treatment was provided in a safe way for service users. 1.1 You failed to assess the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated. The bed we saw in use for post-operative patients was made of wood, which cannot be sufficiently disinfected after use. This did not comply with Health Building Note 00-09 infection control in the built environment that states that finishes should be impervious, smooth and seamless as far as practicable to facilitate cleanliness and cleaning. Around mid-morning we saw a patient being escorted to the post operative room for rest post-surgery. We went to look at the post operative room once the patient had vacated the room and saw the bed had crumpled sheets. We raised this with the clinical services manager and the head of operations who assured us that staff would rectify this. We went back to the post operative room two hours later after further procedures had taken place and saw the bed still had the same crumpled sheets. Surgical lists were still incomplete for the day. We were not assured that bed linen was changed between patients. The service did not use labels or any other methods to indicate when equipment was last cleaned. 1.2 You failed to reduce transmission of bacteria from wet skin. There were no paper hand towels for sufficient drying of hands in multiple areas including the kitchen and decontamination room. Drying of the hands after washing should be an integral part of the hand hygiene process in health care. 1.3 You failed to ensure end to end processes were complete for the decontamination of surgical instruments. We observed staff completing the decontamination

Enforcement actions

process and saw that staff did not have the correct equipment available to complete the entire process as there was no magnifying glass to check the integrity of equipment once it had gone through the decontamination process.

1.4 You failed to ensure that medicines were handed out to patients by appropriately trained staff. 'Aftercare' bags were prepared per patient according to their surgery. We looked at the training logbook for a health care assistant (HCA) which stated that HCAs were responsible for preparing these 'aftercare' bags, which always included antibiotics and gauze. The logbook also showed that HCAs were responsible for making sure patients were given the correct aftercare bag for their surgery. This meant that HCAs were taking antibiotics from a cupboard and giving this medication to patients in their aftercare bags without clinical supervision or written prescription. Three patients we spoke with confirmed that their medication was given to them by an HCA. We looked at training records which showed that health care assistants had not completed the relevant training to hand out medicines, and this did not comply with the providers own policies.

1.5 You failed to ensure that patient records contained accurate records of prescribed medicines. We looked at seven patient records and saw no specific written instructions by a doctor for medicines (including co-amoxiclav and chloramphenicol) 'to take away' These 'take away' medicines were recorded by staff on a 'used medicines' form. This did not comply with the service's own medicine management policy.

1.6 You failed to ensure medicines were labelled correctly before being given to patients. We saw that the medicine management policy stated that medicine should have the patient's name and the date of the supply. The policy stated that medicines should also have the British National Formulary (BNF) cautionary labels. We saw that prescription only medicines had pre-labelled doses. We were told by the clinic manager that no other information was written on the label.

1.7 You failed to provide internal security measures within the building for staff and service users. We saw that patients were not escorted to the toilet, which is located along a corridor behind a closed door off the reception. Once the patient is past this door the patient is able to

This section is primarily information for the provider

Enforcement actions

access restricted areas such as the theatres, the kitchen, and the decontamination room, which presented a potential security risk and safety risk to both patients and staff.

2. The Care Quality Commission conducted an inspection at the location on 15 August 2023 and found that you failed to operate effective systems and processes to assess, monitor and improve the quality and safety of the service.

2.1 You did not identify or escalate relevant risks and issues or identify actions to reduce their impact. We saw service risk registers which did not identify risks we saw during the inspection. These included risks of unauthorised access to theatres and risks identified in the fire risk assessment report from February 2022.

2.2 You failed to ensure appropriate measures were in place to protect confidential patient data and images. We were told by HCA staff and senior members of staff that the sole computer at the reception desk had one log-in identity, which was used by all staff members. This meant that there was no audit of what information was looked at, removed, altered or added and by whom. We saw the digital camera used to take 'before and after' photos of patients on the table in the reception and staff told us that it was routinely left out overnight. This presented a risk of access to and sharing of photographs of patients.

2.3 You failed to ensure good quality patient record keeping. We saw doctors handwriting in patient records was mostly illegible. We reviewed 2 patient records during the inspection with the registered manager who found it difficult to read the handwritten notes. We requested an additional 5 patient records at random to look at after our site visit and found illegible handwritten notes in all 5 records. This was not detected by the medical record audit.

2.4 The service failed to implement effective audits to monitor the service provided. We asked for evidence of audits for assessing, monitoring and improving the quality and safety of the service. The audits we were given as evidence were a cleaning audit, a medical record audit, a monthly quality inspection audit and a fire safety audit.

This section is primarily information for the provider

Enforcement actions

These comprised only of checklists and there was no evidence that areas for improvement were identified. Audits carried out at the service were limited; for example, we were not shown consent audits or WHO audits.

2.5 We saw the fire risk assessment which identified several improvements that were required, along with recommendations for an annual review. The last assessment was conducted 1 February 2022, and a further risk assessment had not been arranged. The review highlighted nine areas of high concern where there was a likely risk of fire occurring and moderate risk of harm to occupants. There were 23 areas of concern with medium risk, five areas with low concerns and two advisory areas of concern. The risk rating was high overall. There were sections of the report that required a signature once risks had been mitigated but this was incomplete. There was also a check list to populate once actions had been completed but this was also incomplete. Some actions required immediate attention one to three months after the report. The service was unable to provide evidence of action taken to make the improvements, so patients were exposed to risk and remained at harm.

2.6 There were unclear methods of communication for cascading information. We asked for records of staff meetings, but the director of clinical services and the registered manager told us these had only been implemented in the week before our inspection. There was no record of the meetings and no evidence of a planned meeting schedule for the future.

2.7 You failed to demonstrate effective systems for recording and investigating clinical incidents occurring in the service, or processes for sharing any learning identified. We saw there had been no clinical incidents reported in the last 12 months despite holding data for surgical site infections. There were no methods in place for staff to learn from incidents.

2.8 You failed to ensure quality assurance for staff competencies for their roles. We saw in staff files that HCAs were being signed off as competent for particular clinical skills. However, there was no evidence that the clinical manager assessing the competencies had the appropriate knowledge and skills to do so.