AIG Aesthetic Care Ltd

# AIG Aesthetic Care

**Inspection report**

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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? | Requires Improvement |
| Are services responsive to people's needs? | Requires Improvement |
| Are services well-led? | Inadequate |

# Summary of findings

## Overall summary

Our rating of this location stayed the same. We rated it as inadequate because:

- The premises and equipment were not safely managed and presented a number of infection risks. Processes and systems to manage infection control risks were not fit for purpose. Staff and leaders did not understand the principles of infection control.
- Medicines management processes did not meet national standards and presented a significant risk to patients.
- The provider had improved some aspects of fire safety in the previous 5 months but practices still did not meet safe standards.
- The service did not ensure the privacy and dignity of patients and information management processes for the use of CCTV were not fit for purpose.
- There was limited evidence of evidence-based practice. The provider did not use established systems and frameworks to benchmark, audit, or monitor clinical activities and patient outcomes.
- The provider did not have a coherent clinical governance framework, the leadership structure was vague, and senior staff had a fundamental lack of understanding of risk. Risks we had previously told the provider to address remained because there was a lack of competence and understanding in the provider about recognising and responding to risks.

However:

- Patients reported high levels of satisfaction with the service.
- The provider had introduced new policies and standard operating procedures.
- Staff provided consistent follow-up care after treatment and worked with patients to meet their expectations.

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|---|---|---|
| **Surgery** | Inadequate  | Our rating of this service remained the same. We rated it inadequate. Please see the main summary. |

# Summary of findings

## Contents

# Summary of this inspection

## Background to AIG Aesthetic Care

AIG Aesthetic Care is operated by AIG Aesthetic Care Ltd and offers cosmetic hair transplant surgery and platelet-rich plasma (PRP) treatment. PRP is a treatment aimed at stimulating hair growth by injecting a patient's own blood cells into the scalp.

Services are provided from a single floor clinic in Walsall town centre. Care is provided on a private basis and patients self-refer or are referred by another organisation, which advertises in this clinic.

The provider registered with us in September 2022 to provide the following regulated activities:

- Surgical procedures
- Treatment of disease, disorder or injury

The service has a registered manager.

We previously inspected the service in September 2023 and took action to suspend the service from providing regulated activities under Section 31 of the Health and Social Care Act 2008. We rated the service inadequate. We reinspected the service in October 2023 to check on the progress of improvements we told the provider they must make. Following that inspection the service resumed providing regulated activities and the rating remained the same. At this inspection the provider had made some improvements. However, significant concerns remained about infection control, patient safety, and leadership competence. We rated it inadequate because it was not safe, effective, responsive, or well led. There was some evidence the service was caring.

## How we carried out this inspection

We carried out an unannounced comprehensive inspection on 1 February 2024. As part of our inspection, we met staff on shift delivering care, spoke with the managing director and with patients.

Our inspection team included a lead inspector, a nurse specialist advisor, and an off-site operations manager and deputy director.

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**:

- The service must ensure consistent standards of infection prevention and control throughout the clinic, including in all areas of the environment, auditing, and staff practice. Regulation 12(1) and 12(2)(a)(b)(c)(d)(e)(h).

# Summary of this inspection

- The service must ensure evidence of patient outcomes is collected and monitored. Regulation 12(1).
- The service must ensure people are protected from the risks of fire related to poor standards and knowledge of health and safety. Regulation 15(1)(d).
- The service must ensure regulated activities are delivered using up to date policies that are evidence-based and fit for purpose. Regulation 17(1) and 17(2)(d)(ii)(f).
- The service must ensure national requirements for the use of CCTV are fully met. Regulation 17(1) and 17(2)(d)(i)(ii).
- The service must ensure clinical governance and risk management systems are functioning, fit for purpose, and meet the needs of the regulated activities. Regulation 17(1) and 17(2)(a)(b)(c)(d)(i)(ii)(e)(f).
- The service must ensure senior staff are competent for their roles and have access to support for development and governance. Regulation 17(1) and (2)(d)(i)(ii).
- The service must ensure staff training meets the needs of patients. Regulation 18(1) and (2)(a)(b)(c).
- The service must ensure all staff have access to suitable appraisal and supervision processes. Regulation 18(1) and (2)(a).
- The service must display their most recent CQC inspection ratings in an area readily accessible to patients. Regulation 20A.

**Action the service SHOULD take to improve:**

- The service should ensure patients have the post-treatment information they need to help them manage recovery and side-effects. Regulation 9.
- The service should ensure all patients receive a 14-day cooling off period prior to surgical treatment. Regulation 9.
- The service should ensure that patients are cared for in an environment that ensures privacy and dignity. Regulation 10.
- The service should ensure safe water management processes are used to reduce the risk of Legionella build-up, in line with Department of Health and Social Care health technical memorandum 04-01. Regulation 12.

# Our findings

## Overview of ratings

Our ratings for this location are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Surgery | Inadequate | Inadequate | Requires Improvement | Requires Improvement | Inadequate | Inadequate |
| Overall | Inadequate | Inadequate | Requires Improvement | Requires Improvement | Inadequate | Inadequate |

Inadequate

# Surgery

| | |
|---|---|
| Safe | Inadequate |
| Effective | Inadequate |
| Caring | Requires Improvement |
| Responsive | Requires Improvement |
| Well-led | Inadequate |

## Is the service safe?

Inadequate

Our rating of safe remained the same. We rated it as inadequate.

### Mandatory training

**The service provided mandatory training in key skills to all staff, but completion and training topics were inconsistent amongst the team.**

Staff received and kept up to date with their mandatory training. The provider had introduced new online training for staff, which included a comprehensive range of modules. However, the provider did not have a structure or policy to guide the training staff were required to complete and there were broad differences between the modules staff completed. For example, staff had access to over 100 modules and the managing director showed us some staff had completed more than this, including an individual who had completed 133 modules in less than 3 months. This did not provide assurance of quality or applicability of the training to the care provided.

The provider had a focus on the quantity of training delivered and there was no understanding at senior level of how to match the quality and specialty of training with the needs of patients and the type of care delivered. All training was delivered online, and staff were responsible for completing updates with no senior level oversight.

It was not evident that the quality of training was sufficient for staff to provide safe care. For example, mandatory modules included infection control, health and safety, and fire safety. However, we found significant risks in all 3 areas with very low levels of competence and knowledge amongst staff.

### Safeguarding

**Staff had training on how to recognise and report abuse.**

The provider had begun to improve the consistency of safeguarding training by establishing the required levels of training for each grade of staff. They required doctors to complete safeguarding training to level 3 and all other staff to complete training to level 2. However, the provider could not evidence the level of training for all staff. Amongst technicians, some had no evidence of safeguarding training while others had completed it to an advanced level. After our inspection the provider told us all safeguarding training had been completed and staff were fully up to date.

Inadequate

# Surgery

The nature of the service meant safeguarding concerns were likely to be rare. At our last inspection staff told us it was common practice to allow patients who did not speak English to bring a friend or relative with them to provide interpretation. This meant the team would be unable to identify patients at risk of coercion or being treated against their will. At this inspection the provider told us this practice had stopped and they would require patients to bring a qualified interpreter with them.

The provider's policy stated the lead doctor, who was the interim lead surgeon, as the safeguarding lead. However, the provider was unable to confirm their level of training during the inspection and staff knowledge of the role was inconsistent. The managing director told us he was the safeguarding lead. However, after our inspection the provider corrected this and said the lead doctor remained in this post. Such discrepancies reflected a need for greater consistency in policies and leadership.

### Cleanliness, infection control and hygiene

**There were substantial, uncontrolled risks of infection in the clinic. The service had limited systems to identify and prevent surgical site infections. Staff did not use effective control measures to protect patients, themselves, and others from infection. Equipment was not decontaminated properly before use and the premises were visibly dirty in places.**

Clinical areas were not all clean and furnishings were not all suitable, clean, and well-maintained. Cleanliness in non-clinical areas was poor. For example, a table in the waiting room was visibly dirty and chairs used by patients, while wipeable, were stained and dirty.

The provider said they had implemented new cleaning schedules and audits to improve infection prevention and control (IPC) following our previous inspection. For example, a cleaning schedule was displayed in the staff kitchen. However, this was undated and missing key information, such as cleaning standards or completion dates. A member of staff said the team "just knew" when to carry out a scheduled clean and there was no need to document it. In addition, the cleaning schedule did not align with the staff rota and there was no system in place to allocate cleaning to another member of staff. The managing director told us this was incorrect, and staff completed weekly cleaning audits. However, they were unable to locate these or provide evidence. The poor cleanliness in some parts of the clinic did not reflect consistent standards of cleaning.

Understanding of cleaning responsibilities varied amongst the team. Staff told us they completed "light" cleaning between patients and all other cleaning was the responsibility of an external agency. The provider told us staff cleaned clinical spaces between patients and this was supplemented with weekly deep cleans by an external contractor.

During our previous inspection, IPC practices were not fit for purpose. Some clinical areas were visibly dirty, and some equipment was dirty and in a poor state of repair. At this inspection, the provider had introduced new cleaning systems that included improved standards of working, such as new checklists, expected standards, and audits. However, clinical areas were not all visibly clean and furnishings were not all clean and well-maintained. For example, some surgical equipment trolleys were rusted, and the bases of treatment beds were visibly dirty.

The service did not have a system in place to provide assurance of performance for cleanliness. When we discussed the poor state of some areas of the clinic with the provider, they told us this was the responsibility of an external cleaning company. The senior team relied on the external company to clean to good standards but had no system of checks or assurance in place. Instead, there was a culture of blame without accepting responsibility.

Inadequate

# Surgery

The provider had changed the surgical procedure policy and staff no longer operated with reusable instruments. Instead, they carried out treatment with single-use surgical instruments. While this reduced the risk of contamination we previously reported, staff did not appropriately and safely manage single-use instruments. For example, during our inspection staff had laid up a surgical room ready for a procedure the following day. They had opened syringes from their packaging, thus breaching the sterile field. The sterile field refers to the designated area, such as the stand and surface on which surgical instruments are placed. It is managed in an aseptic way, which reduces the risk of contamination of equipment and surgical sites. The instruments would be uncovered for up to 24 hours, which risked a build-up of dust and bacteria. In addition, the trolley on which instruments were placed was visibly dirty and rusted. We spoke with the doctor in charge on the day of our inspection. They had no understanding of the sterile field or the risks of breaking this and told us it was usual practice to open equipment early to save time on the day of treatment.

Mops used to clean floors were colour-coded in line with national standards. However, all 3 mop heads were stored in dirty water. The mop heads were visibly dirty and emitted a strong odour. Staff did not keep documentation of how often mop heads were changed. After a previous inspection the provider told us they had ordered new mops. Our findings at this inspection reflected ongoing problems with standards of IPC management.

During our inspection staff correctly used personal protective equipment (PPE) although frequently moved between different areas of the clinic without changing gloves or washing their hands. There were no dedicated handwashing sinks in clinical areas or the kitchen.

There was no tracking or auditing system to show when equipment had last been cleaned.

Staff told us there had never been a surgical site infection. However, there was a fundamental lack of understanding of effective IPC practice in the provider and the leadership team had not identified significant risks. There was therefore a lack of assurance that systems were in place to identify, document, and act on surgical site infections.

The provider had refurbished some areas of the clinic and installed protective wall coverings in surgical suites to prevent damage. While this reflected some improvement, the provider had an overarching lack of understanding of acceptable standards, such as those set by the Department for Health and Social Care (DHSC) through health building notices (HBNs) and health technical memoranda (HTM). For example, sinks in clinical areas were not compliant with national guidance because they had overflow outlets, which present a risk of bacterial growth. The provider had not recognised this and did not have a risk assessment in place. In addition, a sink in 1 surgical suite had begun to sink into the wooden benchtop, exposing the interior. As the interior was porous, this presented a risk of bacterial growth and contamination. The provider had not recognised this as a risk.

At our previous inspection in October 2023, the service was suspended, which meant we were unable to observe clinical practice. The provider told us new cleaning processes had been implemented for clinical areas between patients. At this inspection there remained poor and inconsistent standards of cleanliness in patient areas.

The room used for platelet-rich plasma (PRP) treatments presented significant uncontrolled IPC risks. The treatment couch was visibly dirty, and its support struts were rusted. Stools used by staff to move around the patient were dirty, damaged, and corroded. A fabric cushion on the treatment couch had dried blood on it. This presented a risk of infection from viruses that can live in dried blood for lengthy periods of time, such as Hepatitis B. The artificial ceiling above the treatment couch was damaged with 2 holes exposing the concrete structure of the building, risking contamination of surgical sites from falling dust. Staff said the room was in normal use and they had not identified any concerns about it. The provider could not supply evidence of cleaning of the room.

We discussed our concerns with the managing director at the time of the inspection. They said a whole-clinic deep clean had taken place within the previous 7 days. The record for this stated simply that a strong disinfectant had been applied to all floors, skirting and beds. After our inspection they told us they had changed external cleaning contractor.

### Environment and equipment

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

The provider had installed a new, centralised fire safety system. This included fire alarm call points and emergency lighting. The senior team said all staff had completed training in its use and had implemented a new policy that required regular systems checks and fire drills. However, some staff on duty during our inspection said they had been on annual leave during the fire training and so had not completed it. In addition, the last documented fire drill had taken place in November 2023.

The provider had reduced fire safety risks in some areas since our last inspection. For example, they had decommissioned electrical sockets located next to sinks. The provider told us a fire marshal had been trained although this individual was not on shift at the time of our inspection. There was no system in place for other staff to carry out the fire marshal role in the absence of the named individual.

The provider had implemented documentation for fire safety checks, such as checks of emergency lights and the fire alarm. This was a new system and while checklists were in place, they had yet to be implemented consistently.

While fire safety standards had improved to some extent since our last inspection, there remained a lack of knowledge and understanding of fire risks amongst the team. For example, staff continued to use a space heater surrounded by, or directly touching, shoes, clothes, and other material. The heater was unattended and had not been tested for electrical safety. This presented a fire risk not recognised, understood, or mitigated by staff.

The design of the environment did not follow national guidance and was not compliant with Department of Health and Social Care (DHSC) standards. The service had no dedicated hand washing sink for clinical staff and instead sinks were also used to clean equipment. Sinks were in a poor state of repair, such as 1 sink was partially sunk into the wooden bench, exposing an area in which bacteria could build up and present an infection control risk. None of the clinical sinks were compliant with DHSC standards because they had overflow outlets, which presents a risk of bacterial growth.

The service was not compliant with the Control of Substances Hazardous to Health (COSHH) Regulations. The service had a labelled, locked COSHH storage unit but there was missing information about the contents. For example, an unlabelled spray bottle was kept in the unit. It was full of a clear liquid, but staff could not tell us about the contents. This meant patients and staff were at risk of harm from the potential unsafe use of a chemical. While the cupboard was lockable, it was usual practice for staff to keep the key in the lock, which presented a risk of unauthorised access.

The clinic had equipment to manage medical emergencies including an automatic external defibrillator (AED), oxygen, and resuscitation medicines. There was signage in place for the location of the AED and oxygen, which was good practice. However, the location of first aid kits was inaccurate. There were 3 cupboards in the clinic labelled as such, but none contained a first aid kit. We asked a member of staff for the location of this, and they did not know. The service did not keep a formal anaphylaxis kit but had adrenaline, a medicine used to counteract anaphylaxis, available in the clinic. However, this had expired in October 2023, 4 months before our inspection. Using expired medicine means it may not work in the intended way.

Inadequate

# Surgery

The service was not compliant with DHSC HTM 07/01 in relation to the safe management and disposal of healthcare waste. This was because staff did not manage sharps bins safely or in line with manufacturer guidance. A sharps bin in a surgical room was in use and contained used sharps but the lid was not sealed correctly. This presented a risk of spillage and contamination if dropped and a risk of needlestick injuries. Staff had not completed the labels on any of the sharps bins in use in the clinic. It is a requirement to complete sharps bin labels for waste tracing and to ensure they are used and emptied within the manufacturer's published timeframes. In 1 room of the clinic, there were 2 sharps bins in use, stored inappropriately and unsafely. Both bins were stored on the floor, which was against good practice, and 1 bin had an open aperture. This presented a risk of needlestick injury. Staff stored 3 overfilled sharps bins, all of which were unlabelled, in a cupboard in a room used for patient treatment, of which 1 bin was stored horizontally, which was against safe practice. Overall, sharps management was inadequate, and staff demonstrated no knowledge of safe practice. The provider had no monitoring in place to assess sharps management and no auditing or competent leadership to assess local practice against national standards.

The service was not compliant with the DHSC HBN 00/10 in relation to safe clinical environments. The flooring in clinical areas was in a poor state of repair and visibly dirty with ingrained dirt. Part of the welding between the floor and the skirting had deteriorated, which meant the floor was not watertight. This presented a risk of bacterial growth and contamination. Staff said this area of cleaning was the responsibility of an external cleaner. However, staff had not noticed or reported the risks, and there was no auditing system in place that could have identified the need for repairs.

The artificial ceiling was damaged in several places throughout the clinic, with holes, cracks, and liquid damage present. The ceiling in the clinical room used for PRP injections had a hole above the treatment couch. This presented a risk of dust and dirt contamination by falling on patients during treatment. While staff had noticed the damage, they were unable to identify how it happened and had not recognised the risk caused to patients. The senior team had not investigated how the damage happened or where the liquid damage came from. This meant the provider did not have assurance the liquid was not toxic or harmful or that the ceiling was structurally sound.

All staff had basic life support training and doctors held immediate life support training, which was appropriate for the nature of the service.

The service was not compliant with DHSC HTM 04-01 in relation to water safety. For example, the registered manager arranged an annual Legionella check of the water system. However, the most recent check indicated the external testing company were unaware of the purpose of the premises and so the risk assessment was not fully relevant. Staff did not document regular flushing of water outlets, including those used occasionally.

The registered manager said the team carried out regular water flushing of all outlets. However, documented evidence was inconsistent, with only 6 'monthly' checks taking place in the previous 12 months. In each case staff noted the checks had included all taps but there were no variances in temperature for any outlet, indicating a need for a more accurate and thorough audit tool.

### Assessing and responding to patient risk

**Staff completed risk assessments for each patient. Staff identified and quickly acted upon patients at risk of deterioration. The service made sure patients knew who to contact to discuss complications or concerns.**

Inadequate

# Surgery

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The nature of the service meant this was a rare occurrence. Where patients had felt unwell during a treatment, staff had acted quickly to keep them safe. For example, when a patient felt dizzy after a treatment, staff monitored their blood pressure, elevated their legs, and increased ventilation to the room. Staff worked to a clear threshold of the conditions they could manage, and at which stage they would contact 999 for emergency help.

Staff provided patients with detailed post-treatment instructions, including contact details for a duty doctor in the event of pain or unexpected side effects. They discussed with patients what to expect and when to seek urgent help, such as if they had symptoms of an infection.

Staff completed risk assessments for each patient at the pre-treatment stage. This included a check of existing medical conditions that might impact treatment, such as high blood pressure, diabetes, or a mental health condition. Staff said they required approval for the procedure from the patient's GP if they had pre-existing conditions of concern. However, the management of high blood pressure did not reflect good practice.

Risk management processes for patients who presented with high blood pressure were not evidence-based and meant patients were at risk of potential harm. Elevated blood pressure presented a risk of complications during surgery and staff checked patients' readings just prior to treatment. However, the blood pressure control protocol did not have an evidence-based rationale for the use of these medicines. For example, doctors administered oral diazepam, followed by up to 2 doses of antihypertensive medicine to lower blood pressure before cancelling a procedure. This was risky because National Institute for Health and Care Excellence (NICE) guidance requires a comprehensive process for confirming diagnosis before the initiation of treatment. Instead, doctors initiated treatment based on a single blood pressure reading, which meant they were temporarily initiating treatment that should be established by a GP or in a secondary care setting. In addition, the service had a much lower blood pressure exclusion threshold than those established nationally without a rationale for this. As doctors relied on each patient's understanding and accurately providing their medical and prescription history, there was a lack of safety controls in such situations. The anti-hypertensive medicines used, lisinopril and amlodipine, risked potential harm to the patient if administered without the doctor having access to their medical history.

We spoke with clinical staff about the management of high blood pressure. They were not aware of national guidance and did not understand the risks or inappropriate treatment in their practices. In addition, they showed us a monitoring form they had prepared for patients, which provided instructions for 5-day home monitoring of blood pressure. After this, the patient would return to be assessed if treatment was safe. While this process may have enabled clinical staff to establish a baseline blood pressure for each patient, they did so without any contact with the patient's GP and so risked missed diagnoses or inappropriate treatment.

After our inspection the provider told us they had stopped such treatment and monitoring for high blood pressure and would manage the risk in other ways.

### Staffing

**There was limited assurance the service had enough 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 clinical team comprised of 3 doctors and 7 technicians, including the dual role registered manager. Doctors were registered with the General Medical Council (GMC) and at the time of our inspection 2 were active in the service.

Inadequate

# Surgery

Doctors did not have named mentors and the provider did not have a system in place to assess standards of clinical practice other than patient feedback.

The service did not have a minimum staffing level and instead scheduled the team based on planned procedures.

The provider was compliant with recruitment legislation. The senior team obtained 2 references for each new member staff and ensured each individual had an appropriate Disclosure Barring Service (DBS) check. All 5 staff files we checked included the required evidence.

After our inspection we made contact with the GMC about our concerns and to mitigate the risk of care provided by inappropriate staff.

## Records

**Staff kept variable records of patients' care and treatment.**

Patient notes included completed health questionnaires and details of ongoing issues, such as high blood pressure. Staff documented each patient's name, date of birth, and confirmation of identification check in each record. The provider had introduced an individual identifier system so that patients could easily be tracked in the electronic system.

Staff completed paper notes and then transcribed or scanned them into the electronic records system. While standards of completion were mostly consistent amongst the sample we looked at, there was no system in place to audit standards of completion.

There was 1 computer with access to patient records in the clinic. Records were stored securely by the system with encrypted access.

## Medicines

**The service did not use safe systems and processes to prescribe, administer, and record medicines. Storage and stock control systems were not fit for purpose.**

Medicines management policies and standard operating procedures (SOPs) were not fit for purpose. The documents had inaccurate and misleading version controls and did not provide clear guidance to staff. For example, the provider's prescribing medicines policy was simply a list of hyperlinks to NHS or NICE guidance. There was no information to tailor the use of medicines to this clinical setting. The SOP for the use of intravenous diazepam did not reflect our findings on site and was dated May 2023 and May 2024. However, at our inspection in September 2023, staff were unable to locate any medicines management policies. Such discrepancy in dates and version control was a concern across the provider's wider practices because it did not provide assurance of good safety management.

Staff documented prescribed medicines in each patient's treatment record. In 2 examples we looked at, this included batch numbers, dosage, and expiration dates. This reflected good practice.

Staff followed NICE guidance on antibiotic prophylaxis for hair transplant treatment. However, they did not audit practice to provide assurance of good standards.

The provider did not have good systems in place to safely store medicines and stock control procedures were not fit for purpose. Medicines were stored securely but staff did not monitor temperatures in these areas. Temperature monitoring provides assurance medicines are stored within the safe range published by manufacturers.

Inadequate

# Surgery

Staff told us a monthly stock control audit had been implemented in October 2023 to avoid overstocking of medicines and ensure they used items in order of expiry date. The system was not fit for purpose. We found expired adrenaline in situ in a clinical room and staff could not explain why the audit had not identified this. They could also not identify why staff operating in the room on a daily basis had not recognised the need for disposal. The last audit took place in December 2023 and staff could not explain why an audit had not taken place in January 2024. The stock list did not reflect the medicine stored on site. For example, the stock list detailed 2 boxes of diazepam in liquid form. However, the medicine storage cabinet contained 30 ampules of liquid diazepam not contained in a box. The inconsistencies between actual stock and recorded stock reflected ineffective medicine tracing.

The clinic stocked unusual, unjustified quantities of diazepam, a benzodiazepine used to treat anxiety, for intravenous use. This was unusual in a cosmetic hair surgery clinic. Staff told us they stocked this to manage seizures although these were uncommon. The first line of management for a seizure is rectal diazepam only. The provider could not explain why local procedures differed from national guidance or why they considered seizures to be such a risk. Medicines policies directed staff to the British National Formulary but there was no pharmacist oversight or clinical lead to maintain consistent standards of practice.

### Incidents

**The service had a system in place to manage patient safety incidents, but these were not yet embedded in practice. There was little evidence of learning from events or action taken to improve safety. There was no structured process to ensure patient safety alerts were implemented and monitored.**

Staff said they would report incidents to the registered manager. At our previous inspection there was limited assurance of an incident reporting or monitoring policy. The provider had implemented an incident reporting policy in October 2023 and staff had reported 6 incidents since then, including 1 clinical incident without harm to the patient. Of the total, 4 incidents related to the environment, including a leak, a related electrical failure, a trip hazard, and staff discovery of rusted scissors in a clinical room. The managing director acted in each case to remove or mitigate the risk.

It was not evident the incident reporting process was fully embedded in the service. For example, staff told us about an incident that involved a patient who felt dizzy and had low blood sugar, which they confirmed using a blood glucose monitor. Staff responded appropriately by giving the patient a sugary drink and giving them time to lie down and recover before proceeding. However, this incident was not documented in the incident log. This meant the provider did not have assurance of good oversight of trends and themes involving incidents and risk.

While the improvements in incident management reflected good practice, the lack of recognition of the safety risks in the clinic from staff meant there was limited assurance the team had the skills or training to recognise reportable issues.

The provider did not have a formal policy to monitor national patient safety alerts. A doctor said they monitored updates themselves and the senior team received updates from the Medicines and Healthcare products Regulatory Agency. There was no record of regular checking.

## Is the service effective?

Inadequate

Our rating of effective remained the same. We rated it as inadequate.

Inadequate

# Surgery

## Evidence-based care and treatment

**The service had no structured or formal auditing system to establish or provide assurance of evidence-based care and treatment. The provider required staff to follow national guidance but did not check this.**

At our previous inspection staff had no knowledge of local policies and standard operating procedures (SOPs). They were unfamiliar with the content and instead they followed instructions from the provider regarding care. We asked the provider to send us evidence of the national guidance and best practice they expected staff to follow when delivering care. The senior team sent us details of prescribing and clinical standards from the National Institute for Health and Care Excellence (NICE) and UK Health Security Agency. However, the guidance was not specific to this type of service and the provider had no audits or other means of assurance that use of the guidance was effective. The provider told us they followed industry standards from the International Society of Hair Restoration Surgery although there were no audits or policies to establish formal links or monitoring.

At this inspection the provider was in the process of updating key policies and SOPs. This included the medical emergency policy and NICE guidelines to recognise and manage sepsis. There was a new provider-level system in place to monitor policy updates although responsibility for this was vague. After our inspection the provider sent us evidence a new electronic monitoring system was in use for policies with better access and version controls.

There was limited understanding of the markers of evidence-based care, or strategies to achieve these, amongst the staff team. At a previous inspection the provider told us they planned to recruit a patient liaison officer, who they said would establish benchmarking against other similar clinics to identify opportunities for learning and improvement. This had not yet taken place and we were unable to establish if this remained a tangible plan.

After our inspection the provider told us they had recruited a new chief compliance officer, who would also replace the registered manager. This individual would take a lead role in improving standards of evidence-based practice.

Doctors completed a maximum of 2,500 hair grafts per clinical session. This was an informal, nationally accepted standard kept by comparable services.

## Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. All treatments took place using local anaesthetic and doctors administered dosage based on individual needs.

Staff used a pain management plan for each patient based on their medical history and current medication. This included guidance on how to manage post-treatment pain and the effective use of follow-up care. Staff included non-pharmacological pain management in recommendations, such as the use of ice packs and exercises to reduce inflammation.

The service had acted on patient feedback to improve pain management. For example, patients who underwent platelet-rich plasma treatment said they felt some pain during administering of the treatment. As a result, the service introduced numbing cream, which staff applied prior to the treatment.

## Patient outcomes

**Staff did not monitor the effectiveness of care and treatment and there were no quality assurance systems in place.**

Inadequate

# Surgery

The provider had implemented a clinical audit cycle using an electronic platform that would alert staff to areas of non-compliance. This was connected to the provider's new policies and SOPs system and aimed to provide assurance of the effectiveness of care and patient outcomes. However, the system was in its infancy and despite requiring the provider to make progress 4 months earlier, they had not yet completed any clinical audits. This meant there remained no system in place to monitor the effectiveness of care.

The service used patient feedback and 'before and after' treatment photographs as the only measure of evidence-based care and patient outcomes. Staff discussed consent for photography during the pre-treatment process and most patients agreed to this process to help measure the success of working towards their outcome expectations. While this reflected good practice in patient-centred care, the lack of a comparable measure of outcomes and treatment effectiveness at a clinical level meant the provider had limited assurance.

Patient feedback suggested outcomes met expectations. A recent patient noted, "Everyone has commented on how neat my hairline looks and it's not even grown yet." Another patient said, "[I'm] happy with the results and I am already getting on with my normal routine."

After our inspection the provider told us the new chief compliance officer had implemented a patient outcomes tool to better assess standards of practice by comparing the clinical outcomes between surgeons.

### Competent staff

**The service did not have a clinical education or competency system. There was no staff supervision process. The provider did not have assurance of consistency of staff skills and practice.**

Staff were qualified but the provider had limited assurance they had the right skills and knowledge to meet the needs of patients. For example, technicians completed a trichology course that enabled them to extract hair in preparation for transplant by a doctor. However, there were no training opportunities for the team as a whole and surgeons did not have assurance that technicians completed appropriate training.

There was no documented evidence of inductions or a mentoring programme, no regular supervision, and no appraisals. The provider had no assurance of the continuing professional competencies of staff.

The provider had introduced weekly team meetings, which provided staff with the opportunity to meet during protected time to discuss concerns and needs.

There were discrepancies around the supervision and appraisal of doctors. The provider had previously told us each doctor underwent an appraisal as part of their GMC registration with an approved responsible officer. However, the senior member of staff responsible for monitoring this process was unfamiliar with it and there was no documented evidence appraisals had been checked.

While all staff held appropriate qualifications, there was limited assurance of consistent specialist training for cosmetic hair transplant surgery. For example, the provider did not have a standard requirement for technician training and the interim lead surgeon had no clinical area of specialty.

The service had no evidence of appraisals in the previous 12 months despite the provider telling us previously they planned to complete appraisals in November 2023.

Inadequate

# Surgery

### Multidisciplinary working

**There was no evidence of multidisciplinary working to provide good care.**

Surgeons treated patients independently and outside of wider care pathways. Staff did not coordinate care and treatment with other professionals when patients presented with pre-existing health conditions.

Where patients disclosed medical history or current conditions in their records, doctors did not document if they held multidisciplinary meetings with other clinicians involved in the patient's care. For example, doctors managed high blood pressure directly with patients without involving their GP. This meant there was a lack of assurance procedures were carried out effectively with regards to other health conditions.

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

**Staff supported patients to make informed decisions about their care and treatment. There was inconsistent evidence of a standard 14-day cooling off period.**

Staff clearly recorded consent in patients' records. The consent process included details of photographing and videoing treatment, including for the use of 'before and after' photos to help patients track the progress of treatment against their goals.

The pre-treatment health questionnaire included a check of mental health needs. Where patients disclosed a diagnosed condition or concern, the service required a letter of approval for treatment from the patient's GP or a mental health professional.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. However, evidence of the standard national 14-day cooling off period was inconsistent and not all patient records we looked at included this information.

## Is the service caring?

Requires Improvement

Our rating of caring remained the same. We rated it as requires improvement.

### Compassionate care

**Staff treated patients with compassion and kindness although there was a need for improved privacy and dignity.**

Staff did not always ensure care and treatment was delivered with privacy and dignity. At a previous inspection in September 2023, we found a treatment room with floor to ceiling windows was visible from the street. While the service had a roller blind in place, the treatment bed was still visible from outside. In addition, we saw staff did not always close doors to surgical rooms during treatment and treatment was visible to those passing by. Staff did not use privacy or 'do not enter' signs in clinical areas, which meant patients were not assured of privacy and dignity. We told the provider to improve patient dignity and privacy standards. However, at this inspection staff had not made changes to practice. Patients undergoing treatment were still visible from the street and staff continued to keep doors open during procedures.

Inadequate

# Surgery

Patients said staff treated them well and with kindness and we observed this in practice during our inspection. A patient told us they felt safe and respected in the clinic and that they looked forward to their treatments.

Staff used personal mobile phones around the clinic, and it was not clear how they managed confidentiality and privacy risks associated with this.

### Emotional support

**Patients said staff provided emotional support to minimise their distress.**

All treatment was cosmetic and elective without diagnostics. This meant the need to provide emotional support was limited in scope. While feedback from patients was consistently positive, staff relied on medicine to reduce anxiety rather than skilled communication or empathy. For example, patients often presented with increased blood pressure, which was a reaction to pre-surgical anxiety, common particularly amongst patients seeking the treatment for the first time. In the first instance staff treated this with medicine rather than other methods, such as giving patients time and space to talk and reduce their worries. After our inspection the provider told us staff were trained to using calming methods before they administered medicine. The policy stated, “All staff are training to do this”, which indicated this was an ongoing process not yet completed.

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

**Staff supported patients to make decisions about their care and treatment but did not always make sure they fully understood treatment side effects and recovery.**

Staff made sure patients understood how their care and treatment worked in practice. A patient during our inspection told us they felt staff had explained things to them clearly. They said staff had spent time discussing costs and potential side effects and they felt happy with this.

There was evidence of inconsistencies in how the service involved patients in their care. For example, patient feedback repeatedly mentioned how happy individuals had been with staff communication whilst on site. However, most feedback also asked follow-up questions that followed a theme of insufficient information, such as questions about why shedding had not stopped or when they needed to schedule follow-up appointments. Staff documented an incident whereby the patient had been unable to remove bandages themselves and returned to the clinic for support. This reflected a need for greater depth of guidance provided before patients left the clinic.

## Is the service responsive?

Requires Improvement

Our rating of responsive improved. We rated it as requires improvement.

### Meeting people’s individual needs

**The service had very limited scope to manage individual needs.**

The treatment cycle was designed to provide patients with a calm and unhurried experience. Staff gave patients a break between each stage, such as between the initial incisions made in the scalp and then at stages during the implant process.

Inadequate

# Surgery

Staff recognised the importance of managing patients' expectations and discussed these using photographs and potential outcomes before treatment commenced.

The clinic was accessible by those with reduced mobility and had a disabled access toilet.

At a previous inspection we found the service had no provision for patients who could not communicate verbally or in English. Staff said they relied on friends or relatives who patients brought with them to interpret or translate. This presented a risk because the service did not have assurance the person providing interpretation had an accurate understanding of medical terminology, including to communicate the potential risks associated with treatment. At this inspection the provider had implemented a new policy that required patients to secure a qualified interpreter in advance of treatment. In addition, the staff team represented several other languages, including Hindi, Urdu, Punjabi, and Spanish. While the provider said staff could support patients with language needs, they did not receive training to do so.

The service had no provision for patients living with learning disabilities, dementia, or any other type of mental health condition that could impact understanding and communication. The provider said they only accepted patients with no mental health conditions for treatment, which reflected a fundamental lack of understanding of the abilities of people living with diverse conditions. There was no formal policy that guided treatment acceptance and staff made decisions on a case-by-case basis.

### Access and flow

**People could access the service when they needed it and received the right care.**

A separate organisation provided referrals to the clinic and carried out an initial check of suitability for treatment. The service also accepted self-referrals from patients. The service opened 6 days per week and provided patients with flexibility in treatment times, such as opening later on request so patients could attend after work.

Hair transplant patients committed to a minimum of 5 follow-up appointments over 12 months following the completion of treatment, 3 of which involved in-person reviews in the clinic.

### Learning from complaints and concerns

**It was easy for people to give feedback and raise concerns about care received but we could not establish how the service investigated or resolved complaints. The service did not have a system for referring unresolved complaints for independent review.**

The service clearly displayed information about how to raise a concern in patient areas. However, the complaints policy had expired, there was no named complaints lead, and there had been no documented clinical complaints. This meant the provider did not have assurance the complaints system was fit for purpose.

## Is the service well-led?

Inadequate

Our rating of well-led stayed the same. We rated it as inadequate.

Inadequate

# Surgery

## Leadership

**Leaders could not evidence they had the skills and abilities to run the service. They did not understand and manage the priorities and issues the service faced. Significant risks persisted for 5 months without action from senior staff. However, they were visible and approachable in the service for patients and staff.**

At the time of our inspection the provider was in the process of a change of registered manager. They recruited a new manager in March 2024 who planned to register with CQC. They were supported by the managing director who was based off site and staff said this individual visited regularly.

The leadership structure was informal, and the provider did not have a clear framework for responsibility. During previous inspections we were unable to establish clear lines of accountability or roles and asked the provider to supply us with documented evidence of the structure. This did not exist and although the provider tried to prepare a visual leadership structure, this was inaccurate. At this inspection leadership remained highly ineffective. A senior member of the provider team told us the registered manager was accountable for almost all of the clinic's failings and said the manager repeatedly "forgot" to do audits and was unable to manage the poor performance of the team. This reflected a dysfunctional leadership structure without the knowledge or competence to safely deliver regulated activities.

The interim lead surgeon had unclear management responsibilities although staff said they had good working relationships with the senior team and felt listened to.

## Vision and Strategy

**The service had a tenuous vision for what it wanted to achieve. Leaders and staff had limited understanding of vision and strategy and there was no evidence staff applied either in their work.**

The provider told us the vision of the service was to "provide high quality, safe, professional services." However, there was limited evidence this applied in practice or was supported by a strategy specific to the provider.

The clinic building was 'wrapped' in advertising for another organisation under a marketing agreement. A crumpled A4 notice on the entrance door was the only indication this was the address of the provider. Notices inside the clinic referred to another organisation, which staff told us was a patient-facing administrative group that identified potential patients for treatment. There was no indication of a strategy specific to AIG Aesthetic Care.

After a previous inspection the provider told us they were developing a vision and strategy although this had not progressed in the previous 5 months.

## Culture

**Staff felt respected, supported, and valued. However, there was not a coherent or identifiable culture that focused on patient care and staff development.**

Staff told us they had good working relationships with managers and each other and that the working culture had improved recently. For example, a member of staff said the provider had provided new equipment and resources, which improved the standard of care they provided.

Inadequate

# Surgery

There was not a cohesive, team-oriented working approach in the clinic. The managing director was highly critical of the registered manager but had no evidence of support structures, training, or leadership guidance they had sourced. While a new manager was subsequently recruited, the approach of othering responsibilities and a culture of blaming colleagues remained in place. During our inspection staff were defensive when asked for a rationale or justification for unsafe procedures and policies and there was no clear support mechanism in place for them.

## Governance

**Leaders did not operate effective governance processes. There was no process to review key items such as the strategy, values, objectives, plans or the governance framework. Significant risks across the clinic reflected a governance system not fit for purpose.**

At the time of our inspection the provider was in the process of a wide-ranging good governance improvement plan. However, this lacked a structured framework or an evidence base. There were profound, longitudinal, and significant gaps in governance that reflected a lack of competent leadership, provider oversight, and organisational integrity. Despite preparing weekly updates on an action plan, there was no real checks or understanding of safety issues. For example, the provider had acted on risks we highlighted relating to infection prevention and control (IPC) and fire safety but had addressed only specific points of concern. Staff had not recognised other, comparable risks, and the provider continuously asked CQC for specific instructions on improvement. There was no organisational drive to improve internal audit systems and no governance system in place to drive improvements.

The senior team had initiated weekly team meetings that included a review of governance and operational performance. While this reflected good practice in principle, the provider did not track learning, developments, or actions. The provider did not keep a record of attendance and staff could not tell us about any recent meetings or outcomes from them.

There was a lack of integrity in the provider. For example, new guidance for staff did not reflect practice. A new fire safety policy required staff to carry out weekly checks. However, staff believed the requirement was for monthly checks and had not documented a check in over 2 months. After our inspection we asked the provider for urgent clarification on their unusual use of diazepam as a front-line treatment given the nature of the service. The provider supplied a policy with a first version date of May 2023. However, during our previous inspection in September 2023, no such policy had been available. Such discrepancies presented a significant unmet risk caused by inadequate governance, transparency, and honesty.

There were no effective, consistent audits in place and no comparable system through which the provider established quality assurance. The provider was in the process of introducing a rolling schedule that included 46 monthly or quarterly audits, which reflected a move towards improvement in standards. However, these were still largely in the planning or implementation stage.

## Management of risk, issues, and performance

**There were no systems to manage performance effectively. The leadership team had very little understanding of risks and issues and staff did not act on visible, obvious hazards.**

There was a fundamental lack of knowledge of risk management across the whole team, which was exacerbated by gaps in oversight and leadership at provider level. The service had no overarching risk register or system to identify, escalate, and mitigate risks. For example, staff we spoke with, including the interim lead surgeon, were unconcerned by the unsanitary state of treatment rooms or the discrepancies in medicines stock control.

Inadequate

# Surgery

Throughout the inspection we raised concerns about safety and risk with staff, including the doctor in charge and the managing director. There was very little understanding of these risks until we highlighted them and nobody on the staff team had recognised the issues or escalated them.

Risk management and clinical governance systems were not functioning effectively. At our previous inspections we found a number of concerns relating to water safety and the need for Legionella risk reduction. The most recent Legionella risk assessment had taken placed in May 2022, leaving a gap significantly more than the recommended 12 months between assessments. The assessment highlighted 5 areas of information deficiency, including a lack of competent and trained staff. The next risk assessment was due in May 2025, reflecting a 2-year gap. This was unusual for healthcare premises, which usually have an annual check as good practice. In addition, the provider had not recognised the need to take action following the assessment.

The provider did not have a comprehensive understanding of risk management principles and good practices. For example, in September 2023 we took action under Section 31 of the Health and Social Care Act 2008 and suspended the service following serious concerns about the safety and management of the clinical environment. While we found risks throughout the clinic, poor IPC practices were central to our decision. The provider had made some improvements, such as removing reusable surgical instruments and refurbishing some elements of the clinical rooms. However, there remained a lack of competent leadership and clinical practice and knowledge. For example, staff had not acted on significant new risks in the clinic. This included the failure to recognise the risks of using blood-stained fabrics in the clinical room during treatment with patients, no recognition of the risks of a damaged, dirty floor, and no understanding of the risks of a damaged ceiling about a patient treatment bed. Audits had not identified these areas as risks and staff continued to deliver care without any awareness of the problematic environment. Senior staff demonstrated no accountability and blamed others for the failure to act.

The provider had implemented a series of new audits aimed at reducing risk and improving operational performance. However, these had been ineffective. For example, a new cleaning audit had not identified dirty, damaged floors as areas in need of more attention. A medicines management audit had not identified expired adrenaline and inaccurately documented stock. There was no competent oversight of the audits and instead staff continued working without acknowledgement of the risks because they believed the audits were sufficient in and of themselves.

### Information Management

**The service did not collect or analyse data to understand performance, make decisions and improvements. There were significant areas of concern in relation to data security. The service did not display their most recent CQC inspection ratings in an area readily accessible to patients.**

CCTV cameras were present throughout the clinic. At our previous inspections we told the provider they must improve information management systems and follow the guidance of the Data Protection Act and that issued by the Information Commissioner's Office (ICO), including the standards of practice. At this inspection the provider had installed a notice to advise patients and visitors that CCTV was in use. However, there was still no named data controller or privacy impact assessment in place. Staff told us they did not know if the CCTV was working, who controlled it, or what or when the system recorded.

We spoke with the managing director about this who said they did not know if the system had ever monitored or recorded audiovisual material in the clinic and had been unable to establish who, if anyone, held recordings. They said the system had been disconnected.

Inadequate

# Surgery

The service did not display their most recent CQC inspection ratings in an area readily accessible to patients. This was a breach of Regulation 20A of the Health and Social Care Act.

## Engagement

**Leaders and staff actively and openly engaged with patients.**

The managing director told us the introduction of weekly meetings had improved communication with staff, who now felt listened to.

Staff routinely engaged with patients after treatment and there was evidence all patients completed this process. Feedback indicated patients were consistently happy with this process and found the provider easy to reach by e-mail or phone.

## Learning, continuous improvement and innovation

**The provider provided some evidence of a commitment to learning and improving services. However, they did not have a good understanding of quality improvement methods and the skills to use them.**

The provider had taken steps to improve standards of practice, safety, and quality of care. They had implemented changes to the use of surgical instruments, refurbished part of the clinic, and installed a new fire alarm system. The provider had also introduced a new governance system that stored policies and which staff could use to record incidents and complaints. While such work reflected improvements, the provider did not have the knowledge or understanding to continue this work independent from regulatory processes. For example, senior staff did not understand how or why they had breached regulations and there was no recognition of ongoing or new risks in the clinic. Improvements made that reduced risk, such as a new cleaning schedule, addressed only specific concerns we raised previously and did not identify other, similar problems.

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<br>Treatment of disease, disorder or injury | Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment<br>The service did not ensure people were protected from the risks of fire related to poor standards and knowledge of health and safety. |

| Regulated activity | Regulation |
|---|---|
| Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 20A HSCA (RA) Regulations 2014 Requirement as to display of performance assessments<br>The service did not display their most recent CQC inspection ratings in an area readily accessible by patients. |

| Regulated activity | Regulation |
|---|---|
| Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>The service did not ensure staff training met the needs of patients.<br>The service did not ensure all staff had access to suitable appraisal and supervision processes. |

| Regulated activity | Regulation |
|---|---|
| Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance |

This section is primarily information for the provider

# Enforcement actions

The service did not ensure regulated activities were delivered using up to date policies that were evidence-based and fit for purpose.

The service did not ensure national requirements for the use of CCTV were fully met.

The service did not have clinical governance and risk management systems that were functioning, fit for purpose, and met the needs of the regulated activities.

The service did not ensure senior staff were competent for their roles and had access to support for development and governance.

| Regulated activity | Regulation |
| --- | --- |
| Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>The service did not ensure consistent standards of infection prevention and control throughout the clinic, including in all areas of the environment, auditing, and staff practice.<br>The service had no evidence of monitoring patient outcomes. |