Announced Inspection Report: Independent Healthcare

Service: Signature Clinic, Glasgow
Service Provider: Signature Medical Glasgow Ltd

29 March 2022
Healthcare Improvement Scotland is committed to equality. We have assessed the inspection function for likely impact on equality protected characteristics as defined by age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation (Equality Act 2010). You can request a copy of the equality impact assessment report from the Healthcare Improvement Scotland Equality and Diversity Advisor on 0141 225 6999 or email his.contactpublicinvolve@nhs.scot
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1  A summary of our inspection

The focus of our inspections is to ensure each service is person-centred, safe and well led. Therefore, we only evaluate the service against key quality indicators which apply across all services. However, depending on the scope and nature of the service, we may look at additional quality indicators.

About our inspection

We carried out an announced inspection to Signature Clinic on Tuesday 29 March 2022. We spoke with the service manager and a number of staff during the inspection. We also received feedback from three patients through an online survey we had asked the service to issue for us before the inspection. This was our first inspection to this service.

The inspection team was made up of two inspectors.

As part of the inspection process, we asked the service to submit a self-evaluation. The questions in the self-evaluation are based on our Quality Framework and ask the service to tell us what it does well, what improvements could be made and how it intends to make those improvements. Although requested, the service did not submit a self-evaluation before the inspection.

What we found and inspection grades awarded

For Signature Clinic, the following grades have been applied to the key quality indicators inspected.

<table>
<thead>
<tr>
<th>Key quality indicators inspected</th>
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<tbody>
<tr>
<td><strong>Domain 5 – Delivery of safe, effective, compassionate and person-centred care</strong></td>
</tr>
<tr>
<td><strong>Quality indicator</strong></td>
</tr>
<tr>
<td>5.1 - Safe delivery of care</td>
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</tbody>
</table>
### Key quality indicators inspected (continued)

#### Domain 9 – Quality improvement-focused leadership

<table>
<thead>
<tr>
<th>Quality indicator</th>
<th>Summary findings</th>
<th>Grade awarded</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.4 - Leadership of improvement and change</td>
<td>A clearly defined leadership and governance structure was in place, with systems and processes to monitor the quality of care delivered. A range of staff and senior management meetings were held. The service acted on lessons learned from audits and feedback, and was responsive to making changes to practice in line with its quality improvement plan. Staff meeting minutes should be shared with staff.</td>
<td>✔️ Good</td>
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The following additional quality indicators were inspected against during this inspection.

#### Additional quality indicators inspected (ungraded)

##### Domain 5 – Delivery of safe, effective, compassionate and person-centred care

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<td>5.2 - Assessment and management of people experiencing care</td>
<td>Patients had a thorough assessment and consultation, allowing them time to consider the risks and benefits of treatment. A comprehensive consent and documentation process was in place for information provided to patients before and after treatment, and during the surgical process itself.</td>
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##### Domain 7 – Workforce management and support

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<tr>
<td>7.1 - Staff recruitment, training and development</td>
<td>Effective systems and processes were in place to safely recruit staff, including checking clinical staff’s professional registration and revalidation status. Induction, mandatory training and appraisal programmes were in place.</td>
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</table>
Grades may change after this inspection due to other regulatory activity. For example, if we have to take enforcement action to improve the service or if we investigate and agree with a complaint someone makes about the service.

More information about grading can be found on our website at:
http://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/ihc_inspection_guidance/inspection_methodology.aspx

Further information about the Quality Framework can also be found on our website at:

What action we expect Signature Medical Glasgow Ltd to take after our inspection

This inspection resulted in three recommendations. See Appendix 1 for a full list of the recommendations.

An improvement action plan has been developed by the provider and is available on the Healthcare Improvement Scotland website:
www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/independent_healthcare/find_a_provider_or_service.aspx

We would like to thank all staff at Signature Clinic for their assistance during the inspection.
2 What we found during our inspection

Service delivery

This section is where we report on how safe the service is.

Domain 5 – Delivery of safe, effective, compassionate and person-centred care

High performing healthcare organisations are focused on safety and learning to take forward improvements, and put in place appropriate controls to manage risks. They provide care that is respectful and responsive to people’s individual needs, preferences and values delivered through appropriate clinical and operational planning, processes and procedures.

Our findings

Quality indicator 5.1 - Safe delivery of care

The environment was clean and well maintained. Good systems were in place to make sure patients and staff were kept safe. Audits were carried out reviewing key aspects of care and treatment. Although a wide range of risk assessments were regularly carried out, a risk register would give an overview of the service’s risk assessments.

The environment and clinical areas were clean and well maintained. All equipment was in a good state of repair. We saw good compliance with infection prevention and control procedures, in line with the service’s infection prevention and control policy. Single-use personal protective equipment (such as gloves and aprons) and medical devices (such as syringes) were used to prevent the risk of cross-infection. The service had an up-to-date contract for the safe disposal of sharps and other clinical waste.

We saw the service’s policies had recently been updated. This included the service’s public protection (safeguarding) policy. This provided clear guidance for staff should they have concerns about a patient.

A safe system was in place for prescribing, storing and administering medicines in the service. All medicines were stored securely in locked cupboards or medical refrigerators in the theatre areas. The temperature of the refrigerators was monitored and recorded to make sure they were maintained at a safe level. The service stored supplies of local anaesthetics appropriately. We saw an appropriately stocked emergency trolley, with emergency equipment and medications, including a defibrillator. We saw that the equipment and medications was checked every week.
Decontamination (cleaning) processes were carried out in the service’s decontamination unit. This was a dedicated decontamination room used for cleaning, sterilising and packaging reusable surgical instruments. The room was divided into clean and dirty areas, ensuring that dirty and clean instruments were kept separate during the decontamination process. Following sterilisation, instruments were placed in pouches and stored until required. All pouches were dated with an expiry date of 6 months from completion of the sterilisation process. Appropriate personal protective equipment was available for staff when carrying out the decontamination process. We saw that daily tests of equipment used in the decontamination process were recorded in a log book. The manager told us that two healthcare assistants were trained in the decontamination process and were responsible for the daily and weekly checks of the decontamination room. We were told that all machinery used in the decontamination process had regular maintenance checks carried out in line with the manufacturer’s guidance.

We saw monthly audits carried out on fire safety, patient care records, and infection prevention and control practices. The service completed both daily cleaning and weekly deep cleaning schedules to show that the required cleaning had taken place. Cleaning products and equipment were stored and used appropriately. We saw that environmental audits were carried out regularly in the theatre area, including auditing the management of blood and bodily fluid spillages.

Feedback from our online survey showed that patients were satisfied with the cleanliness of the environment. Comments included:

- ‘Clinic is clean and I felt safe.’
- ‘Clean and modern.’

Staff we spoke with described the arrangements for reviewing significant incidents and how any shared learning from these was used to promote patient safety and wellbeing. We were told no significant incidents had occurred in the service. A duty of candour policy was in place (where healthcare organisations have a professional responsibility to be honest with patients when things go wrong). The service’s annual duty of candour report was available in the reception area. This detailed that no incidents had triggered the need to act on duty of candour principles.

A comprehensive programme of risk assessments was carried out on a range of aspects, for example staff moving and handling, COVID-19, clinical waste and challenging behaviour. All risk assessments were reviewed every year, where appropriate.
What needs to improve

The service did not gather and record all of the risk assessments carried out into a single risk register. This would help to capture details of all risks and their potential impact, who is responsible for managing each risk, the risk response measures put in place to respond to each risk, and review dates for the risk assessments (recommendation a).

Monthly stocktaking of single-use patient equipment and medicines took place to ensure these items were within their expiry dates. We discussed with the service how the checklist could be further improved to list individual items to be checked and signed by staff. This would reduce the chance of missing any items. We will follow this up at a future inspection.

- No requirements.

Recommendation a

- The service should ensure risk assessments are recorded in a risk register covering corporate and clinical risks.

Our findings

Quality indicator 5.2 - Assessment and management of people experiencing care

Patients had a thorough assessment and consultation, allowing them time to consider the risks and benefits of treatment. A comprehensive consent and documentation process was in place for information provided to patients before and after treatment, and during the surgical process itself.

The patient assessment process was carried out in three stages. The initial online appointment was with the service’s medical consultant. This gave patients the opportunity to discuss and consider the appropriate treatments available to them. The second stage was a telephone call with the surgeon, before the final face-to-face consultation with the surgeon. These stages would be carried out over a number of weeks allowing the patient time to decide on the best option for them.

We reviewed four electronic patient care records. We saw a comprehensive process of documenting patient information and the consultation processes. Patient information included documenting the patient’s GP and next of kin contact details. We saw detailed information on allergies, past medical history, current medicine history and social history covering alcohol intake, smoking and a psychological assessment.
Each patient had a documented treatment plan, initially carried out by the medical consultant and confirmed by the surgeon. The cost of the treatment and payment plan was documented in the patient care records.

Each patient had a detailed consent process carried out. This included:

- the risks and benefits of the treatment
- consent to treatment
- consent to sharing information with other healthcare professionals
- consent to photographs being taken, and
- consent to photographs being shared on social media.

On the day of the surgical treatment, we saw that each patient’s physical observations, for example temperature, pulse and blood pressure were documented before and after treatment by the healthcare assistant. A pre-operative checklist was completed which included further checks such as consent processes, current medicines and allergies.

Before surgery, the team carried out a ‘surgical pause’ in line with the World Health Organization (WHO) guidelines. This involved the team re-checking the patient’s identity, the procedure to be carried out and that all appropriate processes were in place before surgery took place. We saw this documented in each patient care record we reviewed.

The operation notes were completed in each patient care record we reviewed. This included documenting the medicines used during the procedure, including batch number, expiry date and volume used with appropriate signature of the surgeon. Following the procedure, staff completed an aftercare checklist for the patient that covered dietary intake, exercise and how to look after their dressings. The patient received an aftercare pack which may include medicines prescribed by the surgeon, for example antibiotics. We were told any medicines provided were appropriately labelled with instructions on when to take them. In each patient care record we reviewed, aftercare checklists had been signed and dated by the patient. A copy of the aftercare checklist was then given to the patient before they left the clinic. The patient was also given contact details for the out-of-hours on-call clinician.

The service was registered with the Information Commissioner’s Office (ICO) (an independent authority for data protection and privacy rights) to ensure the safe storage of confidential patient information.
Patients who completed our online survey confirmed they were fully involved in any decisions reached about their care and treatment. They also said the practitioner explained the risks, benefits and any potential side effects from the treatment before they agreed to go ahead. Comments included:

- ‘They answered all of my questions and talked me through the treatment from start to finish.’
- ‘Staff talked me through everything.’

- No requirements.
- No recommendations.

**Domain 7 – Workforce management and support**

High performing healthcare organisations have a proactive approach to workforce planning and management, and value their people supporting them to deliver safe and high quality care.

**Our findings**

**Quality indicator 7.1 - Staff recruitment, training and development**

Effective systems and processes were in place to safely recruit staff, including checking clinical staff’s professional registration and revalidation status. Induction, mandatory training and appraisal programmes were in place.

We saw that the service had followed its recruitment and staff selection policy from the five staff files we reviewed. This included staff granted practicing privileges (staff not employed by the provider but given permission to work in the service). Pre-employment checks such as proof of identity, the right to work in the UK, qualifications, occupational health screening and references had been carried out. Staff files contained job descriptions, interview records and signed contracts of employment. We saw processes in place to ensure staff had up-to-date Protecting Vulnerable Groups (PVG) background checks and maintained their registration and insurance. Staff had clear roles, responsibilities and accountabilities.

In 2021, the service employed a human resources (HR) manager to provide support with staff recruitment and staff training. The HR manager was responsible for ensuring that all the appropriate checks had been completed before employing staff or granting practicing privileges. An electronic system was used to monitor when checks were due, such as for professional registration, PVG and insurance. We saw that all staff files had appropriate up-to-date checks in place.
An induction programme for new staff included a 6-month general and role-specific induction and probation period under the supervision of their line manager. This included an online training and education package, hands-on training, and a period of shadowing and supervision. Mandatory topics covered training and policies relevant to staff, such as infection prevention and control, fire safety, basic life support and public protection (safeguarding).

We saw evidence of an ongoing mandatory training programme for staff. This ensured staff maintained their skills and knowledge in a number of areas. An electronic training matrix helped to organise and manage training, and was used to record attendance and completion of online training. Completion of training was monitored to make sure that all staff were up to date and had the necessary knowledge and skills to do their role. Clear actions were in place for addressing any outstanding training requirements. We saw that all staff were up to date with their training requirements.

The service had implemented a staff appraisal policy and we found that an effective appraisal process was in place. We saw evidence that staff, including those granted practicing privileges, had regular formal appraisals. This provided staff with an opportunity to reflect on their personal and professional development and ensure they were on track to achieve their learning goals. The appraisal process also helped feed into the planning of the training matrix.

Annual professional registration and revalidation status checks were carried out for all clinical staff. Revalidation is where clinical staff are required to gather evidence of their competency, training and feedback from patients and peers to their professional body, such as the Nursing and Midwifery Council, every 3 years.

**What needs to improve**
A supervision structure (a formal process of support and learning) was in place and staff had regular planned one-to-one supervision sessions with their manager during their probationary period. Additional, ongoing supervision sessions could be carried out if these were felt to be required either by the staff member or their manager. We suggested the service should formally introduce planned regular clinical supervision sessions post-probation to ensure staff had the skills and knowledge to continue to undertake their role. We will follow this up at a future inspection.

- No requirements.
- No recommendations.
Vision and leadership

This section is where we report on how well the service is led.

Domain 9 – Quality improvement-focused leadership

High performing healthcare organisations are focused on quality improvement. The leaders and managers in the organisation drive the delivery of high quality, safe, person-centred care by supporting and promoting an open and fair culture of continuous learning and improvement.

Our findings

Quality indicator 9.4 - Leadership of improvement and change

A clearly defined leadership and governance structure was in place, with systems and processes to monitor the quality of care delivered. A range of staff and senior management meetings were held. The service acted on lessons learned from audits and feedback, and was responsive to making changes to practice in line with its quality improvement plan. Staff meeting minutes should be shared with staff.

The service had a clear governance process in place. The senior management team appeared to be enthusiastic and motivated. They were keen to provide evidence of the changes they had made to improve the quality of care. A key focus of the senior management team was to promote the education, practice development and leadership of staff.

The service demonstrated a proactive approach to measuring its performance and improving the quality of care it provided. A quality improvement plan set out the key objectives and priorities for the service to deliver its goals in line with its annual strategic plan. The clinical governance policy detailed the quality assurance measures, with activities recorded on the service’s electronic reporting system. This included gathering information on incidents, complaints, audits and patient feedback.

The service held regular staff meetings. This included monthly senior management team meetings and staff team meetings. The clinical governance team met every 3 months where the quality of the service being provided and surgical outcomes were standing items on the agenda. Action plans with clear timeframes for completion were in place for areas identified for improvement and senior staff had clear areas of responsibility for actions.
Patient feedback was collated and reviewed by the senior management team to identify any trends or potential improvements in how the service was delivered. For example, in response to patient feedback, the service had developed standard written aftercare to provide patients with clear and consistent information.

An external private company supported the provider to meet regulatory standards and best practice guidance. This company provided an overview of the service’s performance and identified any areas for improvement. For example, this had resulted in the service updating a number of its policies and procedures.

The senior management team carried out regular walkrounds of the service. These included checking equipment and compliance with policies and procedures, and checking on staff wellbeing. The findings of the walkrounds were recorded and action plans developed for any areas of improvement identified.

Staff could nominate other staff members as part of a recognition programme, for example for going above and beyond their job role. Staff were encouraged to write positive comments about their colleagues and recognition could be given to the staff member.

The service is a Scottish branch of a national provider and benchmarked itself against other clinics for different aspects of service provision, for example cleanliness, medication management, and infection prevention and control. This provided support, enabled the service to assess its performance against similar services and identify any areas for improvement.

**What needs to improve**

Benchmarking data was only verbally fed back to the senior management team by the staff involved (recommendation b).

Minutes from staff meetings were not shared with staff (recommendation c).

Although staff meetings were held, and one-to-one support was available, the senior management team had recognised that there was no formal mechanism for staff to express their views individually or anonymously. We were told a staff survey had been developed and was scheduled to be shared with staff later in the year. We will follow this up at a future inspection.
No requirements.

**Recommendation b**
- The service should document benchmarking data to enable effective collation of data and tracking of results.

**Recommendation c**
- The service should share minutes of staff meetings with all staff to make sure those not attending are kept informed.
Appendix 1 – Requirements and recommendations

The actions that Healthcare Improvement Scotland expects the independent healthcare service to take are called requirements and recommendations.

- **Requirement:** A requirement is a statement which sets out what is required of an independent healthcare provider to comply with the National Health Services (Scotland) Act 1978, regulations or a condition of registration. Where there are breaches of the Act, regulations, or conditions, a requirement must be made. Requirements are enforceable at the discretion of Healthcare Improvement Scotland.

- **Recommendation:** A recommendation is a statement that sets out actions the service should take to improve or develop the quality of the service but where failure to do so will not directly result in enforcement.

### Domain 5 – Delivery of safe, effective, compassionate and person-centred care

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<thead>
<tr>
<th>Requirements</th>
<th>None</th>
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<tbody>
<tr>
<td><strong>Recommendation</strong></td>
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<td>a</td>
<td>The service should ensure risk assessments are recorded in a risk register covering corporate and clinical risks (see page 9).</td>
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Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19

### Domain 9 – Quality improvement-focused leadership

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## Domain 9 – Quality improvement-focused leadership (continued)

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Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19
Appendix 2 – About our inspections

Our quality of care approach and the quality framework allows us to provide external assurance of the quality of healthcare provided in Scotland.

Our inspectors use this approach to check independent healthcare services regularly to make sure that they are complying with necessary standards and regulations. Inspections may be announced or unannounced.

We follow a number of stages to inspect independent healthcare services.

Before inspections

Independent healthcare services submit an annual return and self-evaluation to us.

We review this information and produce a service risk assessment to determine the risk level of the service. This helps us to decide the focus and frequency of inspection.

During inspections

We use inspection tools to help us assess the service.

Inspections will be a mix of physical inspection and discussions with staff, people experiencing care and, where appropriate, carers and families.

We give feedback to the service at the end of the inspection.

After inspections

We publish reports for services and people experiencing care, carers and families based on what we find during inspections. Independent healthcare services use our reports to make improvements and find out what other services are doing well. Our reports are available on our website at: www.healthcareimprovementscotland.org

We require independent healthcare services to develop and then update an improvement action plan to address the requirements and recommendations we make.

We check progress against the improvement action plan.

More information about our approach can be found on our website: www.healthcareimprovementscotland.org/our_work/governance_and_assurance/quality_of_care_approach.aspx
Complaints

If you would like to raise a concern or complaint about an independent healthcare service, you can complain directly to us at any time. However, we do suggest you contact the service directly in the first instance.

Our contact details are:

Healthcare Improvement Scotland
Gyle Square
1 South Gyle Crescent
Edinburgh
EH12 9EB

Telephone: 0131 623 4300

Email: his.ihcregulation@nhs.scot
You can read and download this document from our website. We are happy to consider requests for other languages or formats. Please contact our Equality and Diversity Advisor on 0141 225 6999 or email his.contactpublicinvolvement@nhs.scot