Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Announced Inspection Report: Independent Healthcare

Service: The Skin and Face Place, East Kilbride

Service Provider: The Skin and Face Place (Scotland) Ltd

23 January 2024

NHS SCOTLAND

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.contactpublicinvolvement@nhs.scot

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www.healthcareimprovementscotland.org

Contents

1 Progress since our last inspection

What the service had done to meet the recommendations we made at our last inspection on 10 March 2020

Recommendation

The service should continue to develop its participation approach to demonstrate how feedback from patients is used to improve the quality of the service.

Action taken

Patients were encouraged to leave feedback on a social media platform. However, no method to obtain structured feedback was in place. This recommendation is reported in Domain 3 (Co-design, co-production) (see recommendation d on page 17).

Recommendation

The service should implement a programme of regular audits to cover key aspects of care and treatment. Audits should be documented and improvement action plans implemented.

Action taken

We saw evidence of an audit of employed staff's patient care records carried out every 6 months. However, similar audits did not take place of patient care records for staff working under practicing privileges in the service (staff not employed directly by the provider but given permission to work in the service). No other type of audit was carried out, such as environmental or medicines management. This recommendation is reported in Domain 5 (Planning for quality) (see recommendation k on page 22).

Recommendation

The service should ensure that appropriate re-assessments are carried out to check that no changes have occurred to a patient's health or medications since their last treatment. Re-assessments should be documented in patient care records.

Action taken

We saw documented evidence in the patient care records of appropriate re-assessments taking place. Patients were asked if anything had changed since their last appointment and were asked to complete a medical history form and consent form at each new appointment.

2 A summary of our inspection

Background

Healthcare Improvement Scotland is the regulator of independent healthcare services in Scotland. As a part of this role, we undertake risk-based and intelligence-led inspections of independent healthcare services.

Our focus

The focus of our inspections is to ensure each service is person-centred, safe and well led. We evaluate the service against the National Health Services (Scotland) Act 1978 and regulations or orders made under the Act, its conditions of registration and Healthcare Improvement Scotland's Quality Assurance Framework. We ask questions about the provider's direction, its processes for the implementation and delivery of the service, and its results.

About our inspection

We carried out an announced inspection to The Skin and Face Place on Tuesday 23 January 2024. We received feedback from 46 patients through an online survey we had asked the service to issue to its patients for us before the inspection.

Based in East Kilbride, The Skin and Face Place is an independent clinic providing non-surgical treatments.

The inspection team was made up of one inspector.

What we found and inspection grades awarded

For The Skin and Face Place, the following grades have been applied.

Direction	*How clear is the service's vision and purpose and how supportive is its leadership and culture?*
Summary findings	**Grade awarded**
The service's vision statement should be shared with patients and staff. Governance of practicing privileges staff must be implemented. Key performance indicators should include monitoring the safe care and treatment of patients. Staff meetings should be formalised.	Unsatisfactory
Implementation and delivery	*How well does the service engage with its stakeholders and manage/improve its performance?*
Staff kept up to date with developments in the aesthetics industry. Medicines governance processes, including obtaining informed consent from patients, must be followed and a medicines management policy developed. A risk register would help to manage and reduce risks in the service. An appraisal system must be implemented to review staff performance and development.	Unsatisfactory
Results	*How well has the service demonstrated that it provides safe, person-centred care?*
The environment was clean and well equipped. Patient care was well documented. Appropriate recruitment and ongoing checks on all staff must be carried out. A risk assessment must be carried out on the clinical hand wash basins.	Unsatisfactory

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 Assurance Framework can also be found on our website at:
https://www.healthcareimprovementscotland.org/scrutiny/the_quality_assurance_system.aspx

What action we expect The Skin and Face Place (Scotland) Ltd to take after our inspection

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.

Recommendation: A recommendation is a statement which sets out what a service should do in order to align with relevant standards and guidance.

This inspection resulted in eight requirements and 11 recommendations.

Direction	
Requirement	
1	The provider must develop and follow a practicing privileges policy and have practicing privileges contracts that describe the governance procedures in place to ensure safe delivery of care with individual responsibility and accountability clearly identified and agreed (see page 15). Timescale – immediate *Regulation 12(d)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
Recommendations	
a	The service should share its vision and purpose statement with patients and staff (see page 14). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19

Direction (continued)	
Recommendations	
b	The service should further develop the key performance indicators to include monitoring the safe care and treatment of patients (see page 14). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19
c	The service should formalise its staff meetings, with a record of discussions and decisions reached at these meetings kept. These should detail staff responsible for taking forward any actions (see page 15). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19

Implementation and delivery	
Requirements	
2	The provider must develop a formal role-specific induction package for all staff to evidence that they have the appropriate support to gain the knowledge and skills required for their role (see page 20). Timescale – by 8 July 2024 *Regulation 12(a)(d)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
3	The provider must introduce regular one-to-ones and annual appraisals to allow all staff the opportunity to discuss progress in their role or any concerns (see page 20). Timescale – by 8 July 2024 *Regulation 12(c)(i)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*

Implementation and delivery (continued)	
Requirements	
4	The provider must ensure that when unlicensed medicines are used that appropriate medicine governance arrangements are in place, including documented rationale for use and informed patient consent (see page 20). Timescale – by 8 July 2024 *Regulation 3(d)(iv)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
5	The provider must develop a medicines management policy that describes how medicines will be safely managed in the service (see page 20). Timescale – by 8 July 2024 *Regulation 3(d)(iv)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
6	The provider must develop effective systems that demonstrate the proactive management of risks to patients and staff (see page 22). Timescale – by 8 July 2024 *Regulation 13(2)(a)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
Recommendations	
d	The service should implement a structured approach to gathering and analysing patient feedback to demonstrate the impact of improvements made. Patients should be informed of the changes made as a result of their feedback (see page 17). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.8 This was previously identified as a recommendation in the March 2020 inspection report for The Skin and Face Place.

Implementation and delivery (continued)	
Recommendations	
e	The service should develop and implement a process to actively seek the views of staff working in the service (see page 17). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19
f	The service should regularly review all its policies and procedures and ensure they are up to date with current standards, legislation and guidance (see page 20). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.11
g	The service should develop and implement a safeguarding (public protection) policy (see page 20). Health and Social Care Standards: My support, my life. I have confidence in the people who support and care for me. Statement 3.20
h	The service should produce and publish an annual duty of candour report (see page 21). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19
i	The service should develop a list of mandatory training for staff to complete. This should include clinical training to ensure patient safety, as well as governance procedures such as: - complaints management - duty of candour - obtaining informed consent, and - safeguarding (see page 21). Health and Social Care Standards: My support, my life. I have confidence in the people who support and care for me. Statement 3.14

Implementation and delivery (continued)	
Recommendations	
j	The service should develop and implement a quality improvement plan to formalise and direct the way it drives and measures improvement (see page 22). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19
k	The service should develop an audit programme to include audits of: a) all patient care records b) the clinic environment and equipment c) staff files, and d) medicines management (see page 22). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19 This was previously identified as a recommendation in the March 2020 inspection report for The Skin and Face Place.

Results	
Requirements	
7	The provider must develop a risk assessment for the use of the non-compliant clinical hand wash basins in the treatment rooms and implement the appropriate controls until compliant sinks can be installed, including use of an appropriate cleaning product (see page 25). Timescale – immediate *Regulation 3(d)(i)(ii)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*

Results (continued)
Requirements
8 The provider must implement effective systems that demonstrate that staff working in the service, including staff working under practicing privileges, are safely recruited, including that all staff are enrolled in the Protecting Vulnerable Groups (PVG) scheme by the service, and that key ongoing checks then continue to be carried out regularly (see page 25). Timescale – immediate *Regulation 8(1)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
Recommendations
None

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

The Skin and Face Place (Scotland) Ltd, the provider, must address the requirements and make the necessary improvements as a matter of priority.

We would like to thank all staff at The Skin and Face Place for their assistance during the inspection.

3 What we found during our inspection

Key Focus Area: Direction

Domain 1: Clear vision and purpose	Domain 2: Leadership and culture
How clear is the service's vision and purpose and how supportive is its leadership and culture?	

Our findings

The service's vision statement should be shared with patients and staff. Governance of practicing privileges staff must be implemented. Key performance indicators should include monitoring the safe care and treatment of patients. Staff meetings should be formalised.

Clear vision and purpose

The service told us that its vision and purpose was to:

- provide high quality skin care options and anti-ageing/rejuvenation treatments
- provide a high-quality client journey, and
- be a profitable business.

The clinic management software system used for appointment bookings and patient care records generated reports on the service's key performance indicators, which were:

- business growth
- finance
- patient retention, and
- new patients.

What needs to improve

The service's vision and purpose statement was not visible in the service and there was no evidence that it had been shared with patients and staff. This would help to inform them of the service's purpose and goals (recommendation a).

The key performance indicators did not include monitoring the safe care and treatment of patients, such as adverse events and compliance with clinical audits (recommendation b).

- No requirements.

Recommendation a

- The service should share its vision and purpose statement with patients and staff.

Recommendation b

- The service should further develop the key performance indicators to include monitoring the safe care and treatment of patients.

Leadership and culture

The service was owned and managed by a dentist registered with the General Dental Council who was also an experienced aesthetics practitioner. They provided visible leadership in the service. Employed staff included a dental nurse and a registered nurse. Another registered nurse and another dentist worked in the service under a practicing privileges agreement (staff not employed directly by the provider but given permission to work in the service).

All staff involved in clinical procedures were registered with an appropriate professional body such as the General Dental Council or Nursing and Midwifery Council.

A whistleblowing policy was in place that detailed the process for supporting and encouraging staff to raise concerns about suspected wrongdoing in the service.

What needs to improve

There was no practicing privileges policy and the service did not have practicing privileges contracts with those staff members. This would identify the responsibility and accountability of both the service and the staff to ensure safe delivery of care. There was no evidence that staff working under a practicing privileges arrangement were subject to management and oversight to ensure their compliance with the service's policies and procedures. Staff working under practicing privileges managed and retained their own patient care records, and the manager did not have access to these records to ensure the treatments provided were safe and the records were fully documented (requirement 1).

We were told there was good face-to-face communication between the team and through using an online team chat group. However, there was no evidence of any formal communication. Although we were told that staff meetings took place, there was no documented evidence of the meetings (recommendation c).

Requirement 1 – Timescale: immediate

- The provider must develop and follow a practicing privileges policy and have practicing privileges contracts that describe the governance procedures in place to ensure safe delivery of care with individual responsibility and accountability clearly identified and agreed.

Recommendation c

- The service should formalise its staff meetings, with a record of discussions and decisions reached at these meetings kept. These should detail staff responsible for taking forward any actions.

Key Focus Area: Implementation and delivery

Domain 3: Co-design, co-production	Domain 4: Quality improvement	Domain 5: Planning for quality
How well does the service engage with its stakeholders and manage/improve its performance?		

Our findings

Staff kept up to date with developments in the aesthetics industry. Medicines governance processes, including obtaining informed consent from patients, must be followed and a medicines management policy developed. A risk register would help to manage and reduce risks in the service. An appraisal system must be implemented to review staff performance and development.

Co-design, co-production *(patients, staff and stakeholder engagement)*
The manager told us the service's website had been taken down to make improvements. We were told it would provide information on the types of treatments available, the procedures, risks and benefits, and costs. In the meantime, information leaflets were available in the service and information was available on the appointment booking system.

Following an appointment, patients received an email encouraging them to provide feedback through an online review forum. We saw evidence that all reviews were positive and responded to by the manager. We also saw that social media had been used to ask patients specific questions, such as their opinions on the service's opening times and introducing new treatments.

What needs to improve

During the previous inspection, we were told that a feedback form had been developed and would be given to patients to complete after their treatment. We found no feedback form was in use during this inspection. While the online method used to gather patient feedback was useful, it was difficult for the service to draw any conclusions or identify trends that could be used to help improve the service. This was a previous recommendation in our March 2020 inspection. We also found that any changes made as a result of feedback were not fed back to patients (recommendation d).

Staff did not have a way to formally provide structured feedback about any improvements or changes that would benefit the service, such as through a staff survey (recommendation e).

- No requirements.

Recommendation d

- The service should implement a structured approach to gathering and analysing patient feedback to demonstrate the impact of improvements made. Patients should be informed of the changes made as a result of their feedback.

Recommendation e

- The service should develop and implement a process to actively seek the views of staff working in the service.

Quality improvement

We saw that the service clearly displayed its Healthcare Improvement Scotland registration certificate and was providing care in line with its agreed conditions of registration.

The service was aware that, as a registered independent healthcare service, it had a duty to report certain matters to Healthcare Improvement Scotland, as detailed in our notifications guidance.

An infection prevention and control policy detailed the standard precautions that would be taken to reduce the risks of infection, such as hand hygiene and the use of personal protective equipment (such as disposable aprons, gloves and face masks). A waste contract was in place to make sure that clinical waste was disposed of appropriately.

A health and safety policy described how the service would meet its responsibilities to ensure the health, safety and welfare of its employees, patients and the public.

There was a process in place to document and report accidents and incidents. We were told none had taken place to date.

A yearly fire risk assessment was carried out. Fire safety signage was displayed, and fire safety equipment was in place and checked. The fixed electrical wiring and portable electrical appliances had received appropriate safety checks.

The service delivered laser therapy skin treatments to patients. Laser equipment was well managed and treatments documented in the patient care records. A laser protection advisor had provided the service with appropriate local rules to be followed for the safe use of lasers. Staff had completed core of knowledge training for the use of the lasers and appropriate control measures were in place such as safety signage and eye goggles.

Medicines were stored in locked cupboards and a locked fridge. The fridge temperature was monitored to make sure medicines were stored at the appropriate temperature. Emergency medicines were easily accessible and checked every week. We saw a checklist in place for staff to complete for medicines stock. Protocols to deal with medical and aesthetic emergencies were displayed in the treatment rooms for staff to follow in such an event.

A consent policy detailed how consent would be obtained from patients. Patients received a face-to-face consultation with the practitioner. Patients could request a second consultation if required. A cooling-off period allowed patients to fully consider the information they had been given during the consultation before proceeding with the procedure, if required. Discussions at the consultations included:

- expected outcomes of treatment
- medical history
- risks and side effects, and
- aftercare.

Aftercare information given to patients included contact details for the service, if they had any queries or concerns following their treatment.

Patient care records were stored on a password-protected electronic database. The service was registered with the Information Commissioner's Office (an independent authority for data protection and privacy rights) to make sure confidential patient information was safely stored.

A duty of candour policy was in place (where healthcare organisations have a professional responsibility to be honest with people when something goes wrong).

The service's complaints management process was displayed in the reception area. The complaints information made clear that patients could make a complaint to Healthcare Improvement Scotland at any time. The service told us no complaints had been received since registering with Healthcare Improvement Scotland in March 2018.

We saw that the manager had presented at a conference for dental professionals about complications in aesthetic treatments in 2023. Clinical staff attended conferences and aesthetic industry training events. This made sure that the service kept up to date with changes in the aesthetics industry, legislation and best practice guidance. A staff member we spoke with confirmed many opportunities were provided for additional training for personal development.

What needs to improve

There was no evidence of a formal induction for new staff to make sure they had the appropriate support to gain the knowledge and skills required for their role (requirement 2).

There was also no evidence of one-to-one meetings or formal appraisals taking place to make sure staff's performance was documented and evaluated (requirement 3).

We saw the service used bacteriostatic saline to reconstitute the vials of botulinum toxin; this is when a liquid solution is used to turn a dry substance into a specific concentration of solution. The bacteriostatic saline used is an unlicensed product and the use of this instead of normal saline for reconstitution means that the botulinum toxin is being used outwith its Summary of Product Characteristics and is therefore termed as unlicensed use. We were told this provided better pain relief for patients. However, there was no evidence in the patient care record that the use of unlicensed bacteriostatic saline and the unlicensed use of botulinum toxin had been discussed with patients or that informed consent had been sought before treatment was administered (requirement 4).

The service did not have a medicines management policy that would describe how medicines would be procured, received, stored, prescribed, transported, administered and disposed of (requirement 5).

The service had developed some policies and procedures for the safety, care and treatment of patients and staff. However, many contained out-of-date information in relation to staff in the service, current standards and website links to national guidance (recommendation f).

There was no safeguarding (public protection) policy. A safeguarding policy (which should include details of the local safeguarding contact) would make sure that a clear protocol was in place to respond to any adult protection concerns (recommendation g).

Services are required to produce and publish a yearly duty of candour report, even where the duty of candour has not been invoked. The report should contain information about staff training on duty of candour (recommendation h).

We were told the service had not had any instances requiring the need to implement duty of candour principles. However, the service could not be assured of this as we saw no evidence that staff had completed duty of candour training. We also saw no evidence of staff training for:

- complaints management
- obtaining informed consent, and

safeguarding (recommendation i).

Requirement 2 – Timescale: by 8 July 2024

- The provider must develop a formal role-specific induction package for all staff to evidence that they have the appropriate support to gain the knowledge and skills required for their role.

Requirement 3 – Timescale: by 8 July 2024

- The provider must introduce regular one-to-ones and annual appraisals to allow all staff the opportunity to discuss progress in their role or any concerns.

Requirement 4 – Timescale: by 8 July 2024

- The provider must ensure that when unlicensed medicines are used that appropriate medicine governance arrangements are in place, including documented rationale for use and informed patient consent.

Requirement 5 – Timescale: by 8 July 2024

- The provider must develop a medicines management policy that describes how medicines will be safely managed in the service.

Recommendation f

- The service should regularly review all its policies and procedures and ensure they are up to date with current standards, legislation and guidance.

Recommendation g

- The service should develop and implement a safeguarding (public protection) policy.

Recommendation h

- The service should produce and publish an annual duty of candour report.

Recommendation i

- The service should develop a list of mandatory training for staff to complete. This should include clinical training to ensure patient safety, as well as governance procedures such as:
  - complaints management
  - duty of candour
  - obtaining informed consent, and
  - safeguarding.

Planning for quality

The service had a contingency plan in place with another Healthcare Improvement Scotland registered service in case of emergencies, such as:

- flood
- power failure, or
- sickness.

This arrangement would provide patients with an option to continue their treatment plans with an alternative practitioner.

Appropriate insurances were in-date, such as public and employer liability insurance, and these were displayed in the service.

What needs to improve

The service did not have a structured process in place to manage risk. All risks to patients and staff must be effectively managed. This includes developing a register of risk assessments that will be regularly reviewed and updated (requirement 6).

Quality improvement is a structured approach to evaluating performance, identifying areas for improvement and taking corrective actions. While we were told of improvement activities, the service had not documented these in a quality improvement plan (recommendation j).

The manager carried out audits of patient care records completed by the employed staff every 6 months to ensure they had been fully completed. We saw that actions were taken as a result of the findings. However, the manager did not have access to the patient care records of the staff working in the service under practicing privileges. Therefore, they could not be assured that all the required information had been documented. The service also did not carry out audits on:

staff files (to make sure all recruitment and ongoing checks could be evidenced)

- environment and equipment (to ensure compliance with infection prevention and control, and health and safety), and

medicines management (to ensure medicines were stored, prescribed, administered and disposed of appropriately).

This was a recommendation at our previous inspection in March 2020 (recommendation k).

Requirement 6 – Timescale: by 8 July 2024

- The provider must develop effective systems that demonstrate the proactive management of risks to patients and staff.

Recommendation j

- The service should develop and implement a quality improvement plan to formalise and direct the way it drives and measures improvement.

Recommendation k

- The service should develop an audit programme to include audits of:
  a) all patient care records
  b) the clinic environment and equipment
  c) staff files, and
  d) medicines management.

Key Focus Area: Results

Domain 6: Relationships	Domain 7: Quality control
How well has the service demonstrated that it provides safe, person-centred care?	

Our findings

The environment was clean and well equipped. Patient care was well documented. Appropriate recruitment and ongoing checks on all staff must be carried out. A risk assessment must be carried out on the clinical hand wash basins.

Every year, we ask the service to submit an annual return. This gives us essential information about the service such as composition, activities, incidents and accidents, and staffing details. The service submitted an annual return, as requested. As part of the inspection process, we ask the service to submit a self-evaluation. The questions in the self-evaluation are based on our Quality Assurance 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. The service submitted a limited self-evaluation.

The clinic environment appeared modern, clean and well-equipped. Equipment was in good condition. Cleaning of the treatment rooms and equipment was carried out between patient appointments, as well as a full clean of the clinic every day. All patients who responded to our online survey said they were satisfied with the facilities and equipment in the environment they were treated in. Comments included:

- 'Private, clean and safe clinic.'
- 'Very clean and professional clinic premises.'

Measures were in place to reduce the risk of infection and cross-contamination. For example, the service had a good supply of personal protective equipment and alcohol-based hand gel.

The four patient care records we reviewed showed that comprehensive assessments and consultations were carried out before treatment started. These included taking a full medical history with details of any health conditions, medications, allergies and previous treatments. At further appointments, patients were reassessed and asked about any changes in their medical history.

Records were kept of each treatment session, including a diagram of the area that had been treated for aesthetic treatments, and before and after digital images. Dosage and medicine batch numbers were also recorded for each treatment. Patients were given verbal and written aftercare advice. This was recorded in patient care records.

We saw evidence of the consideration of body dysmorphia when speaking with patients. Body dysmorphia is a mental health condition where a person spends a lot of time worrying about flaws in their appearance.

All patients who responded to our online survey told us they had received adequate information about their procedure and felt involved in the decisions about their care. They also confirmed they were given time to consider all the provided information before having a procedure. Comments included:

- 'Consistently given expert advice to allow me to make an informed decision.'
- 'I'm always given comprehensive information before, during and after consultation and can ask questions at any point.'
- 'Initial consultation then encouraged to go away and think about whether or not to proceed.'

All patients who responded to our online survey felt they were treated with dignity and respect. They also confirmed that they had confidence in the staff:

- 'Friendly professional staff.'
- 'Information is available about qualifications of professionals carrying out treatments.'

What needs to improve

The service had non-compliant clinical hand wash basins in the treatment rooms. No risk assessment had been carried out to help mitigate the risks and an incorrect cleaning product was being used to clean them (requirement 7).

We reviewed the staff files of three staff members, including one under a practicing privileges arrangement. Some recruitment information was held in the files such as insurance policies and aesthetic training certificates. However, not all staff files contained the relevant information that would demonstrate checks had been carried out to make sure they had been safely recruited. For example, not all staff files contained:

- occupational health status
- professional registration

- proof of identity, and
- references.

We also saw no evidence that yearly checks of staff members' professional registration status had been carried out. We also found that the service had not enrolled its employees in the Protecting Vulnerable Groups (PVG) scheme. At recruitment, the service requested the employees provide evidence of their own Disclosure Scotland check. This means that the service would not be directly notified of any PVG updates to ensure staff remain safe to work in the service. The PVG scheme, managed by Disclosure Scotland, helps to ensure people who are unsuitable to work with children and protected adults cannot do regulated work with these vulnerable groups (requirement 8).

Requirement 7 – Timescale: immediate

- The provider must develop a risk assessment for the use of the non-compliant clinical hand wash basins in the treatment rooms and implement the appropriate controls until compliant sinks can be installed, including use of an appropriate cleaning product.

Requirement 8 – Timescale: immediate

- The provider must implement effective systems that demonstrate that staff working in the service, including staff working under practicing privileges, are safely recruited, including that all staff are enrolled in the Protecting Vulnerable Groups (PVG) scheme by the service, and that key ongoing checks then continue to be carried out regularly.

- No recommendations.

Appendix 1 – About our inspections

Our quality assurance system and the quality assurance framework allow us to provide external assurance of the quality of healthcare provided in Scotland.

Our inspectors use this system 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.

Before

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.

During

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.

After

More information about our approach can be found on our website: https://www.healthcareimprovementscotland.org/scrutiny/the_quality_assurance_system.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.
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Please contact our Equality and Diversity Advisor on 0141 225 6999
or email his.contactpublicinvolvement@nhs.scot

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