Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Announced Inspection Report: Independent Healthcare

Service: Lady A Clinic, Ayr

Service Provider: Lady A Clinic Ltd

14 February 2024

NHS SCOTLAND

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1 Progress since our last inspection

What the service had done to meet the recommendations we made at our last inspection on 2 March 2020

Recommendation

The service should further develop how it reviews and records patient feedback and engagement and uses this to drive improvement.

Action taken

The service now had a regular process of reviewing feedback every 2-3 months. Patient feedback also formed part of its key performance indicators. A 'You said, we did' board in the reception area highlighted suggestions patients had made and the service's response to them.

Recommendation

The service should carry out a risk assessment on both sinks in the treatment rooms to mitigate any risk associated with using non-compliant clinical wash hand basins.

Action taken

Risk assessments had not been completed. A new requirement has been made and is reported in Domain 7 (Quality control) (see requirement 3 on page 21).

Recommendation

The service should develop a recruitment policy to ensure the safe recruitment of future staff, and develop a staff file for the employed weekly cleaner.

Action taken

The service now had an up-to-date recruitment policy. However, although the cleaner had changed since the last inspection, there was no staff file in place for this new individual. A new requirement has been made and is reported in Domain 7 (Quality control) (see requirement 4 on page 21).

Recommendation

The service should develop improvement action plans to address issues that have been identified through its audit programme.

Action taken

The service had recently completed several clinical and non-clinical audits and had developed supporting action plans.

Recommendation

The service should ensure that all treatment episodes are stored together in one patient care record.

Action taken

Paper copies of patient care records were now stored in individual plastic folders and included each treatment episode.

Recommendation

The service should develop and implement a quality improvement plan.

Action taken

The service had not developed a quality improvement plan. This recommendation is reported in Domain 5 (Planning for quality) (see recommendation e on page 19).

Recommendation

The service should accurately record minutes of any formal meetings and include details of any actions taken and those responsible for the actions to ensure better reliability and accountability.

Action taken

Staff meetings were now being formally documented and included action plans which identified staff responsible for taking forward any actions, where applicable.

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 Lady A Clinic on Wednesday 14 February 2024. We spoke with the two lead practitioners of the service during the inspection. We received feedback from 10 patients through an online survey we had asked the service to issue to its patients for us before the inspection.

Based in Ayr, Lady A Clinic 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 Lady A Clinic, 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 and purpose was to provide a high standard of individualised care to its patients. Key performance indicators, developed from patient and staff feedback, were used to measure performance and help to inform service improvements. There was continued mentoring support from management for staff working under practicing privileges. Key performance indicators should be further developed.	✓ Satisfactory
Implementation and delivery	*How well does the service engage with its stakeholders and manage/improve its performance?*
Patient feedback was gathered through a variety of ways. A staff survey had recently been completed with mainly positive feedback. Processes were in place for managing infection prevention and control, and for safely managing medicines. Risk assessments must be developed to ensure the service is safe for patients and staff, including an up-to-date fire risk assessment. The complaints process should be easily accessible to patients. An annual duty of candour report should be developed and made available to patients. A quality improvement plan should be developed.	✓ Satisfactory
Results	*How well has the service demonstrated that it provides safe, person-centred care?*
The environment was clean and in a good state of repair. Patient information was documented appropriately in patient care records. Patient care records should include consent to share information with the next of kin in the event of an emergency. Full background checks must be completed on all staff being recruited or working under practicing privileges. A risk assessment must be carried out on the non-compliant sinks in the treatment rooms.	✓ Satisfactory

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 Lady A Clinic 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 four requirements and seven recommendations.

Direction	
Requirements	
None	
Recommendation	
a	The service should further develop a programme of measuring, recording and reviewing key performance indicators (see page 13). 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	
1	The provider must develop effective systems that demonstrate the proactive management of risks to patients and staff, including carrying out risk assessments and developing a risk register (see page 18). Timescale – immediate *Regulation 13(2)(a)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
2	The provider must develop an up-to-date fire risk assessment to demonstrate the fire safety arrangements in the service (see page 19). Timescale – immediate *Regulation 3(a)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
Recommendations	
b	The service should ensure the contact details for Healthcare Improvement Scotland included in the complaints policy are up to date (see page 17). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.20
c	The service should ensure information on how to make a complaint is easily accessible to patients (see page 17). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.20
d	The service should produce and publish an annual duty of candour report (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

Implementation and delivery (continued)

Recommendations

e The service should develop and implement a quality improvement plan to demonstrate and direct the way it measures improvement (see page 19).

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 Lady A Clinic.

Results

Requirements

3 The provider must carry out a risk assessment on the sinks in the treatment rooms to mitigate any risk associated with using non-compliant clinical wash hand basins and consider a refurbishment programme to upgrade these hand basins (see page 21).

Timescale – immediate

Regulation 3(d)(i)
The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011

This was previously identified as a recommendation in the March 2020 inspection report for Lady A Clinic.

4 The provider must ensure that all staff, including those with practicing privileges, working in a registered healthcare service have appropriate, and documented, background and safety checks in place (see page 21).

Timescale – immediate

Regulation 8
The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011

This was previously identified as a recommendation in the March 2020 inspection report for Lady A Clinic.

Results (continued)	
Recommendations	
f	The service should ensure batch numbers and expiry dates of medicines used are recorded on each individual patient care record (see page 22). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.11
g	The service should document consent to share information with the patient's next of kin in the event of an emergency in the patient care record (see page 22). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.14

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

Lady A Clinic 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 Lady A Clinic 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 and purpose was to provide a high standard of individualised care to its patients. Key performance indicators, developed from patient and staff feedback, were used to measure performance and help to inform service improvements. There was continued mentoring support from management for staff working under practicing privileges. Key performance indicators should be further developed.

Clear vision and purpose

The service told us its vision and purpose was to deliver a high standard of care and treatment tailored to the patient's needs, with patient safety and wellbeing at the centre of all decisions. Treatments were by appointment only. Staff told us they aimed to have an open conversation with patients about their expectations and needs. Appointment times were extended to allow sufficient time for the consultation.

The service had developed two main key performance indicators to measure how often patients and staff fed back to the practitioners, and then to measure how the information they received was reviewed and addressed. The results of the key performance indicators were on display in the staff room for staff to review. As a result of reviewing performance against the key performance indicator about patient feedback, a patient feedback QR code was developed and made available to patients in reception as an additional method of gathering patient feedback.

What needs to improve

The key performance indicators should be further developed to include a wider range of aspects within the service (recommendation a).

The practitioners should further develop the service's vision and purpose and make this visible to patients in the service and on social media. We will follow this up at the next inspection.

- No requirements.

Recommendation a

- The service should further develop a programme of measuring, recording and reviewing key performance indicators.

Leadership and culture

The two lead practitioners were registered nurses with one also qualified as an independent prescriber. A number of nurses worked as aesthetic practitioners under practicing privileges in the service (staff not employed directly by the provider but given permission to work in the service). Two rooms were rented out to beauty therapists providing complementary therapies.

Staff working under practicing privileges were supported by the practitioners who were always present in the service. They were encouraged to work to the same values as the practitioners by having the same length of appointment time with their patients and using the same brands of products.

A daily safety brief was carried out by the practitioners with staff. This included reviewing issues of the day, fire safety and environmental aspects. This allowed staff an opportunity to talk through any concerns or issues they may have. Each safety brief was documented and was displayed on the staff noticeboard.

What needs to improve

While there was a number of opportunities for staff to meet with the practitioners, for example daily safety briefs and meetings, the service should consider a more regular, structured programme of staff meetings. We will follow this up at our next inspection.

- No requirements.
- No recommendations.

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

Patient feedback was gathered through a variety of ways. A staff survey had recently been completed with mainly positive feedback. Processes were in place for managing infection prevention and control, and for safely managing medicines.

Risk assessments must be developed to ensure the service is safe for patients and staff, including an up-to-date fire risk assessment.

The complaints process should be easily accessible to patients. An annual duty of candour report should be developed and made available to patients. A quality improvement plan should be developed.

Co-design, co-production *(patients, staff and stakeholder engagement)*

A variety of treatment information leaflets was available in the service for patients to access. The service used social media and an online booking app that detailed treatments available and the costs. Information on each treatment allowed patients to review their options when considering the service. We were told that patients would visit for a free consultation and had the opportunity to take some time to consider the planned treatment before going ahead.

A QR code was available in the reception area for patients to scan and provide feedback through an online survey link. Patients could also provide feedback about their experience using the service's online booking app, or post feedback into a suggestions box in reception. We were told that feedback was also obtained from patients through email, social media and verbally, and that feedback received was mainly positive.

A 'You said, we did' board in reception highlighted feedback the service had received from patients and what action had been taken. Changes made to the service as a result of patient feedback included later opening hours and having a receptionist on duty during clinic times.

The service reviewed patient feedback every 2-3 months, with the results forming one of the key performance indicators of improvement in the service. The service was working to improve the number of feedback responses. The

practitioners ensured that patient and staff feedback was discussed with staff, if applicable. Staff had completed a recent staff survey which had asked specific questions about room hire and the appointment cancellation policy. Staff had fed back that they felt supported while working in the service.

- No requirements.
- No recommendations.

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 practitioners understood the process of notifying Healthcare Improvement Scotland of certain matters and events in the service, in line with our notifications guidance.

A range of policies and procedures were available to help the service deliver safe, person-centred care. This included:

- medicine management
- dealing with emergencies
- health and safety, and
- safeguarding (public protection).

The service's infection prevention and control policy referred to the standard infection control precautions in place to prevent the risk of infection. This included hand hygiene, sharps management, management of blood and bodily fluids, and use of personal protective equipment (gloves, aprons and face masks). A good supply of single-use equipment was available to prevent the risk of cross-infection. A contract was in place with a waste management company for the collection and safe disposal of clinical waste, used syringes and needles. We saw appropriate sharps bins were being used.

All medications used in the service were ordered from appropriately registered suppliers and ordered for individual patients. Systems were in place to record the expiry dates of medicines and the temperature of the dedicated clinical fridge to make sure medications were stored at the correct temperature. A small number of emergency medicines were held in stock, which were stored appropriately and were in-date.

The fire alarm was serviced every year, and appropriate fire equipment and fire safety signage was available in the service. Portable appliance testing on electrical equipment had been completed. A servicing programme was in place for the equipment that provided various advanced skin care treatments.

We saw a process of reporting incidents and accidents was in place. There had been no incidents or accidents in the service since the last inspection in March 2020.

The service had an up-to-date complaints process which included a timeline for dealing with a complaint. A brief version of the complaints process was on display in the reception area for patients to access. This highlighted that patients could contact Healthcare Improvement Scotland at any time. No complaints had been received since the last inspection in March 2020.

There was an up-to-date duty of candour policy. This is where healthcare professionals have a responsibility to be open and honest with a patient if something goes wrong. There had been no duty of candour incidents in the last year.

The service was in the process of switching from paper to electronic patient care records. Paper patient care records were stored securely in a locked cupboard in the service. The service was registered with the Information Commissioner's office (an independent authority for data protection and privacy rights).

Each patient file included the patient's contact details, GP and next of kin contact details. A past medical history questionnaire was completed and included regular medicines being taken and any allergies. The patient consultation included the patient's previous experience of aesthetic treatments, and their expectations. Consent was obtained for treatment, for taking photographs and for sharing information with other healthcare professionals.

The service had a number of nurse practitioners working under practicing privileges. We saw an up-to-date practicing privileges policy. Each nurse working under practicing privileges had a staff file that included a contract and list of recruitment checks, for example appropriate qualifications, up-to-date insurance cover and occupational health checks.

The practitioners were members of a number of national forums, for example the Complications in Medical Aesthetic Collaborative (CMAC), as well as a number of online local groups providing peer support and advice. They also had ongoing support from a plastic surgeon. They had developed a training needs review for themselves, which covered their training carried out to date and planning further training suitable for their role. We were told they were

planning to introduce a similar training needs review for the staff working under practicing privileges. Staff working under practicing privileges had a period of being mentored by the lead practitioners and regular opportunities to meet with them and discuss their development. While staff were seeing patients, the practitioners always ensured they were present in the service and available for advice.

What needs to improve

Although the complaints policy included information on contacting Healthcare Improvement Scotland, our email address was not correct (recommendation b).

Although the complaints process was on display in the service, this should be developed further to ensure patients can easily access this information in other ways (recommendation c).

Part of a provider's duty of candour responsibilities is to produce and publish duty of candour reports every year, even when duty of candour has not been triggered and to make this report available to patients (recommendation d).

- No requirements.

Recommendation b

- The service should ensure the contact details for Healthcare Improvement Scotland included in the complaints policy are up to date.

Recommendation c

- The service should ensure information on how to make a complaint is easily accessible to patients.

Recommendation d

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

Planning for quality

The service carried out a number of regular clinical and non-clinical audits including:

- a monthly fire safety audit
- patient care record audit
- medicine fridge audit
- management of sharps audit, and
- monthly medicine management audit.

For each audit we reviewed, we saw associated action plans were completed. Outcome of audits were displayed on a noticeboard in the staff room.

What needs to improve

The service did not have a structured process in place to identify and manage risk. Risk assessments would demonstrate that potential risks had been considered and that appropriate actions were in place to remove or reduce these. A risk register would also help the service to ensure appropriate processes were in place to help manage and monitor any risks identified (requirement 1).

Fire safety was discussed at the daily staff huddle. The service carried out a formal fire safety audit that included an environmental walkround every week. This was to ensure appropriate fire equipment was in place and functioning, and fire exits were clear. However, the service did not have an up-to-date fire risk assessment (requirement 2).

A quality improvement plan had still not been developed. This would help the service to structure and record its improvement processes. This had been identified as a recommendation at the previous inspection in March 2020 (recommendation e).

We were told the service had built professional relationships with other similar local services. This had included discussion about aspects of business continuity in the event the service had to close. This should be further developed into a business continuity plan. We will follow this up at future inspections.

Requirement 1 – Timescale: immediate

- The provider must develop effective systems that demonstrate the proactive management of risks to patients and staff, including carrying out risk assessments and developing a risk register.

Requirement 2 – Timescale: immediate

- The provider must develop an up-to-date fire risk assessment to demonstrate the fire safety arrangements in the service.

Recommendation e

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

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 in a good state of repair. Patient information was documented appropriately in patient care records. Patient care records should include consent to share information with the next of kin in the event of an emergency.

Full background checks must be completed on all staff being recruited or working under practicing privileges. A risk assessment must be carried out on the non-compliant sinks in the treatment rooms.

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 satisfactory self-evaluation.

The environment was clean and in a good state of repair. The service had a good supply of personal protective equipment available. We saw cleaning schedules showing that cleaning took place between patient appointments and at the end of the clinic day. Steam cleaning was carried out once a month.

We reviewed five patient care records and each one contained the patient's name, date of birth and contact details. We also saw that patients were asked for their GP and next of kin contact details.

A treatment plan was developed between the patient and practitioner, and included information on previous treatments and the sites to be treated on this appointment. This included the completion of a facial diagram to highlight what volumes of medicines were used and where. This was signed by the practitioner. A consent form was signed and dated by each patient and included information on the risks and benefits of the treatment.

Patients who completed our online survey told us:

- ‘In-depth conversation regarding treatment and possible side effects. Also after treatment care information.’
- ‘The staff are very friendly and have my total trust.’
- ‘Staff always give me options on treatments and inform me well.’

What needs to improve

The service had still not completed a risk assessment on the non-compliant sinks used in the treatment rooms. This would ensure the sinks were cleaned appropriately and reviewed regularly to ensure they were safe to use (requirement 3).

Although the service employed a cleaner, there was no employment file available to demonstrate a safe recruitment process had been carried out. The recruitment checks for staff working under practicing privileges were not all consistently completed. For example, no references were obtained for staff; and some staff were still waiting for an update to their Disclosure Scotland Protecting Vulnerable Groups (PVG) check. Not all staff had a health declaration form completed (requirement 4).

Batch numbers and expiry dates of medicines used were documented on the patient-specific prescription list held by the prescriber. This information should also be detailed in the patient care records (recommendation f).

Consent to share information with the next of kin in the event of an emergency should be obtained and documented (recommendation g).

Requirement 3 – Timescale: immediate

- The provider must carry out a risk assessment on the sinks in the treatment rooms to mitigate any risk associated with using non-compliant clinical wash hand basins and consider a refurbishment programme to upgrade these hand basins.

Requirement 4 – Timescale: immediate

- The provider must ensure that all staff, including those with practicing privileges, working in a registered healthcare service have appropriate, and documented, background and safety checks in place.

Recommendation f

- The service should ensure batch numbers and expiry dates of medicines used are recorded on each individual patient care record.

Recommendation g

- The service should document consent to share information with the patient's next of kin in the event of an emergency in the patient care record.

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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