Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

# Announced Inspection Report: Independent Healthcare

**Service:** Profile Aesthetic, Aberdeen

**Service Provider:** Profile Aesthetic Ltd

16 November 2023

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 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 Profile Aesthetic on Thursday 16 November 2023. We spoke with two members of staff during the inspection. We received feedback from six patients through an online survey we had asked the service to issue to its patients for us before the inspection. This was our first inspection to this service.

Based in Aberdeen, Profile Aesthetic is an independent clinic providing non-surgical and surgical treatments.

The inspection team was made up of two inspectors.

## What we found and inspection grades awarded

For Profile Aesthetic, 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 shared its vision with the public. Leadership was visible in the service and team communication. Assessing itself against defined indicators will allow the service to monitor how well it is performing. | ✓ Satisfactory |
| **Implementation and delivery** | *How well does the service engage with its stakeholders and manage/improve its performance?* |
| Patient experience feedback was encouraged. Policies were in place for the safety, care and treatment of patients and staff. Processes were in place to ensure patients were well informed about their treatments and the service produced educational information on its website and social media to raise health awareness. There was a culture of improving the staff knowledge and treatments offered by keeping up to date with the latest developments in the aesthetic industry.<br><br>A water risk assessment and annual gas safety check must be competed. An effective system that demonstrates the proactive management of risks to patients and staff must be implemented. A system must be put in place that traces medical devices through the life cycle. | ✓ Satisfactory |
| **Results** | *How well has the service demonstrated that it provides safe, person-centred care?* |
| The clinic environment and equipment were clean and well maintained. Patient care records showed they received a full consultation before any procedure. Systems must be implemented to ensure staff are safely recruited and that key ongoing checks then continue to be carried out. | ✓ 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 Profile Aesthetic 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 six requirements and 13 recommendations.

| Direction | |
|---|---|
| **Requirements** | |
| | None |
| **Recommendation** | |
| **a** | The service should assess itself against defined corporate objectives, values and key performance indicators (see page 12).<br><br>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 put a system in place that traces all medical devices through the life cycle and can link them to the individual patients they have been used on (see page 20).<br><br>Timescale – by 30 January 2024<br><br>*Regulation 12(2)(a)*<br>*The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011* |
| **2** | The provider must demonstrate that it has obtained or applied for a Home Office license for controlled drugs (see page 20).<br><br>Timescale – by 30 January 2024<br><br>*Regulation 3(d)(iv)*<br>*The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011* |
| **3** | The provider must ensure a risk assessment is in place for the safe management of the water supply to reduce the risk of water borne infection (see page 20).<br><br>Timescale – by 24 April 2024<br><br>*Regulation 3(d)(i)*<br>*The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011* |
| **4** | The provider must ensure an annual gas safety check is carried out on the gas boiler and system (see page 20).<br><br>Timescale – by 30 January 2024<br><br>*Regulation 10 (2)(b)*<br>*The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011* |

| Implementation and delivery (continued) | |
|---|---|
| **5** | The provider must develop effective systems that demonstrate the proactive management of risks to patients and staff (see page 22).<br><br>Timescale – by 24 April 2024<br><br>*Regulation 13(2)(a)*<br>*The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011* |
| **Recommendations** | |
| **b** | The service should develop and implement a staff survey to actively seek the views of staff working in the service (see page 16).<br><br>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 ensure that:<br><br>*(a) Botulinum toxin is used in line with the manufacturer's and best practice guidance, and*<br>*(b) any products being used off licence are discussed with the patient and consent is given (see page 20).*<br><br>Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.11 |
| **d** | The service should update its complaints information on its website to state that complainants can complain to Healthcare Improvement Scotland at any time (see page 21).<br><br>Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.20 |
| **e** | The service should publish an annual duty of candour report (see page 21).<br><br>Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.4 |

| Implementation and delivery (continued) | |
|---|---|
| **f** | The service should ensure that staff files contain a record of all relevant training mandatory training including. Mandatory training should also include:<br><br>*(a) complaints management*<br>*(b) consent, and*<br>*(c) duty of candour (see page 21).*<br><br>Health and Social Care Standards: My support, my life. I have confidence in the people who support and care for me. Statement 3.14 |
| **g** | The service should develop and implement a quality improvement plan to formalise and direct the way it drives and measures improvement (see page 22).<br><br>Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19 |
| **h** | The service should further develop its audit programme to include audits of patient care records and staff files (see page 22).<br><br>Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19 |

| Results | |
|---|---|
| **Requirement** | |
| **6** | The provider must implement effective systems that demonstrate that staff working in the service, including staff working under practicing privileges, are safely recruited and that key ongoing checks then continue to be carried out regularly (see page 26).<br><br>Timescale – by 30 January 2024<br><br>*Regulation 8(1)*<br>*The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011* |

| Results (continued) | |
|---|---|
| **Recommendations** | |
| **i** | The service should develop a formal role-specific induction package for staff to evidence that they have the appropriate support to gain the knowledge and skills required for their role (see page 26).<br><br>Health and Social Care Standards: My support, my life. I have confidence in the people who support and care for me. Statement 3.14 |
| **j** | The service should ensure that staff files contain a record of all relevant and mandatory training (see page 26).<br><br>Health and Social Care Standards: My support, my life. I have confidence in the people who support and care for me. Statement 3.14 |
| **k** | The service should ensure that patients' next of kin or emergency contact details and GP are documented appropriately in patient care records. If the patient refused to provide the information, this should be documented (see page 26).<br><br>Health and Social Care Standards: My support, my life. I am fully involved in all decisions about my care. Statement 2.14 |
| **l** | The service should ensure that consent to share information with GPs and other relevant healthcare professionals is documented in the patient care records (see page 26).<br><br>Health and Social Care Standards: My support, my life. I am fully involved in all decisions about my care. Statement 2.14 |
| **m** | The service should ensure that monitoring of patient observations takes place during all surgical procedures (see page 26).<br><br>Health and Social Care Standards: My support, my life. I have confidence in the people who support and care for me. Statement 3.21 |

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

Profile Aesthetic 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 Profile Aesthetic for their assistance during the inspection.

# 2 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 shared its vision with the public. Leadership was visible in the service and team communication. Assessing itself against defined indicators will allow the service to monitor how well it is performing.**

#### *Clear vision and purpose*

The service shared its vision and aims on its website. It also detailed its qualities as safe, effective and trusted. We were told that the service employed the services of a business strategist.

#### What needs to improve

We were not provided with evidence that the service assessed its progress against its own aims and objectives. We were also not provided with a business strategy or equivalent key performance indicators that could be reviewed to assess the service's performance (recommendation a).

- No requirements.

#### Recommendation a

- The service should assess itself against defined corporate objectives, values and key performance indicators.

### *Leadership and culture*

The service was owned and managed by an aesthetic practitioner who was also a registered nurse prescriber and provided visible leadership in the clinic. Other staff included reception staff, an additional nurse prescriber and theatre nurses. Some staff also worked in the service under a practicing privileges agreement (staff not employed directly by the provider but given permission to work in the service), such as:

- anaesthetists
- a GP, and
- surgeons.

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

The service had a staffing matrix in place detailing the type and amount of staff required for the different procedures provided in the clinic.

We saw clear communication for the day-to-day running of the service through multidisciplinary team meetings to discuss the patients and procedures that day.

A clinical governance policy set out the measures taken to maintain and improve the quality of the care provided to patients and to ensure full accountability of the service.

We saw evidence of staff meetings with a set agenda, including clinic equipment, new treatments and staffing. Staff were asked to complete a reflective practice form before the meeting and this was used for discussion and learning during the meeting. We saw evidence of improvements made after staff raised issues, such as staff being unfamiliar with new equipment that had been implemented while on annual leave. Measures were put in place to help make sure staff were made familiar with equipment on their return to work after a period of absence.

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

The service's vision was discussed with staff during their annual appraisal.

- 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 experience feedback was encouraged. Policies were in place for the safety, care and treatment of patients and staff. Processes were in place to ensure patients were well informed about their treatments and the service produced educational information on its website and social media to raise health awareness. There was a culture of improving the staff knowledge and treatments offered by keeping up to date with the latest developments in the aesthetic industry.**

**A water risk assessment and annual gas safety check must be competed. An effective system that demonstrates the proactive management of risks to patients and staff must be implemented. A system must be put in place that traces medical devices through the life cycle.**

***Co-design, co-production*** *(patients, staff and stakeholder engagement)*
The service had a participation policy in place describing the way it would gather and use patient feedback. The service encouraged patient feedback to find ways to improve patient experience. A customer satisfaction survey was emailed to patients following an appointment. The survey included questions, such as:

- 'Were you involved in any decisions about your treatment?'
- 'Were you offered follow up support?'
- 'Were you treated with dignity and respect?'

All survey responses were collated and reviewed every 3 months. All feedback the service had received had been positive.

A staff member we spoke with said she enjoyed working in the service. The service manager provided lunch for all staff every day.

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

- No requirements.

### Recommendation b

- The service should develop and implement a staff survey 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.

The service had produced policies and procedures for the safety, care and treatment of patients and staff including:

- health and safety
- infection prevention and control
- management of emergencies
- medicines management, and
- safeguarding (public protection).

A safeguarding policy (which included the local safeguarding contact) made sure that a clear protocol was in place to respond to any adult protection concerns. Other polices to protect patients, such as dignity and respect and equality and diversity had been produced. The service had an accident and incident reporting procedure in place and had not had any accidents or incidents.

An infection prevention and control policy detailed the standard precautions that would be taken to reduce the risks of infection. 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 and for other persons who may be affected by its activities.

A yearly fire risk assessment was carried out. Fire safety signage was displayed, and fire safety equipment was in place and checked. A safety certificate was in place for the fixed electrical wiring.

There were procedures in place for laser treatments. Equipment was well managed and treatments documented. A laser protection advisor (LPA) had provided appropriate local rules to be followed in the safe use of lasers.

The service had a medication policy that described how medicines (including controlled drugs) were procured, stored, prescribed and administered in the service. Controlled drugs are medications that require to be controlled more strictly, such as some types of painkillers. Medicines were stored in locked cupboards and a locked fridge and the fridge temperature was monitored to make sure medicines were stored at the appropriate temperature. Emergency medicines were easily accessible and checked weekly. Surgical procedures were carried out using local anaesthetic and mild sedation. We saw an appropriately stocked emergency trolley with emergency equipment and medications, including a defibrillator and oxygen.

Policies were in place for surgical procedures and the theatre that covered:

- instrument cleaning
- medical devices
- operating theatre safe operating procedures
- surgical count policy, and
- surgical safety checklist.

We saw checklists in place for staff to complete, including those for:

- theatre and equipment cleaning
- theatre and anaesthetic equipment checks, and
- emergency drugs and equipment.

A consent policy detailed how consent would be obtained from patients. Patients received a face-to-face consultation with the practitioner or surgeon if a surgical procedure was required. Patients could request a second consultation if required. A 2-week cooling-off period allowed patients to fully consider the information they had been given during the consultation before proceeding with the procedure. Discussions at the consultations included:

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

A body dysmorphia questionnaire was completed if it became apparent to the staff that it may be an issue. Body dysmorphia is a mental health condition where a person spends a lot of time worrying about flaws in their appearance. The service had a referral pathway in place to a private psychology service if required.

Patients had a follow-up appointment 1 week after a procedure. At that stage, a plan was made for further follow-up appointments if required. Patients could also contact the clinic if they had any concerns. Aftercare information was given to patients which included an emergency telephone number where they could contact the clinic staff 24 hours a day, 7 days a week.

The service's website provided detailed information on:

- costs
- procedures and aftercare
- staff, and
- treatments.

Information leaflets were also available in the clinic. Educational events about the procedures and health awareness were held in the clinic, as well as a 'meet the team' event. Informative blogs were posted on the website and social media platforms about health-awareness topics, such as:

- breast cancer awareness
- menopause awareness
- sun health, and
- the latest trends in aesthetics.

Policies for the management of information were in place. Patient care records were stored on a password-protected electronic database and paper documentation in locked cabinets. The service was registered with the Information Commissioner's Office (an independent authority for data protection and privacy rights).

A range of staffing policies set out the procedures for recruitment, induction, training and development. Staff received regular informal one-to-ones with the service manager. The service had a process in place for a formal annual appraisal which included discussions about performance, strengths and areas for development. Staff were asked to complete a self-evaluation form in preparation for the appraisal which prompted further areas for discussion.

We saw a practicing privileges policy was in place and staff signed a practicing privileges agreement when working under the service under this arrangement.

Clinical staff attended conferences, training events and subscribed to professional journals. Clinical staff were also members of The British Association of Aesthetic Plastic Surgeons and the British Association of Plastic Reconstructive and Aesthetic Surgeons. This made sure that the service kept up to date with changes in the aesthetics industry, legislation and best practice guidance.

### What needs to improve

While we saw that most medical devices were tracked, we found that some reusable surgical instruments were not. A system must be put in place which traces all medical devices through the life cycle and can link them to the individual patients they have been used on (requirement 1).

While the service used controlled drugs, we saw no evidence of a Home Office license. The service told us it had been advised that this was not required. Providers must have a Home Office license if they wish to supply or possess controlled drugs (requirement 2).

We were told that water outlets were flushed daily. However, a water risk assessment had not been carried out. A water risk assessment would identify and evaluate the service's exposure to water-related risk (requirement 3).

We requested, but did not receive, a copy of the annual gas safety certificate. A gas safety certificate is to show that all gas appliances in a property are safe and fit for use. It also shows that they are regularly maintained and in line with current safety regulations and standards (requirement 4).

We saw the service used an alternative sterile saline solution from that recommended in the manufacturer's guidance for the reconstitution of botulinum toxin. This is when a liquid solution is used to turn a dry substance into a fluid for injections. This practice is not in line with the manufacturer's guidance. We did not see that this was discussed with patients as part of the consent process in the patient care records as this is off license for this (recommendation c).

The service had a complaints management process in place, which patients could access on the website. The service told us it had not received any complaints. However, the complaints information did not make clear that patients could make a complaint to Healthcare Improvement Scotland at any time (recommendation d).

A duty of candour policy was in place (where healthcare organisations have a professional responsibility to be honest with people when things go wrong). Services are required to produce and publish a yearly duty of candour report, even where the duty had not been implemented. The report should contain information about staff training on the duty of candour obligation. However, a report had not been produced and published (recommendation e).

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. While the service had a list of mandatory training, duty of candour training was not listed. Complaints management and consent training was also not listed as mandatory (recommendation f).

### Requirement 1 – Timescale: immediate

- The provider must put a system in place that traces all medical devices through the life cycle and can link them to the individual patients they have been used on.

### Requirement 2 – Timescale: immediate

- The provider must demonstrate that it has obtained or applied for a Home Office license for controlled drugs.

### Requirement 3 – Timescale: 26 April 2024

- The provider must ensure a risk assessment is in place for the safe management of the water supply to reduce the risk of water borne infection.

### Requirement 4 – Timescale: immediate

- The provider must ensure an annual gas safety check is carried out on the gas boiler and system.

### Recommendation c

- The service should ensure that:

  *(a) Botulinum toxin is used in line with the manufacturer's and best practice guidance, and*
  *(b) any products being used off licence are discussed with the patient and consent is given.*

### Recommendation d

- The service should update its complaints information on its website to state that complainants can complain to Healthcare Improvement Scotland at any time.

### Recommendation e

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

### Recommendation f

- The service should ensure that staff files contain a record of all relevant training mandatory training including. Mandatory training should also include:

  *(a) complaints management*
  *(b) consent, and*
  *(c) duty of candour.*

### *Planning for quality*

The service had a contingency plan in place with other Healthcare Improvement-registered services 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.

The service manager carried out audits every 3 months to assess the environment and equipment and infection control precautions of hand hygiene and staff use of personal protective equipment (PPE). Since the audit findings were 100% compliance, no issues had been required to be documented or actioned.

### 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 5).

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 g).

Patient care record audits were not carried out to help make sure that all 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 (recommendation h).

The service manager carried out audits. Consideration should be given to different staff members carrying out audits so they are not person-dependent and can also be used as a learning opportunity. We will follow this up at future inspections.

### Requirement 5 – Timescale: by 26 April 2024

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

### Recommendation g

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

### Recommendation h

- The service should further develop its audit programme to include audits of patient care records and staff files.

## 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 clinic environment and equipment were clean and well maintained. Patient care records showed they received a full consultation before any procedure. Systems must be implemented to ensure staff are safely recruited and that key ongoing checks then continue to be carried out.**

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 clinic environment was 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 survey said they were satisfied with the facilities and equipment in the environment they were treated in. Comments included:

- 'Very professional and modern facilities and equipment.'
- 'I was thoroughly impressed with the exceptional quality of the equipment used, which surpassed all of my expectations.'
- 'Amazing, clean facilities.'

Measures were in place to reduce the risk of infection and cross-contamination. For example, the service had a good supply of PPE (such as disposable aprons, gloves and face masks) and alcohol-based hand gel.

We discussed with staff how patient needs were assessed and how treatment was planned and delivered in line with patients' individual treatment plans. The five 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.

We saw evidence of treatment plans being developed and agreed with patients. These set out the course and frequency of treatment. Records were kept of each treatment session, including a diagram of the area that had been treated for aesthetic treatments. 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.

All patients who responded to our survey told us that they received adequate information about their procedure and felt involved in the decisions about their care. Comments included:

- 'I have been fully involved in decision-making about my treatment.'
- 'Always involved in decisions in a professional and caring manner.'

They also confirmed that they are given a 'cooling-off' period to consider all the provided information before having a procedure:

- '…had been given ample time to carefully consider all the options available.'
- 'I have always been given appropriate time to reflect before making decisions.'

Patents having a surgical procedure had safety checks carried out in line with World Health Organization guidelines. The staff also advised that a surgical brief took place in the morning before any surgical procedures were carried out, in line with World Health Organization guidelines.

Staff explained how the swab and instrument counts were carried out and we saw this was recorded in patient care records.

The service explained that patients receiving surgical procedures were accompanied to and from the theatre department with a registered nurse. We saw that baseline observations of pulse, blood pressure and blood oxygen levels were carried out before surgery and in the recovery room for all patients. Patients receiving sedation underwent monitoring of vital signs during the operation too and all observations were recorded in the patient care record.

### What needs to improve

We reviewed the staff files of four members of staff who worked in the service, including one under a practicing privileges arrangement. Some recruitment information was held in the files. 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. The service had carried out its own background identity checks with Disclosure Scotland to make sure staff were not included on the list for Protecting Vulnerable Groups (PVG). However, the date of the completed check was not recorded. This meant the service would not know when the check should be repeated (requirement 6).

We were told that the service had an induction process in place, where staff were supernumerary (where a member of staff works in the clinical area but is not counted in the staff numbers for that shift) and supervised until competent to perform their role. New staff were also required to familiarise themselves with the services policies and procedures during the induction period. However, we saw no documented evidence that staff had completed this induction process and met the required competencies (recommendation i).

While details of training some staff had received in their NHS roles had been obtained it had not been cross checked with the services own list of mandatory training. Some training listed as mandatory to work in the service was not listed in staff training records (recommendation j).

Some patient care records we reviewed did not document GP and next of kin details (recommendation k).

Patients' consent to share the information with their GP or next of kin was not documented in any patient care record we reviewed (recommendation l).

Patients receiving surgery using local anaesthetic did not have their observations taken during the procedure to make sure it was safe to continue (recommendation m).

We discussed the safe disposal of blood-stained fluid. The service explained how it planned to improve this with the use of gel to solidify the waste. We will follow this up at future inspections.

### Requirement 6 – 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 and that key ongoing checks then continue to be carried out regularly.

### Recommendation i

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

### Recommendation j

- The service should ensure that staff files contain a record of all relevant and mandatory training.

### Recommendation k

- The service should ensure that patients' next of kin or emergency contact details and GP are documented appropriately in patient care records. If the patient refused to provide the information, this should be documented.

### Recommendation l

- The service should ensure that consent to share information with GPs and other relevant healthcare professionals is documented in the patient care records.

### Recommendation m

- The service should ensure that monitoring of patient observations takes place during all surgical procedures.

## 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.
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

Healthcare Improvement Scotland

| | |
|---|---|
| Edinburgh Office | Glasgow Office |
| Gyle Square | Delta House |
| 1 South Gyle Crescent | 50 West Nile Street |
| Edinburgh | Glasgow |
| EH12 9EB | G1 2NP |
| 0131 623 4300 | 0141 225 6999 |

www.healthcareimprovementscotland.org