Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Announced Inspection Report: Independent Healthcare

Service: Clinic 45, Clydebank

Service Provider: Diane Sim

19 January and 9 February 2026

NHS SCOTLAND

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Contents

1 Progress since our last inspection

What the provider had done to meet the requirement we made at our last inspection on 22 June 2021

Requirement

The provider must have its Healthcare Improvement Scotland registration certificate on display. This certificate should be displayed where patients can view it.

Action taken

The service's Healthcare Improvement Scotland registration certificate was displayed in the main consulting room. **This requirement is met.**

What the service had done to meet the recommendations we made at our last inspection on 22 June 2021

Recommendation

The service should provide patients with COVID-19 guidance before attending their appointment.

Action taken

This recommendation was in line with best practice during the COVID 19 pandemic and is now not applicable for every patient.

Recommendation

The service should screen patients for symptoms of COVID-19 before arrival at the service.

Action taken

This recommendation was in line with best practice during the COVID 19 pandemic and is now not applicable for every patient.

Recommendation

The service should ensure that current national guidance is adhered to and staff should not travel to work in uniform.

Action taken

This recommendation was in line with best practice during the COVID 19 pandemic and is now not applicable for every patient.

Recommendation

The service should carry out infection prevention and control audits. Audits should be documented and improvement actions implemented.

Action taken

We saw that hand hygiene audits were now being carried out. Although cleaning checklists were completed in the main consulting room, no other infection prevention and control audits were being carried out. This is reported in Domain 5 (Planning for quality) (see recommendation h on page 22).

Recommendation

The service should ensure that all patient care records including consent forms are signed by the patient and practitioner before carrying out treatments.

Action taken

The service currently only obtained written consent to treatment during patients' initial consultation appointments. We saw that on the initial consent forms both the patient and the practitioner had signed the forms. However, we were told that only verbal consent from patients was then gained at any further appointments. **A new requirement has been made.** This is reported in Domain 7 (Quality control) (see requirement 4 on page 26).

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 Clinic 45 on Monday 19 January 2026. Having identified some immediate concerns about fire safety during this inspection, we carried out a second announced inspection on Monday 9 February 2026. We advised that the service did not continue to treat patients until we were satisfied that our concerns had been addressed at our second inspection. We spoke with the owner/practitioner during the inspection. We received feedback from 34 patients through an online survey we had asked the service to issue to its patients for us before the inspection.

Based in Clydebank, Clinic 45 is an independent clinic providing non-surgical treatments.

The inspection team was made up of two inspectors.

What we found and inspection grades awarded

For Clinic 45, 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**
An independent nurse prescriber owned and provided treatments in the service. All other staff worked under practicing privileges and were qualified to prescribe medicines. A manager must be appointed that is in full-time day-to-day charge of the service. The service's vision and purpose should be accessible to both staff and patients. Key performance indicators should be developed to measure how well the service was performing. Regular staff meetings should be held.	Unsatisfactory
Implementation and delivery	*How well does the service engage with its stakeholders and manage/improve its performance?*
A range of up-to-date policies set out the way the service would deliver safe care. Issues with fire safety identified at our first inspection had been promptly addressed. The participation policy should be further developed to include a more detailed process for gathering, analysing and using patient feedback to improve the service. Staff should carry out duty of candour training, and the duty of candour report should be made available to patients. The range of risk assessments should be expanded, and an audit programme and quality improvement plan should be developed to help demonstrate a safe service.	✓ 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, with appropriate infection prevention and control practices in place. Patients spoke positively about their experience using the service. The standard of record keeping must be improved, including more detailed information about patients' assessment and treatment plans, and documenting GP and next of kin contact details. Regular review of patients' medical history and consent to treatment at each new treatment appointment	Unsatisfactory

must also be carried out. Good medicines governance must be followed, including obtaining informed consent from patients for the use of unlicensed medicines, and for the use and retention of prescription-only medicines. Processes must be in place to ensure staff are recruited safely, and regular appraisals must be undertaken. Practicing privileges contracts must be in place. Consent to share information with external healthcare professionals should be requested and documented in patient care records.	

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: Guidance for independent healthcare service providers – Healthcare Improvement Scotland

Further information about the Quality Assurance Framework can also be found on our website at: The quality assurance system and framework – Healthcare Improvement Scotland

What action we expect Diane Sim 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 nine requirements and 12 recommendations.

Direction	
Requirement	
1	The provider must ensure that a manager is in full-time day-to-day charge of the service (see page 16). Timescale – by 28 April 2026 *Regulation 14(c)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
Recommendations	
a	The service should ensure that information about the service's vision and values is available to patients and staff (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
b	The service should develop measurable key performance indicators to help monitor how well the service is being delivered (see page 16). 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 develop a structured programme of formal staff meetings. A record of discussions and decisions reached at these meetings should be kept. These should detail staff responsible for taking forward any actions (see page 16). 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	
Requirement	
2	The provider must ensure that patients have access to information on how to make a complaint, including up-to-date contact details for Healthcare Improvement Scotland (see page 20). Timescale – immediate *Regulation 15(6)(a)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
Recommendations	
d	The service should further review its participation policy to consider introducing a wider range of patient feedback methods. The policy should also include details of a structured approach to gathering and analysing patient feedback to drive improvements in the service and how the impact of change from the improvements made will be demonstrated (see page 18). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.8
e	The service should ensure that its duty of candour report is available to patients (see page 20). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19
f	The service should ensure that all relevant staff undertake duty of candour training (see page 20). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.4
g	The service should expand the range of risk assessments carried out to ensure all risks to patients and staff have been identified and are being managed (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

Implementation and delivery (continued)

Recommendations

h The service should develop a programme of audits to cover key aspects of care and treatment. Audits should be documented and improvement action plans implemented (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 June 2021 inspection report for Clinic 45.

i 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

j The service should develop a formal business continuity plan that sets out the arrangements for continuity of care for patients, in the event of the service closing for any reason (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

Results

Requirements

3 The provider must improve the standard of record keeping in patient care records to ensure all records:

- contain a record of the patient assessment, an agreed plan of care or a proposed treatment plan
- are organised in a way that ensures the contents are secured in the file and in chronological order, and
- contain details of the patient's next of kin or emergency contact (see page 25).

Timescale – immediate

Regulation 4(1)(2)(b)(c)
The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011

Results (continued)

Requirements

4 The provider must ensure that there is regular review of patients' medical history and consent to treatment at each new treatment appointment (see page 26).

Timescale – immediate

Regulation 4(1)
The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011

This was previously identified as a recommendation in the June 2021 inspection report for Clinic 45.

5 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 26).

Timescale – immediate

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

6 The provider must 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 26).

Timescale – immediate

Regulation 12(d)
The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011

7 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 26).

Timescale – by 28 April 2026

Regulation 12(c)(i)
The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011

Results (continued)	
Requirements	
8	The provider must ensure that, once reconstituted, the botulinum toxin vial is only used for a single patient, during a single treatment session, and that any unused solution is discarded to comply with the manufacturer's guidance for botulinum toxin (see page 26). Timescale – immediate *Regulation 3(d)(iv)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
9	The provider must ensure that when unlicensed medicines are used that good medicine governance arrangements are in place, including documented rationale for use and informed patient consent (see page 26). Timescale – immediate *Regulation 3(d)(iv)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
Recommendations	
k	The service should request patients' consent to share information with GPs and other relevant healthcare professionals and document this in the patient care records (see page 26). Health and Social Care Standards: My support, my life. I am fully involved in all decisions about my care and support. Statement 2.14
l	The service should develop more detailed cleaning checklists that cover the entire clinic (see page 26). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19

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

Diane Sim, the provider, must address the requirements and make the necessary improvements as a matter of priority.

We would like to thank all staff at Clinic 45 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

An independent nurse prescriber owned and provided treatments in the service. All other staff worked under practicing privileges and were qualified to prescribe medicines.

A manager must be appointed that is in full-time day-to-day charge of the service. The service's vision and purpose should be accessible to both staff and patients. Key performance indicators should be developed to measure how well the service was performing. Regular staff meetings should be held.

Clear vision and purpose

The owner told us that their overall vision for the service was for patients to:

- have a positive experience
- be able to discuss their concerns, and
- feel better about their appearance.

The purpose of the service was to help manage patient expectations and provide appropriate skin and aesthetic treatments.

What needs to improve

The service did not have a website, and its vision and purpose were not available for patients or staff either through its social media accounts or displayed in the service (recommendation a).

No key performance indicators had been developed to monitor and measure the quality and effectiveness of the service. A set of defined and measurable key performance indicators would help the service to demonstrate what was working well and what could be improved (recommendation b).

- No requirements.

Recommendation a

- The service should ensure that information about the service's vision and values is available to patients and staff.

Recommendation b

- The service should develop measurable key performance indicators to help monitor how well the service is being delivered.

Leadership and culture

An independent nurse prescriber registered with the Nursing and Midwifery Council (NMC) owned and provided treatments in the service. On our first inspection, a number of staff were working in the service under a practicing privileges agreement. These are healthcare professionals who are not employed directly by the provider but given permission to work in the service. We noted that not all of these healthcare professionals were nurse prescribers at that time. A qualified prescriber must be present in the service in case of complications following treatment. We were told that, on occasion, the non-prescribing aesthetic practitioners were treating patients without a prescriber being present. On our second inspection, we noted that the number of healthcare professionals working in the service under practicing privileges had reduced to only those who were qualified to prescribe medicines.

What needs to improve

The owner was not always present in the service and, as a result, they were unable to be in full-time day-to-day charge of the service. We were told that the owner would address this issue and appoint a manager who would be present in the service at all times when it is open (requirement 1).

There was no formal programme of staff meetings. We were told that the owner occasionally met with staff on an informal basis. Introducing regular formal meetings, with a set agenda, would help with ongoing sharing of information such as patient feedback, quality improvement activity, health and safety matters, and decision making. This would also allow staff to input into the running of the service, and allow an opportunity for discussion on new treatments and processes. Minutes should be documented and shared with all staff (recommendation c).

Requirement 1 – Timescale: by 28 April 2026

- The provider must ensure that a manager is in full-time day-to-day charge of the service.

Recommendation c

- The service should develop a structured programme of formal staff meetings. A record of discussions and decisions reached at these meetings should be 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

A range of up-to-date policies set out the way the service would deliver safe care. Issues with fire safety identified at our first inspection had been promptly addressed.

The participation policy should be further developed to include a more detailed process for gathering, analysing and using patient feedback to improve the service. Staff should carry out duty of candour training, and the duty of candour report should be made available to patients. The range of risk assessments should be expanded, and an audit programme and quality improvement plan should be developed to help demonstrate a safe service.

Co-design, co-production *(patients, staff and stakeholder engagement)*
As the service did not have a website, the public were kept informed of what treatments the service were providing through its social media accounts and online booking system. This allowed patients to see available treatments and costs before making an appointment. We were told that a high proportion of patients were returning patients.

Patients could book an appointment through the online booking system or directly by contacting the service. We were told that patients could visit the service for a free consultation and had the opportunity for a 'cooling-off period' to consider the planned treatment before proceeding. Patients were made aware of the treating practitioner's out-of-hours contact details. Verbal and written aftercare was given at each appointment.

The service's participation policy referred to encouraging patients to provide feedback. This included reference to providing verbal feedback and completing a feedback questionnaire. A poster was displayed in the reception area with information on how patients could provide feedback on their treatment. This included the service's contact details.

We were told that patients were informed about treatment options and costs, and involved in decisions about their treatment. Patients who completed our online survey told us:

- 'I discussed what I was hoping to achieve from the procedure, I was listened to without interruption and then was talked through the procedure and possible side effects.'
- '… ensures I'm aware of what's happening at each step.'
- 'I had a choice of treatments and pros and cons were explained and a joint decision made.'
- 'All procedures are thoroughly explained and patient medical questionnaire reviewed prior to treatment.'

What needs to improve

We found that the service was not following its participation policy as we saw no evidence of a feedback questionnaire available for patients to complete. While we saw that patients were encouraged to telephone or email the service if they had feedback, we were told that no feedback had been received since the service registered with Healthcare Improvement Scotland in January 2019. No other methods of providing feedback such as electronic survey links or QR codes were available for patients.

The participation policy did not provide any details on what the formal process would be for gathering, analysing and using patient feedback to improve the service. The policy should include how the service would:

- regularly record and analyse results
- implement changes to drive improvement
- measure the impact of improvements to show how these have improved the quality of the service, and
- inform patients about changes made as a result of their feedback (recommendation d).

■ No requirements.

Recommendation d

■ The service should further review its participation policy to consider introducing a wider range of patient feedback methods. The policy should also include details of a structured approach to gathering and analysing patient feedback to drive improvements in the service and how the impact of change from the improvements made will be demonstrated.

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 owner was aware of when to notify Healthcare Improvement Scotland of any incidents or changes in the service, in line with our notifications guidance.

A number of policies helped to support the delivery of safe, person-centred care, including:

- infection prevention and control
- safeguarding (public protection)
- medicine management, and
- privacy and dignity.

The infection prevention and control policy referred to the relevant national infection prevention and control guidance and standards. The policy detailed the 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).

Medicines were ordered directly with an appropriately registered pharmacist. We noted a process was in place to record the temperature of the fridge used to store medicines to make sure these were stored at the correct temperature and safe to use.

An electronic process was in place to document any accidents or incidents that occurred in the service. We saw evidence that these were investigated by the owner and had resulted in actions and learning outcomes for staff to take forward.

The service had an up-to-date complaints process which included a timeline for addressing a complaint. We were told that the service had not received any complaints in recent years.

Duty of candour is where healthcare organisations have a professional responsibility to be honest with people when something goes wrong. The service had an up-to-date duty of candour policy in place and a duty of candour report had been produced.

An up-to-date practicing privileges policy was in place. We were told that staff received a short induction which included fire safety.

Patient care records were in paper format and were stored securely in a locked cabinet which could only be accessed by the owner. 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.

We were told that the owner was a member of a number of online aesthetic forums and subscribed to a number of aesthetic journals to help keep up to date with best practice.

What needs to improve

Information about the complaints process was not available to patients, either in the service or through its social media accounts. We also noted that Healthcare Improvement Scotland's contact details on the complaints policy were out of date (requirement 2).

The service's duty of candour report was not available in the service for patients to access (recommendation e).

We also saw no evidence that staff had completed duty of candour training (recommendation f).

- No requirements.

Requirement 2 – Timescale: immediate

- The provider must ensure that patients have access to information on how to make a complaint, including up-to-date contact details for Healthcare Improvement Scotland.

Recommendation e

- The service should ensure that its duty of candour report is available to patients.

Recommendation f

- The service should ensure that all relevant staff undertake duty of candour training.

Planning for quality

During the first inspection, we found that key aspects of fire safety such as regular checking and maintenance of the fire safety equipment had not taken place since 2019. The recent fire risk assessment carried out by the service in January 2026 referred to safety aspects that were not applicable or relevant to the service. For example, the risk assessment referred to the need for regular testing of its fire alarm but the service did not have a fire alarm at that time. The risk assessment also referred to actions that were in place such as servicing of the fire extinguishers and the portable electrical appliances. However, we were subsequently told that this equipment servicing had not taken place. We also found that the fire exit was locked and no key was available. Due to these safety concerns, we advised that the service did not treat patients until we were satisfied that our concerns had been addressed. We also reported our concerns to the Scottish Fire and Rescue Service.

On our second inspection, we found that the service had addressed all of our concerns about fire safety. This included a new easily accessible lock on the fire exit, new fire extinguishers and a new fire alarm. Testing of the portable electrical appliances had also now been completed as had servicing of the gas boiler. The fire risk assessment had been updated, and we saw a fire safety logbook and fire alarm checklists were now in place to be regularly completed by the owner.

What needs to improve

With the exception of the fire risk assessment, no other risk assessments had been completed to demonstrate that general risks within the service had been assessed such as business, clinical, and other health and safety risks. For example, this could include the risk of trips and falls, needlestick injury and clinical procedure specific risk assessments (recommendation g).

We noted that hand hygiene audits had recently been carried out. However, there was no programme of regular audits in place detailing the type and frequency of audits to be carried out. This would help the service improve how its audit activity was planned. This could include audits carried out on:

- patient care records
- medicine management, and
- infection prevention and control (recommendation h).

We saw no evidence of a quality improvement plan. This would help to demonstrate the ongoing plan of improvements in the service and a timescale of when each quality improvement activity would be completed. This would help the service to structure and record its improvement processes. This could

include outcomes identified from audits, complaints, accidents and incidents, and patient feedback (recommendation i).

No business continuity plan was in place detailing the processes for patients to continue their treatment plans in case of unexpected events that may cause an emergency closure of the service or cancellation of appointments, such as power failure or sickness (recommendation j).

- No requirements.

Recommendation g

- The service should expand the range of risk assessments carried out to ensure all risks to patients and staff have been identified and are being managed.

Recommendation h

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

Recommendation i

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

Recommendation j

- The service should develop a formal business continuity plan that sets out the arrangements for continuity of care for patients, in the event of the service closing for any reason.

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, with appropriate infection prevention and control practices in place. Patients spoke positively about their experience using the service.

The standard of record keeping must be improved, including more detailed information about patients' assessment and treatment plans, and documenting GP and next of kin contact details. Regular review of patients' medical history and consent to treatment at each new treatment appointment must also be carried out. Good medicines governance must be followed, including obtaining informed consent from patients for the use of unlicensed medicines, and for the use and retention of prescription-only medicines. Processes must be in place to ensure staff are recruited safely, and regular appraisals must be undertaken. Practicing privileges contracts must be in place. Consent to share information with external healthcare professionals should be requested and documented in patient care records.

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 environment was clean and in a good state of repair. Cleaning took place between patient appointments and at the end of the day. Appropriate cleaning products and equipment were used. A daily cleaning checklist was completed for the main consulting room. We saw a good supply of personal protective equipment such as disposable gloves and aprons, and alcohol gel was also available. We saw that an appropriate clinical waste contract was in place for the disposal of used sharps and hazardous waste.

Patients who completed our online survey told us:

- ‘Cleanliness of facilities and equipment is exceptional.’
- ‘Excellent cleanliness within the clinical environment high standard of hygiene carried out during my visit.’
- ‘A very welcoming, clean, friendly and professional environment.’
- ‘The salon is well kept, clean and has a relaxing atmosphere.’

We reviewed five patient care records and saw that initial consultations included patients’ contact details, date of birth and their medical history. We saw that expiry dates and batch numbers of medicines used and aftercare advice was documented in the records. We were told that the service was currently trialling an electronic patient care record system.

What needs to improve

From the patient care records we reviewed, we found there was no clear record of the patient assessment, an agreed plan of care or a proposed treatment plan. We also found that the patient care records lacked a structured approach to gathering and documenting information. The records comprised of blank, loose sheets of paper that the practitioner used to write their notes at the consultation and treatment appointments, including hand drawn diagrams. We found that this documentation was also not always legible. Not all sheets had the patient’s identifiable information on them to ensure they were in the correct files. None of the patient care records had the patients’ next of kin or emergency contact details documented. Patient care records must be able to demonstrate that patients’ health, safety, and welfare needs are being assessed and met (requirement 3).

We found there was little evidence of further review of the patients’ medical history before their treatment started and no evidence that this was reviewed again at each subsequent appointment. We also found that consent to treatment was not consistently obtained for patients who were returning for a new treatment (requirement 4).

On our first inspection, we reviewed four staff files. We found gaps in all of the files including a lack of references and that Disclosure Scotland Protecting Vulnerable Groups (PVG) checks had not been completed. On our second inspection, we were told that the owner had been in contact with Disclosure Scotland and staff PVGs were now being updated. There was no annual programme in place to check that the professional registration status of staff working under practicing privileges remained up to date, as well as their indemnity insurance (requirement 5).

We saw no evidence of practicing privileges contracts in place for the clinical staff working in the service. A formal practicing privileges contract would help to identify the responsibilities and accountability of the service and the clinical staff to help ensure the safe delivery of care (requirement 6).

There was no evidence of one-to-one meetings between the owner and individual staff members or formal appraisals taking place to make sure staff's performance was documented and evaluated (requirement 7).

During our first inspection, we were told that a reconstituted (when a liquid solution is used to turn a dry substance into a fluid for injection) patient-specific vial of botulinum toxin injection would be kept for the patient's 2-week follow-up appointment. The manufacturer's guidance states that vials can only be retained for 24 hours. At our second inspection, we were told that practice had changed and that the vials were no longer being kept after the initial appointment (requirement 8).

We saw that the service used bacteriostatic saline to reconstitute the vials of botulinum toxin. 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 out with its Summary of Product Characteristics and is therefore termed as unlicensed use. There was no evidence in the patient care records 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 9).

From the patient care records we reviewed, we found that consent to share information with the patient's GP and next of kin in the event of an emergency was not requested (recommendation k).

Although we saw that a checklist was in place to ensure cleaning was completed in the main consulting room, there was no documentation to show that cleaning was taking place throughout the rest of the clinic (recommendation l).

Requirement 3 – Timescale: immediate

- The provider must improve the standard of record keeping in patient care records to ensure all records:
- contain a record of the patient assessment, an agreed plan of care or a proposed treatment plan
- are organised in a way that ensures the contents are secured in the file and in chronological order, and
- contain details of the patient's next of kin or emergency contact.

Requirement 4 – Timescale: immediate

- The provider must ensure that there is regular review of patients' medical history and consent to treatment at each new treatment appointment.

Requirement 5 – 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.

Requirement 6 – Timescale: immediate

- The provider must 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.

Requirement 7 – Timescale: by 28 April 2026

- 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 8 – Timescale: immediate

- The provider must ensure that, once reconstituted, the botulinum toxin vial is only used for a single patient, during a single treatment session, and that any unused solution is discarded to comply with the manufacturer's guidance for botulinum toxin.

Requirement 9 – Timescale: immediate

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

Recommendation k

- The service should request patients' consent to share information with GPs and other relevant healthcare professionals and document this in the patient care records.

Recommendation l

- The service should develop more detailed cleaning checklists that cover the entire clinic.

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: [The quality assurance system and framework – Healthcare Improvement Scotland]

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

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

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