Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Unannounced Inspection Report: Independent Healthcare

Service: Merchant City Medical Group, Glasgow

Service Provider: MCMGHC Ltd

3 March 2026

NHS SCOTLAND

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1 Progress since our last inspection

What the provider had done to meet the requirements we made at our last inspection on 17 September 2024

Requirement

The provider must have easy access to all recruitment checks to ensure that appropriate staff are safely employed.

Action taken

The provider had introduced a new electronic platform for staff recruitment which the service manager could easily access. **This requirement was met**

Requirement

The provider must ensure that a face-to-face consultation and ongoing assessment is completed and documented in the patient care records.

Action taken

Face-to-face consultations and ongoing assessments were completed in detail on the day of a patient's procedure. **This requirement has been met.**

What the service had done to meet the recommendations we made at our last inspection on 17 September 2024

Recommendation

The service should develop key performance indicators to help achieve its aims and objectives, and a process for monitoring and measuring these.

Action taken

Key performance indicators had been developed.

Recommendation

The service should introduce regular formal staff meetings. A record of discussions and decisions reached at these meetings should be kept, including the staff responsible for taking forward any actions.

Action taken

Monthly team meetings were carried out. We saw minutes of these meetings, which recorded discussions of agenda items.

Recommendation

The service should ensure that information on the website is accurate and up to date and staff job titles reflect their role in the service.

Action taken

Some information on the service's website was inaccurate. This recommendation is reported in Domain 3: Co-design, co-production (see recommendation c on page 23).

Recommendation

The service should develop a process of keeping patients informed of the impact their feedback has on the service.

Action taken

Patient feedback was gathered through an online platform and we saw that this was discussed with staff at daily staff meetings. However, the service did not have a process in place of sharing information about improvements made as a result of feedback with patients.

Recommendation

The service should introduce formal and documented induction and training programmes for staff.

Action taken

The service did not have a formal induction process in place. However, the new service manager planned to develop a formal induction programme.

Recommendation

The service should further develop the range of risk assessments to include more clinically relevant risks, and an appropriate risk scoring system.

Action taken

The service had developed a risk register which included possible risks in each department of the service. This highlighted the control measures in place and each risk had a red, amber, green (RAG) rating.

Recommendation

The service should develop a programme of audits to cover key aspects of treatment and care. These should be documented and include improvement action plans.

Action taken

The service developed a clinical governance and quality improvement framework, which referred to:

- clinical governance
- medicine management
- risk assessments, and
- staff competence.

Clinical audits were in place, including environmental checks, medicine management and infection prevention and control.

Recommendation

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

Action taken

The service had developed a clinical governance and quality improvement framework. This recommendation is reported in Domain 5: Planning for quality (see recommendation d on page 28).

Recommendation

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

Action taken

The service had developed a business contingency policy that highlighted the daily processes in place in the service and levels of ongoing training required. However, it did not demonstrate how staff were to manage an emergency closure of the clinic. This recommendation is reported in Domain 5: Planning for quality (see recommendation f on page 28).

Recommendation

The service should complete and submit a self-evaluation when requested by Healthcare Improvement Scotland.

Action taken

The service completed a satisfactory self-evaluation on request before this inspection.

Recommendation

The service should obtain and document consent to take and store patient photographs.

Action taken

In the patient care records reviewed, we saw that consent to share patient photographs was obtained.

What the service had done to meet the requirements we made following a complaint investigation on 1 May 2025

Requirement

The provider must produce a risk-based staffing establishment setting out the minimum staff required on site each day and the additional specific staff requirements for each procedure which ensures that at all times, suitably qualified and competent persons are working in the service in such numbers as are appropriate for the health, welfare and safety of service users.

Action taken

The service manager rostered staff using an electronic rostering system, which allowed for clear visibility of roster gaps to allow them to be filled. A morning clinic safety huddle had been introduced to help review staffing suitability and allocation daily. **This requirement is met.**

Requirement

The provider must ensure that each person employed in the service receives education and training appropriate to the work they are to perform, which must include dealing with medical emergencies and training specific to the procedures.

Action taken

The service had a learning and education strategy in place for all staff. The service used an electronic system for all training and education. We saw reports that demonstrated that all mandatory training had been completed. An external health professional had provided staff with training on medical emergencies and anaphylaxis. The service planned to use this resource to provide monthly face-to-face sessions on areas staff required education on. **This requirement is met.**

Requirement

The provider must have appropriate documented systems, processes and procedures for all aspects of care and treatment including patient monitoring, dealing with emergencies and the management of medicines. These should reflect relevant national guidance/standards, where appropriate.

Action taken

We reviewed five patient care records and saw a detailed process of regular monitoring patients during their procedures. All clinical staff had been trained in basic life support and an ongoing programme of staff training was in place. The emergency trolley was checked regularly to make sure it was complete and all items were in-date. The service manager completed a Healthcare Improvement Scotland medicine management audit, which demonstrated that:

- all medicine management policies were available to staff
- an adequate number of prescribers were in the service, and
- the service had a process of prescribing in place.

This requirement is met.

Requirement

The provider must make sure that there is a system in place to enable practitioners make contemporaneous records of the following matters:

(a) the date and time of every consultation with, or examination of, the service user by a health care professional and the name of that health care professional;
(b) the outcome of that consultation or examination;
(c) details of every treatment provided to the service user including the place, date and time that treatment was provided and the name of the health care professional responsible for providing it; and
(d) *every medicine ordered for the service user and the date and time at which it was administered or otherwise disposed of.*

Action taken

Reviewing patient care records, we saw a detailed process of assessment in place. This included the date and time of every consultation, with the name of the healthcare professional. A detailed assessment was carried out before the procedure began. All medicines used had a lot number and expiry date documented in patient care records we reviewed. **This requirement is met.**

Requirement

The provider must have a system in place to make the patient care record available to the service user if requested.

Action taken

The service patient access request policy was available on the website with the appropriate access request form available. **This requirement is met.**

What the service had done to meet the recommendations we made following a complaint investigation on 1 May 2025

Recommendation

The service should ensure all incidents are properly investigated, learning shared with the team and action plans developed.

Action taken

The service had an incident and near-miss policy in place. An electronic incident and accident process was in place. We were told that the service had not experienced any recent incidents.

Recommendation

The service must ensure aftercare or follow care for all patients is implemented.

Action taken

We saw that aftercare was addressed with the patient in the patient care records we reviewed. The service provided patients with an aftercare leaflet following their procedure. On the days following the procedure, the service telephoned the patient to check in with them.

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 unannounced inspection to Merchant City Medical Group on Tuesday 3 March 2026. We spoke with a number of staff, patients during the inspection. We received feedback from six patients through an online survey we had asked the service to issue to its patients during the inspection. We received feedback from 11 staff through an online staff survey we sent out during the inspection.

Based in Glasgow, Merchant City Medical Group is an independent clinic providing surgical treatments.

The inspection team was made up of three inspectors.

What we found and inspection grades awarded

For Merchant City Medical Group, 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 had a strategic plan in place with its overall vision and aims. The vision and values were displayed in the staff room. Key performance indicators had been developed. Staff we spoke with spoke positively about working for the service. Staff meetings allowed staff to contribute to the ongoing development of the service. The vision, mission and values should be available for the public to access.	✓ Satisfactory
Implementation and delivery	*How well does the service engage with its stakeholders and manage/improve its performance?*
Information on treatments was available on the service's website. Patient care records detailed thorough consultation and assessment of the patient, with regular observations documented. The service must make sure all staff are aware of the Healthcare Improvement Scotland conditions of registration that apply to the clinic. A process must be put in place for the safe management of hazardous substances. A comprehensive water risk assessment should be completed to ensure a safe water system.	✓ Satisfactory
Results	*How well has the service demonstrated that it provides safe, person-centred care?*
The environment was in a good state of repair. Patient files demonstrated detailed consultation and assessment of the procedures. A new electronic platform was in place for staff training. Adequate cleaning of non-disposable equipment requiring sterilisation must be demonstrated. A track-and-trace system must be in place for non-disposable instruments. An induction program for new staff should be developed.	✓ 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: 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 MCMGHC 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 five requirements and nine recommendations.

Direction	
Requirements	
	None
Recommendation	
a	The service should ensure the public are aware of its vision, mission and values (see page 21). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19

Implementation and delivery	
Requirements	
1	The provider must operate within its conditions of registration at all times. If it intends to do anything that is not covered under its conditions of registration, it must submit for approval an 'application to vary, add or remove a condition of registration' within the timescale indicated in our notifications guidance (see page 26). Timescale – immediate *Regulation 8* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
2	The provider must ensure that a comprehensive water risk assessment is carried out to ensure the service's water systems including tanks, pipes, and outlets are assessed to identify and mitigate risks from harmful bacteria. Records of checks and actions carried out must be retained to demonstrate compliance (see page 28). Timescale – immediate *Regulation 3(d)(i)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
3	The provider must ensure that a system is in place to safely manage the Control of Substances Hazardous to Health (COSHH). Substances must be stored safely, COSHH assessments must be completed and in place and staff must have training (see page 28). Timescale – immediate *Regulation 3(a)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*

Implementation and delivery (continued)	
Recommendations	
b	The service should develop a more structured process of receiving useful feedback and have a process in place to make the patients aware of the improvement outcomes (see page 23). 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 the information on the website is accurate and that individual job titles reflect their role in the service (see page 23). 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 17 September 2024 inspection report for Merchant City medical Group
d	The service should develop and implement a quality improvement plan to formalise and direct the way it drives and measures improvement (see page 28). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19
e	The service should further develop the paper copies of patient care records to demonstrate that the patient consents to sharing their information to GP and next of kin in an event of an emergency (see page 28). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.14
f	The service should further develop the business continuity policy to demonstrate the actions to take should the service close in an emergency (see page 28). 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

4 The provider must put a system in place that ensures that all surgical instruments are cleaned and sterilised appropriately and records are retained (see page 32).

Timescale – immediate

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

5 The provider must put a system in place that traces surgical instruments through the life cycle and can link them to the individual patients they have been used on (see page 32).

Timescale – immediate

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

Recommendations

g The service should develop a formal induction process that addresses both clinical and non-clinical aspects of the service (see page 32).

Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.27

h The service should develop a formal induction process that addresses both clinical and non-clinical aspects of the service. The service should obtain two references for new members of staff, in line with safe recruitment practices (see page 32).

Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.24

i The service should securely destroy original Disclosure Scotland Protecting Vulnerable Groups (PVG) records in line with current legislation and implement a system to record PVG scheme identification numbers for all staff (see page 32).

Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.24

An improvement action plan has been developed by the provider and is available on the Healthcare Improvement Scotland website: Find an independent healthcare provider or service – Healthcare Improvement Scotland

MCMGHC 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 Merchant City Medical Group 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 had a strategic plan in place with its overall vision and aims. The vision and values were displayed in the staff room. Key performance indicators had been developed. Staff we spoke with spoke positively about working for the service. Staff meetings allowed staff to contribute to the ongoing development of the service.

The vision, mission and values should be available for the public to access.

Clear vision and purpose

The service's strategic plan included an overall vision and stated that it aimed to be a leading provider of private medical, anaesthetic and minor surgical services. The service's mission was to 'deliver safe, effective, evidence-based treatments in a professional and supported environment.' Its stated values included:

- clinical effectiveness and excellence
- embedding vision and values in practice
- ethical practice and transparency
- patient safety first
- person centered care, and
- quality and continuous improvement.

The vision, mission and values were displayed in the staff restroom. Key performance indicators (KPIs) had recently been developed and included:

- complaints
- incidents
- patient safety and quality
- patient satisfaction, and
- staff wellbeing.

KPIs were measured through patient and staff feedback and audit results, as well as incident reporting. Weekly senior management meetings discussed progress against the KPIs.

We were told that the service had a service level agreement with a local private hospital to transfer patients if they required an overnight stay after treatment.

What needs to improve

The service did not display its vision, mission and values to the public, for example on its website or in the patient waiting area in reception (recommendation a).

- No requirements.

Recommendation a

- The service should ensure the public are aware of its vision, mission and values.

Leadership and culture

The service was owned and managed by a non-clinician and a range of healthcare and non-healthcare professionals worked in the service, including:

- a registered nurse
- a service manager
- administrative staff
- hair transplant technicians
- medical doctors, and
- operating department practitioners.

The service manager had been in post since November 2025. We saw the manager was developing responsibilities and support arrangements for staff. This helped to provide assurance of safe and consistent patient care and treatment. After our complaint investigation in May 2025, the service changed its operating hours to Monday to Friday, 9am–5pm. The service manager was available in the service during business hours.

A daily morning safety huddle helped to plan tasks and set out the allocated staffing for each day. Staff were also encouraged to participate in and contribute to the day-to-day running of the service at the morning safety huddles.

Staff are encouraged to provide feedback through a box in the reception area. The service planned to introduce incentives, such as employee of the month that would be decided based on the feedback received.

Monthly team meetings were held and we saw minutes of these meetings. The team meeting agenda items included:

- new practices and procedures for shared learning
- patient feedback
- quality improvement, and
- staff training.

What needs to improve

The clinic manager had been in post for 4 months. During our inspection, we saw improvement processes and systems that the service manager planned to introduce soon after our inspection. We will follow this up at future inspections.

- 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

Information on treatments was available on the service's website. Patient care records detailed thorough consultation and assessment of the patient, with regular observations documented.

The service must make sure all staff are aware of the Healthcare Improvement Scotland conditions of registration that apply to the clinic. A process must be put in place for the safe management of hazardous substances. A comprehensive water risk assessment should be completed to ensure a safe water system.

Co-design, co-production *(patients, staff and stakeholder engagement)*
The service's website included information for patients on treatments and their costs. The sales team or reception staff would respond to patients contacting the service through its website. The website provided information on how patients could complete an online feedback form.

Patients receiving hair restoration procedures had regular reviews with the service to determine the success of the treatment. The patient was encouraged to leave feedback at each review.

Copies of treatment information leaflets were available for patients to review. After initial consultations, patients could take a 'cooling off' period before commencing treatment.

Staff we spoke with stated:

- 'The senior team are very open and keep us involved in decisions.'
- 'The team is great to work in.'
- 'We have many positive leaders in here.'

Patients told us:

- ‘Great service from the team, made me feel really assured about the process and procedure.’
- ‘They have been open and honest about all elements and I have felt all pre and post info has been very good.’
- ‘Everyone was very pleasant and welcoming.’
- ‘I was welcomed from the first contact.’

What needs to improve

Patients were encouraged to give feedback in a variety of ways and we saw positive feedback had been received. However, the feedback allowed for free text only and did not include any structured formats with prompts for patients to offer suggestion on improvements. Improvements made as a result of patient feedback were not shared with the public (recommendation b).

The website included some misleading information for patients. For example:

- It suggested that the service offered treatments and procedures unavailable in the clinic, such as a tummy tuck.
- The owner was described as a ‘consultant’ - this is misleading as consultant in a healthcare setting can suggest a medically trained healthcare professional (recommendation c).

- No requirements.

Recommendation b

- The service should develop a more structured process of receiving useful feedback and have a process in place to make the patients aware of the improvement outcomes.

Recommendation c

- The service should ensure that the information on the website is accurate and that individual job titles reflect their role in the service.

Quality improvement

We saw that the service 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 notification's guidance.

The service had policies, procedures and processes in place to deliver safe, person-centred care, including those for:

- health and safety
- infection prevention and control
- responding to an emergency, and
- safeguarding.

An infection prevention and control policy described the precautions in place to prevent patient and staff harm from avoidable infections. The policy referred to appropriate national guidance for prevention of infection. Appropriate products were used to clean equipment and the environment. A cleaning schedule was in place and displayed in each room.

An up-to-date medicine management policy described the process the service followed in prescribing, ordering and storing medicines. The service manager had completed a Healthcare Improvement Scotland medicine management governance tool, which demonstrated a process of safe management of medicines in the service. Medicines were ordered from appropriately registered pharmacies. The service manager ordered medicines and stored them securely in locked cupboards, which only the manager and doctors could access. CCTV monitored each medicine cupboard.

The service had a policy in place for managing incidents and accidents, as well as an electronic process for investigating these. This was available for all staff to access and we were told that the service had not experienced any recent incidents.

The complaints process was available on the service's website and included information on:

- how to make a complaint
- stage 1 and stage 2 of a complaint, and
- the timeline for managing a complaint.

The procedure included the contact details of Healthcare Improvement Scotland.

An emergency trolley was available with a defibrillator. We were told the service was waiting for delivery of a new emergency trolley more suitable for minor surgical procedures.

A duty of candour policy was in place (where healthcare organisations have a professional responsibility to be honest with people when something goes wrong). The service had published a yearly duty of candour report on its website.

Patient care records contained patient information, including:

- a completed medical questionnaire
- a detailed consultation and assessment process, and
- contact details.

The electronic patient care records we reviewed included consent for treatment, to take photographs and to share information with external professionals and next of kin.

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

Systems and processes were in place for training, development and one-to-ones. Before starting their role, new staff were required to complete mandatory online training modules, including those for:

- health and safety
- medical emergencies and anaphylaxis
- medicine management, and
- safeguarding.

What needs to improve

During our inspection, it became clear that patients had been booked in for minor surgical procedures not listed on the service's certificate of registration. When asked, staff were unaware of what treatments the certificate of registration stated that the clinic was allowed to carry out (requirement 1).

- No requirements.

Requirement 1 - Timescale: immediate

- The provider must operate within its conditions of registration at all times. If it intends to do anything that is not covered under its conditions of registration, it must submit for approval an 'application to vary, add or remove a condition of registration' within the timescale indicated in our notifications guidance.

Planning for quality

The service manager had recently developed a register of clinical and non-clinical risks in place for risks in the service, such as:

- general health and safety risks for clinic areas
- risks of procedures such as hair transplant treatments, and
- use of non-compliant fixtures and fittings.

The risk assessments included processes put in place to help manage any risks identified.

As a contingency, the service informed us that it had an agreement with a Healthcare Improvement Scotland registered independent hospital. In the case of an emergency or closure of the clinic, the service would refer patients to this hospital if required. This would help make sure patients could continue their treatment plans.

We saw that a fire risk assessment had been completed for the whole service. Fire cylinders had been serviced and checked. Fire signs were in place in the service.

The manager had recently started to carry out monthly audits in the service, including those for:

- hand hygiene
- housekeeping
- infection prevention and control, and
- waste management

What needs to improve

The legionella risk assessment submitted to Healthcare Improvement Scotland did not include an address, the date it had been carried out or any review date. While the service shared a blank water outlet flushing schedule with us, we saw no records of:

- cleaning and disinfection logs
- temperature checks, or
- testing for legionella (requirement 2).

The service had some data sheets for the control of substances hazardous to health (COSHH) and had recently purchased a cupboard suitable for storage of these items. However, the service did not have a system or procedures in place to manage the control of substances hazardous to health (requirement 3).

The service had developed a clinical governance and quality improvement framework, which referred to:

- clinical governance
- medicine management
- risk assessments, and
- staff competence.

It planned to introduce improvements to the systems and processes in place to ensure the safe quality of care given to patients. However, this was not recorded in a quality improvement plan, which could be reviewed and updated (recommendation d).

Some patient care records were completed in paper format and included contact details for the GP and next of kin. However, we saw no evidence in these patient care records that the patient had consented to using these details in the event of an emergency (recommendation e).

The service's business contingency policy highlighted the daily processes in place in the service and levels of ongoing training required. However, it did not demonstrate set out how staff would manage an emergency closure of the clinic (recommendation f).

The service had developed an audit and risk policy which addressed risk management framework and audit processes. We saw that the audit programme had improved since our last inspection. We discussed with the

service the need to further develop the audit programme and the type of audits carried out. We will follow this up at future inspections.

Requirement 2– Timescale: immediate

- The provider must ensure that a comprehensive water risk assessment is carried out to ensure the service's water systems including tanks, pipes, and outlets are assessed to identify and mitigate risks from harmful bacteria. Records of checks and actions carried out must be retained to demonstrate compliance.

Requirement 3 – Timescale: immediate

- The provider must ensure that a system is in place to safely manage the Control of Substances Hazardous to Health (COSHH). Substances must be stored safely, COSHH assessments must be completed and in place and staff must have training.

Recommendation d

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

Recommendation e

- The service should further develop the paper copies of patient care records to demonstrate that the patient consents to sharing their information to GP and next of kin in an event of an emergency.

Recommendation f

- The service should further develop the business continuity policy to demonstrate the actions to take should the service close in an emergency.

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 in a good state of repair. Patient files demonstrated detailed consultation and assessment of the procedures. A new electronic platform was in place for staff training.

Adequate cleaning of non-disposable equipment requiring sterilisation must be demonstrated. A track-and-trace system must be in place for non-disposable instruments. An induction programme for new staff should be developed.

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 comprehensive self-evaluation.

Since our inspection in September 2024, the provider had changed address and planned to expand the service's provision. The environment was in a good state of repair and had recently been refurbished.

We reviewed five patient care records and saw that all included detailed assessments and treatment plans. Each patient care record documented the calculation of the amount of local anaesthetic used on each patient. This considered the patient's past medical history and their weight. Treatment plans and regular observations were documented throughout the patient's treatment.

The service used a communication board in the staffroom to share information, including information about:

- duty of candour
- incident reporting
- monthly audit review, and
- service mission and values.

The service used an electronic platform to record mandatory training, which included training on:

- advanced life support
- infection control
- medicine management, and
- safeguarding.

We saw evidence that an external trainer had provided anaphylaxis training to staff and that a plan was in place for future face-to-face training.

We saw that the clinic manager had recently introduced yearly appraisals and regular one-to-ones with staff.

Clinical areas were clean and clutter free. Equipment was in good condition. Theatre staff told us they checked equipment daily before use and we saw this recorded in the theatre care record.

To help assess the safety culture in the service, we followed a patient's journey through their surgery. Before the patient arrived in theatre, we observed a pre-safety brief that made sure all staff in theatre were aware of:

- any patient concerns or allergies
- equipment and sundries required
- the patient to be operated on, and
- the planned procedure.

We saw that staff followed World Health Organization guidelines, such as taking a 'surgical pause' before starting surgery to check they had the correct patient and equipment. We also observed staff following safe procedures for managing swabs and instruments in line with guidelines in the theatre area.

We saw that patients were accompanied to and from the theatre department with a suitable member of staff. We saw that baseline observations of pulse, blood pressure and oxygen saturation were carried out before surgery. Monitoring of the patient was carried out during the operation and in the recovery room. These observations were recorded in the patient care record.

An up-to-date recruitment policy was in place, which referred to advertising vacancies, shortlisting and pre-employment checks. The service had recently started using a HR platform to electronically store all staff recruitment documents. We saw that the service manager was transferring staff files from paper format to electronic.

Staff who completed our online survey told us:

- 'Whenever something that doesn't look fine we report to the manager and they get it sorted.'
- 'Clinical and safety-related concerns are taken seriously and addressed appropriately.'
- 'I feel everyone has a voice and is heard.'

Patients who completed our online survey told us:

- 'Very clean and relaxed.'
- 'Place was very modern and spotless.'
- 'The Dr and all his staff were very knowledgeable in my opinion.'
- 'Comfortable environment.'

What needs to improve

The service used disposable and non-disposable instruments with an autoclave on-site for sterilising instruments. We were unable to assess that the non-disposable instruments were being cleaned and sterilised appropriately (requirement 4).

Staff were unable to demonstrate the tracking and tracing of surgical instruments to specific patients at the time of our inspection (requirement 5).

The service did not have a formal induction process in place (recommendation g).

We looked at five staff records and found checks had been carried out on staff members' identity, professional registration and Disclosure Scotland status. However, only one reference had been checked (recommendation h).

Each staff file contained the original Disclosure Scotland Protecting Vulnerable Groups check. For the security of staff personal information, this document should not be stored in the staff files (recommendation i).

The manager was in the process of developing an asset register. We will follow this up at future inspections.

Requirement 4 – Timescale: immediate

- The provider must put a system in place that ensures that all surgical instruments are cleaned and sterilised appropriately and records are retained.

Requirement 5 – Timescale: immediate

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

Recommendation g

- The service should develop a formal induction process that addresses both clinical and non-clinical aspects of the service.

Recommendation h

- The service should obtain two references for new members of staff, in line with safe recruitment practices.

Recommendation i

- The service should securely destroy original Disclosure Scotland Protecting Vulnerable Groups (PVG) records in line with current legislation and implement a system to record PVG scheme identification numbers for all staff.

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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