Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Announced Inspection Report: Independent Healthcare

Service: The Ever Clinic, Glasgow

Service Provider: The Ever Clinic Ltd

18 June 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 21 February 2022

Requirement

The provider must ensure that annual staff performance and development reviews are documented and include staff aims and expectations.

Action taken

Staff had not received annual performance and development reviews. **This requirement is not met** and is reported in Domain 4: Quality improvement (see requirement 7 on page 24).

What the service had done to meet the recommendations we made at our last inspection on 21 February 2022

Recommendation

The service should continue to develop its programme of clinical audits to include patient care records and clinical practice.

Action taken

The service had a programme of clinical audits in place, including audits of patient care records, infection prevention and control and laser safety.

Recommendation

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

Action taken

A quality improvement plan was in place that included actions taken for improvement of the service.

2 A summary of our inspection

Background

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

Our focus

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

About our inspection

We carried out an announced inspection to The Ever Clinic on Thursday 18 June 2026. We spoke with the service manager during the inspection. We received feedback from eight patients through an online survey we had asked the service to issue to its patients for us before the inspection.

Based in Glasgow, The Ever Clinic is an independent clinic providing non-surgical and minor surgical treatments.

The inspection team was made up of two inspectors.

What we found and inspection grades awarded

For The Ever Clinic, the following grades have been applied.

Direction	*How clear is the service's vision and purpose and how supportive is its leadership and culture?*
Summary findings	**Grade awarded**
Leadership processes were in place to support staff delivering care. Key performance indicators were reviewed regularly. Sharing the statement of purpose would inform patients of the services vision, aims and objectives. The introduction of formalised meetings would keep all staff informed and provide a record of discussions and actions to be taken for service improvement.	✓ Satisfactory
Implementation and delivery	*How well does the service engage with its stakeholders and manage/improve its performance?*
Risk management and a quality improvement plan helped demonstrate a culture of continuous improvement. A detailed website provided patient information on the treatments offered. Staff involved in laser treatments had completed laser safety training. Reviewing emergency arrangements, making sure safe staffing is in place and improved patient monitoring when required would improve the safety provision for patients. An appropriate process and facilities for sterilisation of reusable equipment would further reduce the risk of infection. Implementing governance of the audit process would make sure non-compliances are identified and improvements implemented. Staff appraisals would provide a structured opportunity to discuss staff performance, achievements, personal development and suggestions for service improvements.	Unsatisfactory

Results	*How well has the service demonstrated that it provides safe, person-centred care?*
Summary findings	**Grade awarded**
The environment was clean, tidy and well maintained. Patients were satisfied with care and treatment provided and told us they were treated with dignity and respect. An improved process for patient monitoring would allow early detection of a change in a patient's condition and that they are safe for discharge. A process of formal checks during the recruitment process would help make sure staff are safe to work in the service. Appropriate documentation of controlled drugs held in the clinic would help identify any discrepancies of the amount in stock. Correctly labelled dispensed medicine would ensure patient safety and compliance with legal requirements.	Unsatisfactory

Grades may change after this inspection due to other regulatory activity. For example, if we have to take enforcement action to improve the service or if we investigate and agree with a complaint someone makes about the service.

More information about grading can be found on our website at: 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 The Ever Clinic Ltd to take after our inspection

The actions that Healthcare Improvement Scotland expects the independent healthcare service to take are called requirements and recommendations.

- **Requirement:** A requirement is a statement which sets out what is required of an independent healthcare provider to comply with the National Health Services (Scotland) Act 1978, regulations or a condition of registration. Where there are breaches of the Act, regulations or conditions, a requirement must be made. Requirements are enforceable.
- **Recommendation:** A recommendation is a statement which sets out what a service should do in order to align with relevant standards and guidance.

This inspection resulted in 13 requirements and 9 recommendations.

Direction	
Requirements	
	None
Recommendations	
a	The service should share its vision and purpose statement with patients (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
b	The service should: *(a) implement a programme of regular structured staff meetings, and* *(b) formalise all staff and management meetings, with an agenda and record of discussions and decisions reached at these meetings kept. These should detail staff responsible for taking forward any actions (see page 17).* Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19

Implementation and delivery	
Requirements	
1	The provider must notify Healthcare Improvement Scotland of certain matters as detailed in our notifications guidance (see page 23). Timescale – by 18 September 2026 *Regulation 5(1)(b)* *The Healthcare Improvement Scotland (Applications and Registration) Regulations 2011*
2	The provider must ensure that complete complaint files are held to demonstrate that complaints are fully investigated (see page 23). Timescale – by 18 September 2026 *Regulation 15(3)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
3	The provider must review its staffing model and ensure there are appropriate staff present during all treatments (see page 23). Timescale – immediate *Regulation 12(1)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
4	The provider must ensure its own policies and procedures reflect national guidance and are followed and appropriate emergency equipment is available (see page 23). Timescale – immediate *Regulation 3(a)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*

Implementation and delivery (continued)
Requirements
5 The provider must ensure that it does not use any reusable instruments unless: *(a) the instruments are collected and sterilised by an external approved contractor, or* *(b) a dedicated, fully compliant decontamination room is built within the clinic and associated documentation and training is in place (see page 23).* Timescale – immediate *Regulation 3(d)(ii)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
6 The provider must review its laser safety arrangements to ensure that: *(a) the appointed laser protection advisor provides an updated set of local rules* *(b) the local rules are available for staff involved in laser treatments* *(c) the authorised users and supervisor have read, understood and signed the local rules, and* *(d) there is evidence that any other staff who work with the lasers have read and understood the local rules (see page 24).* Timescale - by 18 September 2026 *Regulation 3(d)(v)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*

Implementation and delivery (continued)	
Requirements	
7	The provider must ensure that annual staff performance and development reviews are documented (see page 24). Timescale – by 18 September 2026 *Regulation 12(c)(i)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011* This was previously identified as a requirement in the February 2022 inspection report for The Ever Clinic.
8	The provider must ensure audits are carried out and accurate findings are recorded (see page 26). Timescale – by 18 September 2026 *Regulation 13(2)(b)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
Recommendations	
c	The service should develop a formal process to obtain staff feedback and suggestions for improvements (see page 19). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19
d	The service should ensure that policies are relevant to the service, reflect national guidance, and provide clear information and guidance for staff (see page 24). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.11
e	The service should ensure that patients consent to sharing their information with other healthcare practitioners is obtained and documented in the patient care record prior to any treatment (see page 24). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.11

Implementation and delivery (continued)	
Recommendations	
f	The service should ensure that all staff complete the mandatory training relevant to their role. Evidence of all completed staff training should be documented (see page 24). Health and Social Care Standards: My support, my life. I have confidence in the people who support and care for me. Statement 3.14

Results	
Requirements	
9	The provider must implement effective systems that demonstrate that staff working in the service 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 30). Timescale – immediate *Regulation 8.1* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
10	The provider must ensure that appropriate systems are in place for the management of controlled drugs (see page 30). Timescale – immediate *Regulation 5(2)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
11	The provider must ensure that all medicine that is dispensed is correctly labelled (see page 30). Timescale – immediate *Regulation 3(d)(iv)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*

Results (continued)

Requirements

12 The provider must ensure botulinum toxin is used in line with the manufacturer's and best practice guidelines (see page 30).

Timescale – immediate

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

13 The provider must ensure that appropriate monitoring of patient observations takes place during all procedures involving the use of sedation and are documented in the patient care record (see page 30).

Timescale – immediate

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

Results (continued)

Recommendations

g The service should have a system in place for ensuring all fridge temperature checks carried out are recorded at the time along with any actions taken (see page 30).

Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.11

h The service should ensure gas cylinders are stored appropriately (see page 30).

Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.11

i The service should complete and submit a self-evaluation when requested by Healthcare Improvement Scotland (see page 31).

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:
Find an independent healthcare provider or service – Healthcare Improvement Scotland

The Ever Clinic Ltd, the provider, must address the requirements and make the necessary improvements as a matter of priority.

We would like to thank all staff at The Ever Clinic for their assistance during the inspection.

3 What we found during our inspection

Key Focus Area: Direction

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

Our findings

Leadership processes were in place to support staff delivering care. Key performance indicators were reviewed regularly. Sharing the statement of purpose would inform patients of the services vision, aims and objectives. The introduction of formalised meetings would keep all staff informed and provide a record of discussions and actions to be taken for service improvement.

Clear vision and purpose

The service outlined its aims, vision and purpose in a statement, which was available in the clinic for staff. The vision included providing safe, evidence-based care that patients have confidence in and the purpose was to provide specialist medical skin treatments. The core aims of the service and its values were also included.

Clinical key performance indicators (KPIs) had been identified, including patient safety indicators. KPIs were reviewed monthly and rated using a red-amber-green system used to indicate performance, risk, or compliance. In this system, red signals a problem, amber indicates caution and green shows satisfactory status. The service also had business KPIs, such as financial performance, growth and patient numbers in place.

The service told us that no other similar services existed to allow it to benchmark against. However, we were told that it assessed the service against inspection reports of other Healthcare Inspection Scotland-registered services, as well as industry guidance.

What needs to improve

The service's vision and purpose statement was not shared with patients (recommendation a).

- No requirements.

Recommendation a

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

Leadership and culture

The service had a clear leadership structure and there were named leads for laser safety, infection prevention and control and complaints management. The service directly employed all the staff who worked in the service. The clinical lead who provided governance and assurance of all clinical-related matters in the service was a General Medical Council registered doctor. The doctor was also a founder member of the Complications in Medical Aesthetics Collaborative (CMAC), which supports clinicians worldwide in managing risk, diagnosing and managing complications in medical aesthetics.

A quality assurance framework detailed the systems and processes in place to help support staff deliver care safely and make sure the service was continuously improving.

The service provided opportunities for staff development. For example, a clinical staff member had received additional training to expand the range of treatments they could perform.

Communication between staff was through an online group chat app. Any changes to the service or policies and procedures were shared in the group chat. Staff were requested to acknowledge that the communication had been read.

What needs to improve

During a previous inspection in July 2021, the service received recommendations to formally record the minutes of management meetings and to develop a regular programme of structured staff meetings. During the next inspection in February 2022, we saw management meeting minutes and were told that a programme of staff meetings had been scheduled. However, during this inspection we were told that management meetings were not minuted and no staff meetings took place (recommendation b).

- No requirements.

Recommendation b

- The service should:

  (a) implement a programme of regular structured staff meetings, and
  (b) formalise all staff and management meetings, with an agenda and record of discussions and decisions reached at these meetings kept. These should detail staff responsible for taking forward any actions.

Key Focus Area: Implementation and delivery

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

Our findings

Risk management and a quality improvement plan helped demonstrate a culture of continuous improvement. A detailed website provided patient information on the treatments offered. Staff involved in laser treatments had completed laser safety training.

Reviewing emergency arrangements, making sure safe staffing is in place and improved patient monitoring when required, would improve the safety provision for patients. An appropriate process and facilities for sterilisation of reusable equipment would further reduce the risk of infection. Implementing governance of the audit process would make sure non-compliances are identified and improvements implemented. Staff appraisals would provide a structured opportunity to discuss staff performance, achievements, personal development and suggestions for service improvements.

Co-design, co-production *(patients, staff and stakeholder engagement)*
The service engaged and shared information with patients through its website and social media pages. This helped to keep patients up to date with developments in the service.

The service's website provided information on:

- costs
- consultation and treatment prices
- the clinic team, and
- treatments, including risks and benefits and aftercare.

This allowed patients to make an informed decision about accessing the service for treatment. All patients who answered our survey told us that they felt fully informed and involved in the decisions about their care. Comments included:

- 'Very professional team who took care of me and listened to any questions or concerns I had and addressed these. Very person centred to my needs.'
- 'All procedures were explained fully and possibly complications. I was involved in the decision-making process throughout.'
- '…there was no pressure & plenty of time to adsorb information before consenting to treatment.'

Patient feedback was obtained through an online review platform. We saw these patients' reviews were shared on the services website and social media pages. We were told that a patient survey had been conducted. However, it was not useful as a measure of how the service was performing due to the low response rate.

Patient feedback was shared with staff on their online chat group. All feedback we saw was positive and we were told that if any changes were made as a result of patient feedback, it would be shared with patients.

What needs to improve

The service did not have a formal process in place for staff to provide suggestions for improvements, such as an item for discussion on a meeting agenda (recommendation c).

- No requirements.

Recommendation c

- The service should develop a formal process to obtain staff feedback and suggestions for improvements.

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.

Policies and procedures were reviewed annually and updated when required.

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

goes wrong). A duty of candour statement and the service's yearly duty of candour report was available on the service's website.

A process for reporting any incidents and accidents that may occur in the service was in place. We saw lessons learned were shared with staff.

A complaints policy detailed the process for how patients could make a complaint to Healthcare Improvement Scotland. Information on how to make a complaint was available on the website for patients to view.

All patient information was stored securely on password-protected electronic devices. This helped to protect confidential information in line with the service's information management policy. The service was registered with the Information Commissioner's Office (an independent authority for data protection and privacy rights) and we saw that it followed appropriate date protection regulations.

Patients had a face-to-face consultation before any aesthetics treatments. All medical procedures had a consultation with a clinical or medial practitioner, which included:

- a full medical history
- expected outcomes of treatment
- risk and benefits, and
- the provision of aftercare advice.

Standard operating protocols were in place for the use of sedation and controlled drugs. The clinical lead reviewed the protocols yearly. Protocols are step-by-step sets of instructions that guide healthcare professionals in performing routine and critical tasks safely, consistently and in line with medical standards. This helps to make sure that every action supports quality care and patient safety.

Emergency medicines were available for patients who may experience aesthetic complications following treatment. An eye wash and first aid kit were also available.

The service had an external registered laser protection advisor to make sure laser safety rules and guidance were followed to support the safe delivery of laser treatments for its patients. We saw the advisor had developed a laser risk assessment and local rules (the local arrangements developed by the advisor to manage laser safety) for the laser. Relevant staff had completed their core of

knowledge safety training. A laser warning sign was displayed on the outside of the treatment room door. All laser machines were keycode operated or had a key, which was stored securely.

The service kept up to date with industry developments and best practice through its membership of professional organisations. Memberships included the American Society for Laser Medicine and Surgery, as well as the Complications in Medical Aesthetics Collaborative.

What needs to improve

As a registered independent healthcare service, the service has a duty to report certain matters to Healthcare Improvement Scotland as detailed in our notifications guidance. However, a notification had not been submitted for a notifiable incident of vascular occlusion (requirement 1).

The service had a complaints log that listed two complaints. We requested the associated complaint management documentation. However, the information we received did not provide evidence of response dates or communication with the complainant and relevant staff members. Therefore, we did not see evidence that the complaints were fully investigated (requirement 2).

Some procedures were carried out using moderate sedation. A doctor was responsible for the procedure. Current guidance states a second trained staff member must also be present. However, we were told that an aesthetics practitioner or a healthcare assistant assisted the doctor. We saw no evidence that these members of staff had completed sedation training (requirement 3).

The service's medicines emergency policy referred to using an automated external defibrillator (AED, a portable electronic medical device used to treat individuals experiencing sudden cardiac arrest) in an emergency. It also stated that oxygen and an emergency bag would be used in an emergency 'if available' and that checks on an AED and oxygen were carried out. Current sedation safety guidance and the service's own sedation standard operating procedure states that emergency equipment, oxygen, suction, airway equipment and a pulse oximeter must be immediately accessible. A pulse oximeter is a medical device that monitors the level of oxygen in the blood. During our inspection, we found that only a pulse oximeter was available. We were told that a first aid kit and eye wash kit were the only emergency equipment available in the service (requirement 4).

Some reusable instruments were sterilised using an autoclave. An autoclave is a device that uses pressurised steam to sterilise equipment and materials, killing:

- bacteria
- fungi
- spores, and
- viruses.

However, we observed that this process was not carried out in a dedicated decontamination area. In addition, we saw equipment cleaned in a scrub sink that should be designated for handwashing only. Staff we spoke with confirmed that the service did not have a formal, step-by-step decontamination protocol in place. Following our inspection, the service confirmed that it would stop the use of reusable instruments (requirement 5).

The service had measures in place to make sure the environment and equipment was safe for delivering laser treatments. The laser safety local rules were held digitally and were not available in the room where laser procedures were carried out. We saw that only one staff member was named as an authorised user in the laser safety local rules an external laser protection advisor had written. They had not signed to state they had read and understood the rules. We were also told that two other staff members were involved in laser treatments. However, we saw that these staff members were not listed in the local rules (requirement 6).

We were told that staff did not receive an annual appraisal or any other formal performance and development review (requirement 7).

While policies were in place and reviewed regularly, they did not always provide clear and specific information and guidance to support staff in the delivery of care. For example:

- the infection prevention and control policy did not refer to national guidance or give specifics about what products should be used, and
- the recruitment policy did not list all checks that should be carried out before employment.

Some policies did not reflect the arrangements in the service. For example, the sedation and medicines management policies referred to equipment the service did not have and an audit that was not carried out (recommendation d).

We saw a process in place for patients to provide informed consent for their treatment and for digital images. However, patients were not requested to consent to share their patent information with other healthcare professionals in some situations, such as if an emergency arose. We were told that this would only be requested if there was a need after the treatment (recommendation e).

A mandatary training matrix had recently been developed and implemented for a new staff member. However, the current staff had not been required to complete any mandatory training unless working with lasers. We were told that all staff would need to complete the mandatory training or supply evidence that they had completed the training in previous employment (recommendation f).

Requirement 1 – Timescale: by 18 September 2026

- The provider must notify Healthcare Improvement Scotland of certain matters as detailed in our notifications guidance.

Requirement 2 – Timescale: by 18 September 2026

- The provider must ensure that complete complaint files are held to demonstrate that complaints are fully investigated.

Requirement 3 – Timescale: immediate

- The provider must review its staffing model and ensure there are appropriate staff present during all treatments.

Requirement 4 – Timescale: immediate

- The provider must ensure its own policies and procedures reflect national guidance and are followed and appropriate emergency equipment is available.

Requirement 5 – Timescale: immediate

- The provider must ensure that it does not use any reusable instruments unless:

  (a) the instruments are collected and sterilised by an external approved contractor, or
  (b) a dedicated, fully compliant decontamination room is built within the clinic and associated documentation and training is in place.

Requirement 6 – Timescale: immediate

- The provider must review its laser safety arrangements to ensure that:

  (a) the appointed laser protection advisor provides an updated set of local rules
  (b) the local rules are available for staff involved in laser treatments
  (c) the authorised users and supervisor have read, understood and signed the local rules, and
  (d) there is evidence that any other staff who work with the lasers have read and understood the local rules.

Requirement 7 – Timescale: by 18 September 2026

- The provider must ensure that annual staff performance and development reviews are documented.

Recommendation d

- The service should ensure that policies are relevant to the service, reflect national guidance, and provide clear information and guidance for staff.

Recommendation e

- The service should ensure that patients consent to sharing their information with other healthcare practitioners is obtained and documented in the patient care record prior to any treatment.

Recommendation f

- The service should ensure that all staff complete the mandatory training relevant to their role. Evidence of all completed staff training should be documented.

Planning for quality

We were told a contingency plan was in place for events that could cause an emergency closure of the service or cancellation of appointments, such as power failure or sickness. Patients would be able to continue their treatment plans in another Healthcare Improvement Scotland registered clinic.

Appropriate insurances were in-date, such as those for:

- employer liability
- medical malpractice, and

- public and products liability.

Systems were in place to proactively assess and manage risk to staff and patients, including:

- auditing
- reporting systems
- risk assessments, and
- risk register.

This helped to make sure that care and treatment was delivered in a safe environment. The service's risk register was regularly reviewed and covered environmental and patient safety risks.

Quality improvement is a structured approach to evaluating performance, identifying areas of improvement and taking corrective actions. The service's quality improvement plan identified areas of improvement, with documented action plans and staff responsible for carrying out these actions. Examples of improvements included:

- a communication app to improve patient management
- documentation checklist to ensure all patient documentation completed
- patch testing following a rare allergic reaction of a patient, and
- standard operating procedure produced for biopsies to ensure correct labelling.

What needs to improve

A programme of audits was in place to assess performance and identify areas of improvement. Some examples of audits carried out included those for:

- infection prevention and control
- medicines management, and
- patient care records.

These audits were documented and reviewed with any actions. However, the findings of the audits we saw did not reflect our findings during our inspection. For example, the medicines management audit indicated that a temperature log for the drug refrigerator was completed daily. We were told during the inspection that the temperatures were not documented. The staff file audit indicated that the professional registrations of all relevant staff had been

checked and that five of the six staff had fully completed the mandatory training matrix. We were told that professional registrations had not been checked and only one staff member had been requested to complete mandatory training. We also saw no evidence of this in the staff files (requirement 8).

Requirement 8 – Timescale: by 18 September 2026

- The provider must ensure audits are carried out and accurate findings are recorded.

- No recommendations.

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, tidy and well maintained. Patients were satisfied with care and treatment provided and told us they were treated with dignity and respect.

An improved process for patient monitoring would allow early detection of a change in a patient's condition and that they are safe for discharge. A process of formal checks during the recruitment process would help make sure staff are safe to work in the service. Appropriate documentation of controlled drugs held in the clinic would help identify any discrepancies of the amount in stock. Correctly labelled dispensed medicine would ensure patient safety and compliance with legal requirements.

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.

The environment was clean, tidy and well maintained. Staff cleaned the treatment rooms and equipment between patient appointments and a full clean was carried out twice a day. Cleaning checklists were in place and completed to show that appropriate cleaning was carried out. Patients felt safe in the clinics and were positive about the equipment and environment. Comments included:

- 'Top class facilities, equipment & warm & friendly environment.'
- 'Lovely clean, bright, hygienic environment.'

Measures were in place to reduce the risk of infection and cross-contamination. For example, the service had a good supply of personal protective equipment (such as disposable aprons and gloves) and alcohol-based hand gel. The correct product was used for cleaning sanitary fittings, including clinical hand wash basins. A stronger dilution was used for the management of blood contamination. We saw that an appropriate waste management contract was in place. Appropriate sharps disposal units and clinical waste bins were located in the treatment areas.

Equipment was clean and in good condition. We saw that an equipment maintenance register was kept.

We reviewed three patient care records and saw that that all had the following information documented:

- consent to treatment
- general patient information (contact details, emergency contact, GP)
- medical history
- medicines
- treatment plan, and
- the aftercare advice given.

Patients who responded to our online survey told us they were treated with dignity and respect and were satisfied with the care and treatment they received from the service. Some comments included:

- 'I am a longstanding patient and am always treated with compassion, empathy and kindness.'
- 'Felt welcomed, listened to and understood.'
- 'The entire experience was completely seamless and professional. From the moment I walked into their clinic.'

What needs to improve

We reviewed three staff files, including two registered healthcare professionals and one healthcare assistant. We saw that only one staff member had received a Disclosure Scotland check. We also saw no evidence of the following safety checks:

- appropriate professional registers
- occupational health status
- professional qualifications, and
- references (requirement 9).

Following our inspection, the service advised that it had applied for appropriate Disclosure Scotland checks of all staff.

The service held a stock of a controlled drug used for sedation. The service had a controlled drug standard operating procedure that detailed how sedation drugs would be appropriately documented. However, it did not have a

controlled drug register in place or any documentation providing a record of a running balance of the drug. This meant that any discrepancy in the stock level would not be identified (requirement 10).

Following our inspection, we saw that the service had developed a controlled drug register.

We saw that discharge medicines were not labelled appropriately. For example, while the directions for taking the medication was included in a leaflet, they were not detailed on the medicines box. The following must appear on the label of any prescribed medicine:

- name of the patient
- name and address of the supplying pharmacy or clinic
- date of dispensing
- approved (scientific or generic) name and strength of the medicine
- directions for use of the medicine, and
- precautions relating to the use of the medicine (requirement 11).

During our inspection, we found evidence of an opened, re-constituted vial of botulinum toxin (when a liquid solution is used to turn a dry substance into a fluid for injection) in the service's medicine fridge. We were told this was used to treat patients who were attending the service for 'top up' anti-wrinkle treatments. This is not in line with manufacturer's guidelines (requirement 12).

We were told that patients who had received sedation had only recently started to be monitored with a pulse oximeter, a device to check a patient's heart rate and level of oxygen in the blood. Blood pressure monitoring was not carried out. The service did not use a documented scale to monitor patients from before, during and after their treatments to make sure they were safe during the procedure and then safe for discharge (requirement 13).

The service did not have a system in place to record the temperature of the dedicated clinical fridge to make sure medicines were stored at the correct temperature (recommendation g).

The service stored one spare cylinder of Entonox (a mixture of nitrous oxide and oxygen, commonly referred to as 'gas and air' used to help manage pain and anxiety during medical procedures). The cylinder was not stored appropriately and could be knocked over and damaged (recommendation h).

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. Although requested, the service did not submit a self-evaluation before the inspection (recommendation i).

Requirement 9 – Timescale: immediate

- The provider must implement effective systems that demonstrate that staff working in the service 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 10 – Timescale: immediate

- The provider must ensure that appropriate systems are in place for the management of controlled drugs.

Requirement 11 – Timescale: immediate

- The provider must ensure that all medicine that is dispensed is correctly labelled.

Requirement 12 – Timescale: immediate

- The provider must ensure botulinum toxin is used in line with the manufacturer's and best practice guidelines.

Requirement 13 – Timescale: immediate

- The provider must ensure that appropriate monitoring of patient observations takes place during all procedures involving the use of sedation and are documented in the patient care record.

Recommendation g

- The service should have a system in place for ensuring all fridge temperature checks carried out are recorded at the time along with any actions taken.

Recommendation h

- The service should ensure gas cylinders are stored appropriately.

Recommendation i

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

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

Healthcare Improvement Scotland

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