Announced Inspection Report: Independent Healthcare

Service: Laura Wylie Aesthetics, Paisley
Service Provider: Laura Wylie Aesthetics

19 December 2019
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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 9 July 2019

Requirement
The provider must update patient information to make it clear to complainants that they can refer a complaint to Healthcare Improvement Scotland at any stage of the complaints process.

Action taken
A patient information sheet given to all patients included information on how to make a complaint to Healthcare Improvement Scotland. This requirement is met.

Requirement
The provider must put appropriate measures in place to identify and manage risk in the service.

Action taken
The provider had developed a risk assessment policy, included in its clinical governance policy to manage risks. This requirement is met.

Requirement
The provider must ensure that all staff working in a registered healthcare service have appropriate safety checks in place.

Action taken
The provider had completed registration checks and had a process in place to review registrations every year. This requirement is met.

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 registration certificate was displayed in the service’s treatment area. This requirement is met.
**Requirement**
The provider must ensure patient care records are stored in a secure, locked filing cabinet which only they can access.

**Action taken**
Patient care records were kept in a locked filing cabinet that only the service manager had access to. The filing cabinet was kept in a locked room. **This requirement is met.**

**Requirement**
The provider must implement a suitable system of regularly reviewing the quality of the service. A written record of the review must be made available to Healthcare Improvement Scotland and service users.

**Action taken**
The provider had developed a patient survey and gave it to every patient after treatment for their feedback. While we were told it planned to regularly review the quality of the service, we did not see an audit system in place at the time of our inspection. **This requirement is not met** and will be carried forward with a revised timescale.

**What the service had done to meet the recommendations we made at our last inspection on 9 July 2019**

**Recommendation**
The service should continue to develop and implement its participation policy to direct the way it engages with its patients and uses their feedback to drive improvement.

**Action taken**
The provider had developed a participation policy that included feedback from patients to ensure comments, complaints and improvements are actioned. However, we saw no evidence of the service implementing the policy at the time of our inspection. **This recommendation is not met** and will be carried forward.

**Recommendation**
The service should implement a structured approach to cleaning the environment and patient equipment that sets out all cleaning tasks, methods, responsibilities and a system for verifying that cleaning tasks are being carried out appropriately.
**Action taken**
The service manager cleaned the treatment area of the clinic at the start and end of each working day and between patients. We saw completed checklists that recorded when all areas had been cleaned. **This recommendation is met.**

**Recommendation**
The service should develop a programme of audit to cover key aspects of care and treatment so learning can take place. Audits must be documented and improvement action plans implemented.

**Action taken**
We saw some completed feedback forms the service had recently received and we were told an audit was planned after 3 months. The service also planned to audit patient care records every month to start with and every 3 months in the future. **This recommendation is met.**

**Recommendation**
The service should develop and implement a procedure for reviewing the prescriber’s compliance to all aspects of the practicing privileges arrangement and for regularly renewing the agreement.

**Action taken**
The provider planned to carry out a yearly appraisal for the prescriber to review their registration and development to make sure they remain compliant with practicing privileges. **This recommendation is met.**

**Recommendation**
The service should develop and implement a duty of candour policy setting out the actions to be followed in response to unintended or unexpected patient harm.

**Action taken**
This is reported under Quality Indicator 2.1 **This recommendation is met.**

**Recommendation**
The service should make sure all entries in paper and electronic records are clearly written, dated and timed to comply with professional standards from the Nursing and Midwifery Council about keeping clear and accurate records.

**Action taken**
We saw patient consent and the service manager’s signature were recorded in all five patient care records we reviewed. Records were clearly written, dated and timed. **This recommendation is met.**
**Recommendation**
The service should record patient consent for sharing information with their GP and other medical staff in an emergency, if required, in patients’ care records.

**Action taken**
Patient consent to share information with their GP was documented in all five patient care records we reviewed. **This recommendation is met.**

**Recommendation**
The service should carry out regular audits of patient care records.

**Action taken**
While the service planned to audit patient care records monthly, it had not carried out any audits at the time of our inspection. **This recommendation is not met** and will be carried forward.

**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 had not been developed. This recommendation is reported under Quality Indicator 9.4. **This recommendation is not met** (see recommendation e).
2 A summary of our inspection

The focus of our inspections is to ensure each service is person-centred, safe and well led. Therefore, we only evaluate the service against three key quality indicators which apply across all services. However, depending on the scope and nature of the service, we may look at additional quality indicators.

About our inspection

We carried out an announced inspection to Laura Wylie Aesthetics on Thursday 19 December 2019. This was a follow-up to our first inspection to the service on Tuesday 9 July 2019. We did not receive any feedback from patients to an online survey we had asked the service to issue for us before the inspection.

The inspection team was made up of one inspector

What we found and inspection grades awarded

For Laura Wylie Aesthetics, the following grades have been applied to three key quality indicators.

<table>
<thead>
<tr>
<th>Key quality indicators inspected</th>
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</thead>
<tbody>
<tr>
<td><strong>Domain 2 – Impact on people experiencing care, carers and families</strong></td>
</tr>
<tr>
<td><strong>Quality indicator</strong></td>
</tr>
<tr>
<td>2.1 - People’s experience of care and the involvement of carers and families</td>
</tr>
<tr>
<td><strong>Domain 5 – Delivery of safe, effective, compassionate and person-centred care</strong></td>
</tr>
<tr>
<td>5.1 - Safe delivery of care</td>
</tr>
</tbody>
</table>
Domain 9 – Quality improvement-focused leadership

| 9.4 - Leadership of improvement and change | The service manager maintained current best practice through training and attending events in the aesthetics industry. A quality improvement plan would help to identify and measure the impact of changes made. | ✔ Satisfactory |

The following additional quality indicators were inspected against during this inspection.

Domain 5 – Delivery of safe, effective, compassionate and person-centred care

| 5.2 - Assessment and management of people experiencing care | The prescriber and the service manager jointly carried out clinical assessments before any treatment was prescribed. |

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

More information about grading can be found on our website at: http://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/ihc_inspection_guidance/inspection_methodology.aspx

What action we expect Laura Wylie Aesthetics to take after our inspection

This inspection resulted in five recommendations. See Appendix 1 for a full list of the recommendations.

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

Laura Wylie Aesthetics, the provider, must make the necessary improvements as a matter of priority.

We would like to thank all staff at Laura Wylie Aesthetics for their assistance during the inspection.
3 What we found during our inspection

Outcomes and impact

This section is where we report on how well the service meets people’s needs.

Domain 2 – Impact on people experiencing care, carers and families
High performing healthcare organisations deliver services that meet the needs and expectations of the people who use them.

Our findings

Quality indicator 2.1 - People’s experience of care and the involvement of carers and families

The service gathered feedback from patients in line with its participation policy. A duty of candour policy and complaints policy were in place.

Patients discussed their treatment options and costs at a face-to-face or telephone consultation. After this consultation, the patient had a cooling-off period for as long as they needed to be sure about treatment. If they decided to have the proposed treatment, the service manager and prescriber carried out a joint assessment.

The service’s participation policy set out ways feedback would be gathered, such as through feedback forms and comments on social media. The service manager had started to ask all patients to complete a feedback form at the end of the treatment session to increase the responses received. Some comments we saw included:

- ‘Very professional service.’
- ‘Good service.’

The service had a complaints policy in place. An information sheet was given to patients after every treatment that detailed how they could make a complaint to the service and Healthcare Improvement Scotland. The service had not received any complaints since registration.

Duty of candour is where healthcare organisations have a professional responsibility to be honest with patients when things go wrong. The service had a duty of candour policy in place.
What needs to improve
While we saw the service gathered feedback from patients, we saw no evidence the feedback had been reviewed and no action plans had been developed to document how improvements would be made based on the issues raised (recommendation a).

- No requirements.

Recommendation a
- The service should develop action plans in response to feedback collected, including a review of effectiveness.
Service delivery

This section is where we report on how safe the service is.

Domain 5 – Delivery of safe, effective, compassionate and person-centred care

High performing healthcare organisations are focused on safety and learning to take forward improvements, and put in place appropriate controls to manage risks. They provide care that is respectful and responsive to people’s individual needs, preferences and values delivered through appropriate clinical and operational planning, processes and procedures.

Our findings

Quality indicator 5.1 - Safe delivery of care

Patients were cared for in a clean and safe environment. The service was cleaned every day it was in use. The clinical governance policy included risk management and assessment of safety of the environment.

We saw the clinic was clean, well maintained and a cleaning schedule was followed on the days the service was operating. The service manager cleaned the equipment used before and after every patient. Single-use equipment was used for clinical procedures to prevent the risk of cross-infection. Personal protective equipment (such as disposable gloves and aprons) was available. We saw a clinical waste contract in place and waste was removed every 3 months. A sharps box was in place and dated appropriately.

The service’s clinical governance policy included risk management and assessment of the environment when the clinic was open. This helped to make sure patients and staff were safe.

The service’s medication policy detailed the procurement, prescribing and administration of medicines. No medication was kept on the premises. Any stock required was through prescription and collected from the pharmacist on the day of appointment.

We saw policies and procedures in place that helped make sure care and treatment for patients was delivered safely. For example, the service had a policy to involve its patients in their treatment and use evidence-based practice.

The service’s prescriber worked under a practicing privileges arrangement, where staff are not employed by the service but given permission to work there. We saw all registration checks completed for the prescriber. Protecting
Vulnerable Groups (PVG) checks and insurance were up to date and the service manager had a process in place for carrying out yearly professional registration checks for the prescriber.

**What needs to improve**
The service started to gather feedback at the end of October 2019. It planned to use the information to direct its audit activity of care and treatment every 3 months (recommendation b).

An audit programme had been developed to identify and minimise risk for patients and the service. However, no audits had been completed at the time of our inspection. We will follow this up at future inspections.

- No requirements.

**Recommendation b**
- The service should develop and implement an audit programme to evidence the actions taken in care and treatment.

**Our findings**

**Quality indicator 5.2 - Assessment and management of people experiencing care**

The prescriber and the service manager jointly carried out clinical assessments before any treatment was prescribed.

The service manager and nurse prescriber jointly carried out clinical assessments before any treatment was prescribed. We saw assessment records completed with details of the treatment discussed with patients.

Patient care records were kept securely. The service manager was the only person with access. The five patient care records we reviewed showed that treatment was discussed with patients and documented. This included medical history, any current health conditions and medicines administered, dosage and batch number. Patients’ consent to treatment was recorded in all patient care records were reviewed and all were signed by the service manager.

Information was given to patients about what to do if any emergencies should arise following treatment. Aftercare advice leaflets were provided, which included contact details of the service for advice at any time.
**What needs to improve**

The service manager reviewed entries into the patient care records to help make sure entries were accurate and complied with professional standards. However, this information was not gathered in a structured way that would allow it to be audited. Using a monthly audit tool could help to make sure all this information is accurate (recommendation c).

In certain circumstances, a service may need to inform a patient’s GP about something relevant to their treatment, such as an adverse reaction to a medicine or a complication. In order to share information, the service needs the patient’s consent. The service did not record patient consent to share their medical information with their GP (recommendation d).

- No requirements.

**Recommendation c**

- The service should use audit tools to make sure information gathered through audit activity is consistently recorded.

**Recommendation d**

- The service should record patient consent to share information with their GP and other medical staff in an emergency (if required) in patient care records.
Vision and leadership

This section is where we report on how well the service is led.

Domain 9 – Quality improvement-focused leadership

High performing healthcare organisations are focused on quality improvement. The leaders and managers in the organisation drive the delivery of high quality, safe, person-centred care by supporting and promoting an open and fair culture of continuous learning and improvement.

Our findings

Quality indicator 9.4 - Leadership of improvement and changes

The manager maintained current best practice through training and attending events in the aesthetics industry. A quality improvement plan would help to identify and measure the impact of changes made.

The service manager, who was also the service owner and nurse practitioner manager, attended regular conferences and training days organised by pharmaceutical companies to maintain their skills and development. This allowed them to keep up to date with changes in the aesthetic industry, legislation or best practice. They were aware of their limitations and competencies in the industry and had fellow practitioners for advice and support if required.

We saw that policies were in place to minimise any risk to patients, such as environmental checks and infection control. The owner also asked patients for their opinions on the environment to make sure the patient experience was pleasant.

What needs to improve

The service did not have a quality improvement plan in place. A quality improvement plan would help to develop a more structured approach to evaluating feedback, identifying improvement actions and measuring the impact of improvements made in the service (recommendation e).

- No requirements.

Recommendation e

- The service should develop a quality improvement plan to evaluate and measure the impact of service improvements.
Appendix 1 – Requirements and recommendations

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 at the discretion of Healthcare Improvement Scotland.

- **Recommendation**: A recommendation is a statement that sets out actions the service should take to improve or develop the quality of the service but where failure to do so will not directly result in enforcement.

### Domain 2 – Impact on people experiencing care, carers and families

<table>
<thead>
<tr>
<th>Requirements</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recommendation</strong></td>
<td></td>
</tr>
<tr>
<td>a</td>
<td>The service should develop action plans in response to feedback collected, including a review of effectiveness (see page 11).</td>
</tr>
</tbody>
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Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19

### Domain 5 – Delivery of safe, effective, compassionate and person-centred care

<table>
<thead>
<tr>
<th>Requirements</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recommendations</strong></td>
<td></td>
</tr>
<tr>
<td>b</td>
<td>The service should develop and implement an audit programme to evidence the actions taken in care and treatment (see page 13).</td>
</tr>
</tbody>
</table>

Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19
The service should use audit tools to make sure information gathered through audit activity is consistently recorded (see page 14).

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 record patient consent to share information with their GP and other medical staff in an emergency (if required) in patient care records (see page 14).

Health and Social Care Standards: My support, my life. I am fully involved in all decisions about my care and support. Statement 2.14

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**Domain 9 – Quality improvement-focused leadership**

**Requirements**

None

**Recommendation**

e The service should develop a quality improvement plan to evaluate and measure the impact of service improvements (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

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**Requirement and Recommendations carried forward from our 9 July 2019 inspection**

**Requirement**

The provider must implement a suitable system of regularly reviewing the quality of the service. A written record of the review must be made available to Healthcare Improvement Scotland and service users.

Revised timescale – immediate

*Regulation 13(1)*  
*The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
## Recommendations

The service should continue to develop and implement its participation policy to direct the way it engages with its patients and uses their feedback to drive improvement.

Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.8

| The service should carry out regular audits of patient care records. |
| Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19 |
Appendix 2 – About our inspections

Our quality of care approach and the quality framework allows us to provide external assurance of the quality of healthcare provided in Scotland.

Our inspectors use this approach 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.

**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.

**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](http://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.

More information about our approach can be found on our website: [www.healthcareimprovementscotland.org/our_work/governance_and_assurance/quality_of_care_approach.aspx](http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/quality_of_care_approach.aspx)
**Complaints**

If you would like to raise a concern or complaint about an independent healthcare service, you can complain directly to us at any time. However, we do suggest you contact the service directly in the first instance.

Our contact details are:

**Healthcare Improvement Scotland**  
Gyle Square  
1 South Gyle Crescent  
Edinburgh  
EH12 9EB

**Telephone:** 0131 623 4300

**Email:** hcis.ihcregulation@nhs.net