Announced Inspection Report: Independent Healthcare

Service: Temple Medical, Aberdeen
Service Provider: Temple Medical Limited

17 October 2019
Healthcare Improvement Scotland is committed to equality. We have assessed the inspection function for likely impact on equality protected characteristics as defined by age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation (Equality Act 2010). You can request a copy of the equality impact assessment report from the Healthcare Improvement Scotland Equality and Diversity Advisor on 0141 225 6999 or email contactpublicinvolvement.his@nhs.net
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1 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 Temple Medical on Thursday 17 October 2019. We spoke with three members of staff during the inspection. Before the inspection, we asked the service to display a poster asking patients to provide us with feedback on the service. We received feedback from 10 patients who had received treatment. This was our first inspection to this service.

The inspection team was made up of one inspector.

What we found and inspection grades awarded

For Temple Medical, the following grades have been applied to three key quality indicators.

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

| 9.4 - Leadership of improvement and change | The leadership was visible within the service and staff were encouraged to contribute ideas to improve the service they deliver. The service does not have a quality improvement plan to support and manage the delivery of any improvements. | ✔ Satisfactory |

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

## Additional quality indicators inspected (ungraded)

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

| 5.2 - Assessment and management of people experiencing care | Patients received a full consultation prior to any treatment. Risks and benefits were fully explained during the consent process. Patients were provided with aftercare information and follow-up appointments were offered. While patient care records we saw were complete, the service did not carry out audits to monitor the quality of these records. |

### Domain 7 – Workforce management and support

| 7.1 - Staff recruitment, training and development | We saw evidence of staff files for the majority of staff who worked in the service. Staff were appropriately qualified and we saw evidence of ongoing training. The service must ensure essential recruitment checks are carried out. |

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](http://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/ihc_inspection_guidance/inspection_methodology.aspx)
What action we expect Temple Medical Limited to take after our inspection

This inspection resulted in five requirements and seven recommendations. The requirements are linked to compliance with the National Health Services (Scotland) Act 1978 and regulations or orders made under the Act, or a condition of registration. See Appendix 1 for a full list of the requirements and 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

Temple Medical Limited the provider, must address the requirements and make the necessary improvements as a matter of priority.

We would like to thank all staff at Temple Medical for their assistance during the inspection.
2 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 patient feedback in a number of ways including through social media and online patient satisfaction surveys. This process should be more structured to include how feedback is used to drive improvements.

The service had two websites. One provided general information about the service and all treatments offered. It included pricing guides for aesthetic and skin treatments. The second website was specifically for the service’s weight loss programme. Patients received more detailed information about this programme, such as pricing, after initial contact was made. Both websites included contact information and patients could request a consultation. We saw general information leaflets were also available in the reception area.

We saw a service user policy that described how feedback was gathered. The service’s main source of feedback was through social media. However, we were told patients were also emailed a link to a patient satisfaction survey. Patients received follow-up phone calls following aesthetic treatments to check their expectations were met and to ask for verbal feedback. We were told feedback was discussed at internal meetings and resulted in service improvements.

Feedback received from our online survey was positive, as were the majority of reviews we saw on social media. Comments included:

- ‘The process was clearly explained both verbally and by email. I was able to ask any questions I had and these were always answered in full.’
- ‘Informative and honest in all dealings.’

We saw positive interactions between staff and patients.
While we were not aware of any complaints the service had received, we saw the complaints policy included timescales for the management of complaints. We were told that patients would be provided with information about how to make a complaint if requested.

**What needs to improve**

The service’s complaints policy and patient information did not state that patients could contact Healthcare Improvement Scotland at any time. Information on how patients could make a complaint was not easily accessible (requirement 1).

While the service gathered patient feedback in a number of ways, it did not appear to have a clear process for when this would be done. While we were told feedback led to service improvements, we did not see evidence of this (recommendation a).

The service did not have a duty of candour policy in place. Duty of candour is where healthcare organisations have a professional responsibility to be honest with patients when things go wrong (recommendation b).

**Requirement 1 – Timescale: Immediately**

- The provider must ensure patients can easily access information about how to make a complaint and that all complaint information contains the details of Healthcare Improvement Scotland.

**Recommendation a**

- The service should develop its service user policy and processes to ensure a structured approach to gathering patient feedback and how feedback leads to service improvement.

**Recommendation b**

- The service should develop and implement a duty of candour policy.
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 received treatments in a clean and safe environment. The service did not carry out any audits to assure the cleanliness and safety of the environment. No formal risk assessments were being carried out.

The service was clean, tidy and generally well maintained. Floors and work surfaces in the treatment areas could be easily cleaned. Contracts were in place for general cleaning. Completed cleaning schedules were kept by the company and could be obtained by the service if required. Any concerns regarding the cleanliness would be discussed with the company. Staff cleaned treatment areas between appointments and at the end of each day. Patients that responded to our online survey told us:

- ‘The clinic is always very clean.’
- ‘The rooms are very nice.’

The service had an infection prevention and control policy in place. We saw that personal protective equipment, such as disposable aprons and gloves, were available. Single use equipment was used for the majority of treatments carried out. The service had appropriate sharps and clinical waste bins. A clinical waste contract was also in place.

Appropriate fire safety equipment and a carbon monoxide monitor was in place. A fire risk assessment had also been completed. We saw evidence of:

- fire drills
- fire alarm testing
• gas boiler servicing, and
• portable appliance testing.

The service had a medicines management policy in place. Stocks of various medications, including botulinum toxin were held in a clinical drugs fridge. The temperature of the fridge was monitored daily. We saw medicines were in date and processes were in place to ensure medications were used before expiry dates.

We saw appropriate emergency equipment and medications. A safeguarding policy was also in place.

The service had an incident and accident book in place. We saw one incident had taken place where a member of staff had fallen. This was recorded and managed appropriately. Staff we spoke with were aware of Healthcare Improvement Scotland’s notification process. This was evident by the service recently notifying us that a new service manager had been recruited.

**What needs to improve**

We saw that the service had a shower room that was not frequently used. The service must implement a process to minimise the risk of potential infection from the water outlet (requirement 2).

The service does not carry out any formal risk assessments. We were told that a member of staff was due to attend a training course and a programme would then be put in place (requirement 3).

The service does not carry out any audits and has no formal process to monitor the cleanliness and safety of the service (recommendation c).

The service used vials of botulinum toxin for more than one patient. While we were told that needles and syringes were single use and changed between patients, this is not in line with manufacturers and best practice guidance (recommendation d).

As well as using disposable paper rolls for treatment couches, the service also used linens that are laundered on the premises. While the risk of infection from bodily fluids was low, linen is required to be laundered at a minimum temperature for a minimum length of time. We advised the service, if they wished to continue to use linen, a process should be put in place (recommendation e).
**Requirement 2 – Timescale: Immediately**
- The provider must implement a programme of water flushing to reduce the risk of infection from the less frequently used water outlets.

**Requirement 3 – Timescale: by 13 March 2020**
- The provider must introduce a programme of risk assessment and management.

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

**Recommendation d**
- The service should ensure botulinum toxin is used in line with the manufacturers and best practice guidance and update its medicines management policy to accurately reflect the processes in place.

**Recommendation e**
- The service should ensure that all linen is laundered according to national guidance.

**Our findings**

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

Patients received a full consultation prior to any treatment. Risks and benefits were fully explained during the consent process. Patients were provided with aftercare information and follow-up appointments were offered. While patient care records we saw were complete, the service did not carry out audits to monitor the quality of these records.

All patients received a face-to-face consultation. Patients who received general aesthetic and skin treatments discussed treatment options, costs and their expectations at this appointment. A completed health questionnaire also informed this consultation. We were told that if any other health conditions were identified at the initial consultation, the service may refer the patient to other health services or professionals. This would only be done with the patient’s consent.
Patients interested in entering the weight loss programme would have a full consultation that included:

- a full description about the programme
- medical assessment, including blood tests, and
- discussions about target weight.

Patients were assessed to ensure suitability for this programme including a review of past medical history and an assessment of their mental health and wellbeing. They would be advised that the service would contact their GP if needed.

A non-invasive body analysis would also be carried out that provided a detailed breakdown of their body composition, which included percentages of water and fat. Advice about diet was provided and patients were supplied with appropriate foods as part of the programme. They were also provided advice about physical activity and psychological support was also available.

Patients would then have weekly follow-up appointments that included a structured process of assessment. Deep tissue massage to promote weight loss was part of this process. Repeat blood tests, body analysis tests and further mental health and wellbeing assessments were carried out every 4 weeks.

A consent policy was in place for all treatments. Consent forms used for aesthetic and skin treatments included a record of the treatment carried out and any injection sites. Details of the products used and any complications were recorded in the treatment record. Photographs were taken, with patients’ consent, for all treatments carried out and stored on an electronic management system.

Aftercare was provided in writing and patients were provided with the information about what to do in an emergency, as well as contact details for the service. Follow-up appointments were also offered.

Patient care records we saw were both paper based and electronic. Paper patient care records were stored in lockable cabinets in a room that locked. Electronic records were managed using a secure cloud based system that was password protected with different levels of access. We were told that the service was registered with the Information Commissioner’s Office.
We reviewed six patient care records that were all legible, dated and signed. We saw evidence of the initial consultation, signed consent forms, treatment records and progress notes.

**What needs to improve**
While the service had a consent policy and associated consent forms in place, patients should be advised that their information may be shared with other health professionals, if and when appropriate (recommendation f).

- No requirements.

**Recommendation f**
- The service should record patient consent to share information with other health professionals if required, such as in case of an emergency.

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**Domain 7 – Workforce management and support**
High performing healthcare organisations have a proactive approach to workforce planning and management, and value their people supporting them to deliver safe and high quality care.

**Our findings**

**Quality indicator 7.1 - Staff recruitment, training and development**

We saw evidence of staff files for the majority of staff who worked in the service. Staff were appropriately qualified and we saw evidence of ongoing training. The service must ensure essential recruitment checks are carried out.

We saw that the service had a recruitment policy in place and we were told that the services of a human resources company had recently been secured to provide support with personnel management.

The service employed nine members of staff. A volunteer also carried out talking therapies as part of the psychological support given for the weight loss programme.

We reviewed four staff files and saw all had contracts in place. Two files had evidence of an induction and some contained evidence of previous appraisals. A plan was in place to carry out updated appraisals for all staff.
Training for individual staff members was recorded on a spreadsheet and we saw training and qualification certificates for most staff. A date had been arranged to develop a training plan for next year. We were told that staff were encouraged undertake general clinic training as well as that specific to their role. The manager delivered in-house training for staff. They were also encouraged to attend external training courses and the service would pay any costs.

**What needs to improve**

While we saw evidence the service had recently registered with Disclosure Scotland, we saw no evidence that previous protecting vulnerable groups (PVG) checks or updates had been completed (requirement 4).

A recruitment policy was in place, however we did not see a policy that supported the recruitment or management of the volunteer who worked in the service (requirement 5).

We saw inconsistencies in the content of staff files we reviewed. The service could ensure that a consistent approach is taken to the recording of information in staff files. We will follow this up at future inspections.

**Requirement 4 – Timescale: by 17 January 2020**

- The provider must ensure appropriate recruitment checks, including protecting vulnerable groups (PVG) checks, are completed for all existing and new staff.

**Requirement 5 – Timescale: by 17 January 2020**

- The provider must develop a policy to support the recruitment and management of volunteers working in the service.

- No recommendations.
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 change

The leadership was visible within the service and staff were encouraged to contribute ideas to improve the service they deliver. The service does not have a quality improvement plan to support and manage the delivery of any improvements.

The manager was a doctor registered with the General Medical Council (GMC) and the only prescriber in the service. They were also a member of the British College of Aesthetic Medicine (BCAM). As a member of BCAM they carry out appraisals for other aesthetic practitioners and maintain their professional registration through the GMC revalidation process. Revalidation is where every registered doctor sends evidence of their competency, training and feedback from patients and peers to the GMC every 3 years. The manager was also a member of the Aesthetic Complications Expert (ACE) group (a group of practitioners regularly report on difficulties encountered with aesthetic procedures and the potential solutions). The service was registered with Safe Face, a national register of accredited aesthetic practitioners.

The manager told us that they have professional relationships with aesthetic peers for advice on complication management and to provide cover during holidays.

The service was awaiting confirmation of Acne and Rosacea Association UK (ARAUK) accreditation. This accreditation allows aesthetic practitioners to effectively assess and treat patients with acne and rosacea.

The manager intended to offer the service’s weight loss programme to other services under franchise agreements.
The manager worked full time and told us they see the majority of staff on a daily basis. Informal one-to-one discussions took place between the manager and staff.

Staff meetings were held regularly and we were told attendance was good and everyone contributes to these meetings. Minutes were shared with staff who were unable to attend. We saw previous minutes where patient feedback was discussed. We also saw minutes from regular meetings between the manager, finance manager and other key members of staff where the financial and strategic aims of the business were discussed.

The service had an electronic system that allowed updates to be easily shared with all members of staff. This included updates on actions from staff meetings.

**What needs to improve**

While the service had a quality management policy, there was no quality improvement plan that included the use of audit to support and manage the delivery of service improvements (recommendation g).

The manager could consider formalising one-to-one discussions with staff. This would inform the appraisal process and staff development.

- No requirements.

**Recommendation g**

- The service should develop a quality improvement plan that will support and manage the delivery 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.

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<td><strong>Requirement</strong></td>
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<td>Timescale – immediately</td>
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<td>Regulation 15(6)(a)</td>
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<td>Health and Social Care Standards: I have confidence in the organisation providing my care and support. Standard 4.8</td>
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<td>b The service should develop and implement a duty of candour policy (see page 8).</td>
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## Domain 5 – Delivery of safe, effective, compassionate and person-centred care

### Requirements

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<td>Regulation 10(1)</td>
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<td>Regulation 13(2)(a)</td>
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### Recommendations

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</table>
## Domain 5 – Delivery of safe, effective, compassionate and person-centred care (continued)

### Recommendations

- The service should record patient consent to share information with other health professionals if required, such as in case of an emergency (see page 13).

  Health and Social Care Standards: I have confidence in the organisation providing my care and support. Standard 4.14

## Domain 7 – Workforce management and support

### Requirements

- **4** The provider must ensure appropriate recruitment checks, including protecting vulnerable groups (PVG) checks, are completed for all existing and new staff (see page 14).

  Timescale – by 17 January 2020

  *Regulation 8(2)(c)*  
  *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*

- **5** The provider must develop a policy to support the recruitment and management of volunteers working in the service (see page 14).

  Timescale – by 17 January 2020

  *Regulation 8(1)*  
  *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*

### Recommendations

None

## Domain 9 – Quality improvement-focused leadership

### Requirements

None
## Domain 9 – Quality improvement-focused leadership (continued)

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<thead>
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<th>Recommendation</th>
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<td>g The service should develop a quality improvement plan that will support and manage the delivery of service improvements (see page 16).</td>
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Health and Social Care Standards: I have confidence in the organisation providing my care and support. Standard 4.11
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