Announced Inspection Report: Independent Healthcare

Service: The Ever Clinic, Glasgow
Service Provider: The Ever Clinic Ltd

19 July 2021
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 his.contactpublicinvolvement@nhs.scot
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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 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 The Ever Clinic on Monday 19 July 2021. We spoke with the manager and the medical director 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 nine patients who had received treatment. This was our first inspection to this service.

The inspection team was made up of one inspector.

As part of the inspection process, we asked the service to submit a self-evaluation. The questions in the self-evaluation are based on our Quality Framework and ask the service to tell us what it does well, what improvements could be made and how it intends to make those improvements. The service submitted a limited self-evaluation.

What we found and inspection grades awarded

For the Ever Clinic, the following grades have been applied to two key quality indicators.

<table>
<thead>
<tr>
<th>Key quality indicators inspected</th>
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<tr>
<td><strong>Domain 5 – Delivery of safe, effective, compassionate and person-centred care</strong></td>
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<td>5.1 - Safe delivery of care</td>
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Domain 9 – Quality improvement-focused leadership

| 9.4 - Leadership of improvement and change | Regular reviews of the quality of treatment provided must be carried out and a quality improvement plan developed. Staff and management meetings and actions taken should be formally documented. | Unsatisfactory |

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 | All patient care records documented the initial and ongoing consultations during and after treatment. A comprehensive consent process for patient treatment was in place. Patients should receive appropriate written and verbal aftercare advice after treatment. |

**Domain 7 – Workforce management and support**

| 7.1 - Staff recruitment, training and development | A recruitment policy was in place. Not all recruitment checks were consistently carried out. Improvements must be made to ensure the safe recruitment of staff. |

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 The Ever Clinic Ltd to take after our inspection**

This inspection resulted in four requirements and seven recommendations. 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

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.
2 Where we found during our inspection

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

The care environment and patient equipment was clean and well maintained. Risk management systems, procedures and regular audit programmes were not in place. Most patients provided positive feedback about their care.

The service had recently moved into a newly refurbished clinic on the ground floor of a city-centre building. The clinic has two treatment rooms and reception area. We saw that the environment was clean and well maintained.

We were told that the clinic was cleaned twice a day. Enhanced cleaning of high-touch areas was carried out after every patient appointment. Enhanced cleaning is a processes for cleaning introduced due to the pandemic. Appointments were arranged with appropriate gaps in between to allow time for cleaning surfaces and to avoid unnecessary contact with other patients. Alcohol-based hand rub dispensers were available from the front door of the clinic and at reception. We were told about the service’s COVID-19 screening process through email before the appointment and further screening was carried out on arrival at the clinic. All patients were told not to attend their appointment if they suspected they had symptoms of COVID-19.

We saw an adapted infection prevention and control policy was in place that included information on the COVID-19 pandemic. This included a cleaning process which documented staff responsible for cleaning various items. This also provided guidance on the use of personal protective equipment. The service carried out COVID-19 risk assessments before re-opening the clinic after the Scottish Government COVID-19 lockdown.
We saw that all medications were stored safely. We were told that the service manager purchased medicines every 2 weeks. A suitable clinical waste contract was also in place.

Appropriate servicing of equipment was in place. A laser safety policy was in place included ‘local rules’, the local arrangements to manage laser safety. We saw that the laser protection advisor had carried out a review of the lasers since June 2021.

Feedback from patients suggested they were all extremely satisfied with the environment. Comments included:

- ‘Facilities were excellent. Very clean and professional’.
- ‘All looks pristine and functional as befits a clinic’.

**What needs to improve**

While the service had developed and carried out COVID-19 risk assessments, we saw no structured approach to manage other potential risks. All risks to patients and staff in the service must be effectively managed continuously. Proactive risk management processes must be developed, which include:

- a comprehensive risk register
- appropriate risk assessments to protect patients and staff, and
- an accident and incident investigation procedure (requirement 1).

We saw that the clinic was well organised and tidy. However, a small number of items of single-use patient equipment were out of date and one item of medicine had recently expired. The service disposed of these appropriately at the time of our inspection. A regular process of checking equipment and medication expiry dates must be in place to help make sure the service is safe. We saw no evidence of audit activity carried out in the service. A programme of regular audit should be implemented which, as a minimum includes:

- medicine management, including checking expiry dates of equipment and medicines.
- patient care records
- health and safety, and
- cleaning and maintenance of the care environment (recommendation a).

The service’s infection prevention and control policy documented the staff who were assigned to clean different aspects. However, we were told the service
manager carried out all the cleaning. A daily cleaning schedule that included staff responsibility for cleaning would help make responsibilities for tasks clearer. We will follow this up at the next inspection.

**Requirement 1 – Timescale: immediate**

- The provider must develop effective systems that demonstrate the proactive management of risks to patients and staff.

**Recommendation a**

- 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.

### Our findings

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

All patient care records documented the initial and ongoing consultations during and after treatment. A comprehensive consent process for patient treatment was in place. Patients should receive appropriate written and verbal aftercare advice after treatment.

The service had recently changed from using paper patient care records to an electronic format. All four electronic patient care records we reviewed included the patient’s contact details, emergency and GP contact details. An initial and follow-up consultation was documented for all patients. We saw evidence of treatment plans documented and in some cases photographs were documented as part of the treatment plan.

All patient care records had details of patients’ medical history, allergies and routine medications taken where appropriate. Most patient care records had documented batch numbers and expiry dates of medications used during the treatment.

We saw that all patients had consent forms completed for the treatment, which included details of the risks and benefits. Consent was also obtained for sharing information and for taking photographs. The patients had signed and dated all electronic consent forms.

Following their treatment, patients were given information about how to contact staff out-of-hours if required. We were told staff would review progress
with the patient through telephone or video call for up to 10 days afterwards, depending on the type of treatment received.

Patients who completed our online survey told us they received adequate information about their treatment. Comments included:

- ‘I was most professionally guided with regard to my laser treatment.’
- ‘Totally professional. I was given enough information to give my informed consent to the treatment.’

**What needs to improve**

While we were told the service had a thorough process in place of supporting patients after their treatment, this information was given verbally. Aftercare leaflets or written information was not available for patients to take home with them following treatment (recommendation b).

- No requirements.

**Recommendation b**

- The service should provide written aftercare information to patients following their treatment. This should include possible complications and details of who to contact when the service is closed.

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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**

A recruitment policy was in place. Not all recruitment checks were consistently carried out. Improvements must be made to ensure the safe recruitment of staff.

All staff were employed by the service and we saw a comprehensive staff recruitment and staff training policy was in place. Two members of staff were on maternity leave and due to return to work in the 2–4 months after our inspection. We saw an electronic check list in place for checking professional registers, Nursing and Midwifery Council (NMC) revalidation and Protecting Vulnerable Groups (PVG) checks.
The service manager told us about the induction process for new staff, as well as a process of yearly performance and development review carried out in two stages. Staff would meet and discuss their performance and development with the manager and the medical director separately. An ongoing discussion with staff about their performance and development took place and we were told that staff had been supported to train in laser therapy and as an independent prescriber.

We reviewed the recruitment process of four staff. We saw that all staff identity was confirmed as part of recruitment. We saw that some PVG checks were obtained or had been applied for, where applicable.

**What needs to improve**
While the recruitment policy was in place, it was not being followed consistently for all staff. Of the four staff reviewed, only one had a complete recruitment process carried out, which included:

- job application
- obtaining references
- PVG submitted
- interview notes, and
- an email confirming the job offer.

We saw that two PVGs had been submitted in February 2021 and Disclosure Scotland had not responded with the results. While the service had not followed these up, one member of staff had been recruited (requirement 2).

We were told about a yearly performance and development review process in place. However, the service had no documented evidence of this. The service must document appraisals, which should include staff aims and expectations (requirement 3).

While we were told that staff were encouraged to develop professionally, we saw only one certificate for a member of staff confirming the completion of training. Each staff member should have a file where their recruitment details, their qualifications and documented evidence of training is stored. Where applicable, this should include evidence of yearly statutory and mandatory training (recommendation c).
Requirement 2 – Timescale: immediate
■ The provider must ensure that it follows recruitment guidelines on safe recruitment this should ensure carrying out PVG checks and obtaining references.

Requirement 3 – Timescale: immediate
■ The provider must ensure that annual staff performance and development reviews are documented and include staff aims and expectations.

Recommendation c
■ The service should ensure that each staff member has a file that stores their recruitment application, professional qualifications, and ongoing development.
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

Regular reviews of the quality of treatment provided must be carried out and a quality improvement plan developed. Staff and management meetings and actions taken should be formally documented.

We were told that the clinical director and the manager met informally every day and discussed matters to do with the service. We were told these meetings would result in actions that would then be addressed.

The manager promoted an open-door culture to all staff, allowing for frequent discussions and staff to feel able to talk freely about any concerns they had. We were told that staff contributed to an ongoing online group conversation daily.

The clinical director had developed enhanced training to manage complications in aesthetics successfully. Patients who had developed complications were often referred to the service from across the country.

What needs to improve

We saw no overarching quality assurance structures in place, and no system for reviewing the quality of the service being delivered. We saw no evidence of lessons learned from complaints, incidents or audits which would help improve service delivery. Regular reviews of the service will help make sure the service delivered is of a quality appropriate to meet the needs of patients (requirement 4).

We were told that regular informal management meetings were held between the service manager and the medical director. However, these meetings were not formally recorded and action plans were not developed to address any service delivery or improvement issues highlighted in the management meetings (recommendation d).
We were told that the service had an open approach with all staff and informal conversations were held regularly. However, formal staff meetings were not held. Regular staff meetings would allow staff to contribute to the service development (recommendation e).

The service did not have a formal quality improvement plan in place (recommendation f).

Following a patient’s appointment and treatment, an email was sent to them that asked them to submit feedback to the service through the website. We saw no documented evidence that the feedback was reviewed and considered. Feedback can be used to improve the quality of care provided, how the service is delivered and to inform patients of their positive impact (recommendation g).

**Requirement 4 – Timescale: by 11 November 2021**

- The provider must implement a suitable system of regularly reviewing the quality of the service.

**Recommendation d**

- The service should formally record the minutes of management meetings. These should include a documented action plan highlighting those responsible for the actions.

**Recommendation e**

- The service should develop a regular programme of staff meetings. This would allow staff to have an opportunity to participate in the service delivery and development.

**Recommendation f**

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

**Recommendation g**

- The service should develop a more structured programme of reviewing patient feedback that demonstrates and informs the patient of how their feedback has been addressed and improved the service.
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 5 – Delivery of safe, effective, compassionate and person-centred care

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<tr>
<th>Requirement</th>
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<tr>
<td>1</td>
<td>The provider must develop effective systems that demonstrate the proactive management of risks to patients and staff (see page 9).</td>
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| | Regulation 3(1)(a)  
The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011 |

#### Recommendations

- a 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 (see page 9).

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

- b The service should provide written aftercare information to patients following their treatment. This should include possible complications and details of who to contact when the service is closed (see page 10).

  Health and Social Care Standards: My support, my life. I am fully involved in all decisions about my care and support. Statement 2.9
## Domain 7 – Workforce management and support

### Requirements

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<td><strong>2</strong></td>
<td>The provider must ensure that it follows recruitment guidelines on safe recruitment this should ensure carrying out PVG checks and obtaining references (see page 12).</td>
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|   | *Regulation 8(1)*  
*The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011* |
| **3** | The provider must ensure that annual staff performance and development reviews are documented and include staff aims and expectations (see page 12). |
|   | Timescale – immediate |
|   | *Regulation 12(1)(c)(i)*  
*The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011* |

### Recommendation

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<td>Health and Social Care Standards: My support, my life. I have confidence in the people who support and care for me. Statement 3.14</td>
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### Domain 9 – Quality improvement-focused leadership

#### Requirements

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<th>The provider must implement a suitable system of regularly reviewing the quality of the service (see page 14).</th>
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**Regulation 3(1)(a)**  
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#### Recommendations

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<th>The service should formally record the minutes of management meetings. These should include a documented action plan highlighting those responsible for the actions (see page 14).</th>
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<td>g</td>
<td>Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.8</td>
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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:** 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