Announced Inspection Report: Independent Healthcare

**Service:** Kirkwood Fyfe, Aberdeen

**Service Provider:** Kirkwood Fyfe Limited

17 August 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 Kirkwood Fyfe on Tuesday 17 August 2021. This was our first inspection to this service.

The inspection team was made up of three inspectors (one of whom was observing).

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. Although requested, the service did not submit a self-evaluation.

What we found and inspection grades awarded

For Kirkwood Fyfe, the following grades have been applied to two key quality indicators.

<table>
<thead>
<tr>
<th>Key quality indicators inspected</th>
<th>Summary findings</th>
<th>Grade awarded</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>
<td>Medicines were managed safely and all equipment was maintained and serviced. Although the service was clean, a more structured approach to cleaning is needed. Improvements must be made to the service’s risk management systems and procedures, and a regular programme of audit implemented. A laser safety advisor must be appointed.</td>
<td>Unsatisfactory</td>
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### Domain 9 – Quality improvement-focused leadership

| 9.4 - Leadership of improvement and change | The service owner and service manager kept up to date with current practice through ongoing training and development. 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 indicator 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 consultation and assessment before any treatment was provided. We saw clear and accurate documentation in patient care records. Patients were fully informed about the risks and benefits of treatments. Patients should be made aware that information will be shared with other healthcare professionals if required. |

#### Domain 7 – Workforce management and support

| 7.1 - Staff recruitment, training and development | Training and development opportunities were accessible and yearly appraisals were carried out. All staff must have employment or practicing privileges contracts. Staff files were incomplete and the service could not demonstrate that recruitment checks were carried out. Formal induction and ongoing training programme should be developed for all 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 Kirkwood Fyfe Limited to take after our inspection

This inspection resulted in three requirements and 13 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

Kirkwood Fyfe 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 Kirkwood Fyfe for their assistance during the inspection.
2 What 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

Medicines were managed safety and all equipment was maintained and serviced. Although the service was clean, a more structured approach to cleaning is needed. Improvements must be made to the service’s risk management systems and procedures, and a regular programme of audit implemented. A laser safety advisor must be appointed.

The service provides injectable aesthetic treatments and minor eye surgery in separate rooms, as well as laser treatments in a room downstairs.

We saw that all areas of the clinic were clean. Relevant policies and procedures were in place to ensure the safe delivery of care, such as:

- infection prevention and control policy
- safeguarding policy, and
- service contracts.

The service had a clinical waste contract in place, including for medical sharps such as syringes and needles. Staffs were knowledgeable about infection prevention and control procedures. The clinical area was clean.

Equipment in all rooms was found to be clean and free from signs of contamination and dust. We saw that the minor surgical room had a completed cleaning checklist. Clinical hand wash sinks were being cleaned in line with current guidance.
Appropriate personal protective equipment available in all three rooms and stored appropriately included:

- aprons
- gloves
- surgical masks, and
- visors or goggles.

We saw that the service had several blood spillage kits in place which were in-date. Staff we spoke with could explain how they would manage a blood spillage in line with guidance.

We saw the service had emergency medication and suitable equipment for its procedures.

Most medical instruments and equipment were single-use to prevent the risk of cross-infection. We saw that contracts were in place for the maintenance of the steriliser for surgical equipment and the ventilation system.

We saw that the service had a process in place for ordering medicines. Medicines were stored securely in locked cupboards or locked medication fridges at the correct temperature where appropriate. We saw all medicines were in date.

Controlled drugs were stored in a locked cupboard and we saw a controlled drug book was fully and confirmed that it was accurately completed. Keys to all of the drug cupboards were stored in locked safe which was located in a separate room. We saw the process followed for ordering controlled drugs.

Feedback from our survey was very positive about patients’ experience of using the service. All patients agreed they had been:

- informed about the risks and benefits before going ahead with treatment
- involved in decisions about their care, and
- extremely satisfied with the cleanliness and the environment.

Comments included:

- ‘I was given a very thorough explanation.’
- ‘Kept fully informed with each step of procedure in professional manner.’
- ‘Clean environment.’
What needs to improve

We were shown a copy of the local rules which were dated 2004 and had not been reviewed. We saw no details for the laser protection advisor. While a laser policy was in place which contained local rules and a list of authorised users, the service laser protection supervisor had left the service. We received an updated version of the laser policy which listed who the current service laser protection supervisor was, along with a list of who the current authorised users were. However, this document had not been written in consultation with a laser protection advisor. The register of authorised users in the local rules was not up to date and protective eyewear available for the laser or IPL operators was not in line with the local rules (requirement 1).

All risks to patients and staff in the service must be effectively managed on an ongoing basis. We did not find a structured approach to risk management in the service. 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 2).

The environment was seen to be clean in all three rooms. However, we saw evidence of disrepair in some of the rooms, such as cracks in the wall and skirting boards. This meant that the environment could not be effectively decontaminated (recommendation a).

While new cupboards had been installed in one room, some clean supplies were stored in boxes in the sluice. The service should remove all surplus equipment from the sluice room (recommendation b).

The service did not have a structured cleaning schedule or current infection prevention and control policy in line with guidance in Health Protection Scotland’s National Infection Prevention and Control Manual (recommendation c).

While medications were seen to be in-date, we did not see documented evidence that medications were regularly checked. A medication policy was in place. However, this should be updated to reflect:

- that the service used controlled drugs
- the ordering process for medication, and
- who the prescribers are and that medication checklists are in use (recommendation d).
The service used separate temperature recording books for each of the medication fridges. However, we found that the temperatures were not always fully and accurately recorded (recommendation e).

The service did not audit key aspects of care and treatment such as infection prevention and control, and medicines management (recommendation f).

The cleaning checklist in the minor surgical room would benefit from more detail of what equipment is being cleaned. We will follow this up at future inspections.

**Requirement 1 – Timescale: immediate**

- The provider must review its laser safety arrangements to ensure that:
  
  (a) A laser protection advisors is appointed who writes a comprehensive set of local rules.

  (b) A laser protection supervisor is appointed

  (c) All laser operators have read, understood and signed the local rules and must adhere to them.

  (d) Each laser machine has list of authorised users attached to it.

**Requirement 2 – Timescale: by 17 November 2021**

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

**Recommendation a**

- The service should carry out a review of the environment with an appropriate maintenance and redecoration schedule put in place.

**Recommendation b**

- The service should remove all surplus equipment from the sluice room and develop a structured cleaning schedule and update its infection prevention and control policy, in line with Health Protection Scotland’s *National Infection Prevention and Control Manual*.

**Recommendation c**

- The service should develop a structured cleaning schedule and update its infection prevention and control policy, in line with Health Protection Scotland’s *National Infection Prevention and Control Manual*.
Recommendation d
- The service should update their medication policy to include that the service uses controlled drugs, the ordering process for medication and who the prescribers are and that medication checklists are being used to ensure that medications are checked regularly.

Recommendation e
- The service should ensure that the temperature of the medication fridges are recorded daily.

Recommendation f
- The service should develop a programme of regular clinical 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

Patients received a consultation and assessment before any treatment was provided. We saw clear and accurate documentation in patient care records. Patients were fully informed about the risks and benefits of treatments. Patients should be made aware that information will be shared with other healthcare professionals if required.

We reviewed 10 patient care records - five aesthetic and five surgical, which showed that comprehensive assessments and consultations were carried out before treatment started. These included taking a full medical history with details of any health conditions, medications, allergies and previous treatments.

We saw evidence of treatment plans being developed and agreed with patients which set out the course and frequency of treatment. Records were kept of each treatment session, including a diagram of the area that had been treated.

Dosage and medicine batch numbers were also recorded for each treatment.

Surgical patients were given verbal and written aftercare advice, including an out-of-hours contact number. This was recorded in patient care records. The surgical patient care records we reviewed were clear and well documented.

To assess the safety culture in the service, we discussed with staff the importance of following World Health Organization guidelines during surgical procedures. For example, taking a ‘surgical pause’ before starting surgery to check they had the correct patient and equipment. Staff told us they were aware of these checks and carried them out. We did not have the opportunity to observe a surgical pause in practice. However, we also saw evidence in the patient care records that patients having surgical procedures had a surgical safety checklist completed in line with the World Health Organization guidelines.

What needs to improve
We were told that aftercare advice was given to patients attending for aesthetic procedures. However, this was not recorded in the aesthetic patient care record. The service should formally document what aftercare has been provided to patients including an out-of-hours contact number (recommendation g).
While consent to share information with relevant other was included, we found that GP details were not always recorded in surgical patient care records. The service should accurately record GP details (recommendation h).

- No requirements.

**Recommendation g**

- The service should formally document what aftercare has been provided to aesthetic patients including an out of hours contact number. This would enable patients to be better informed about their care.

**Recommendation h**

- The service should accurately record GP details within the surgical patient care record.
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

Training and development opportunities were accessible and yearly appraisals were carried out. All staff must have employment or practicing privileges contracts. Staff files were incomplete and the service could not demonstrate that recruitment checks were carried out. Formal induction and ongoing training programme should be developed for all staff.

Staff we spoke with demonstrated a good understanding of their role and told us they could speak to the service manager at any time. They felt valued and that the service manager supported them to develop their skills.

We saw evidence that staff received a post-induction review 2 months after they started in the service and that regular staff appraisals were being carried out. Staff we spoke with confirmed that they were encouraged to identify learning or development needs at their performance review and that their manager supported applications for specialist training or additional training. We saw evidence that two staff members had recently completed training from the laser machine manufacturers about how to operate them safely.

What needs to improve

We looked at staff files which included surgeons who hold practising privileges (staff not employed by the provider but given permission to work in the service). Formal employment and practising privileges contracts setting out the responsibilities and expectations between and the service and surgeons were not in place.

We found multiple gaps in the staff personnel files we looked at. This included a lack of:

- application forms
- interview notes
- pre-employment checks, including identity checks, protecting vulnerable groups (PVG) checks, relevant professional indemnity insurance, professional registration checks, qualifications and employment references (requirement 3).
We looked at the recruitment policy in place that set out the procedure to follow to recruit any new members of staff. The policy did not detail the pre-employment checks the clinic would complete to help make sure new staff were suitably qualified and fit to work at the clinic (recommendation i).

Staff we spoke with told us they had good access to training and development relevant to their role. However, the service did not have a documented training policy and limited information was available about the training that staff had completed. Staff training records did not detail whether induction and further training was completed. A process should be implemented to record training effectively (recommendation j).

While staff had yearly appraisals, regular one-to-ones were no longer taking place at the time of our inspection (recommendation k).

**Requirement 3 – Timescale: immediate**

- The provider must ensure that employment and practicing privileges contracts are introduced for staff working in the service to ensure safe delivery of care, with individual responsibility and accountability clearly identified. Pre-employment checks in line with current legislation and best practice guidance must be carried out.

**Recommendation i**

- The service should ensure that its recruitment policy is updated to outline the pre-employment checks undertaken to help ensure any new members of staff are fit to work at the clinic.

**Recommendation j**

- The service should develop and implement a training policy and a formal induction and ongoing training programme for all staff. A process should be implemented to record training effectively.

**Recommendation k**

- The service should reintroduce regular staff one-to-ones as part of the staff appraisal process to allow staff the opportunity to discuss progress in their role or any concerns.
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 service owner and service manager kept up to date with current practice through ongoing training and development. 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.

The service is owned and managed by an experienced optometrist, registered with the General Optical Council (GOC). A nurse manager had recently been appointed who was registered with the Nursing and Midwifery Council (NMC). The service engaged in regular continuing professional development. This is managed through the GOC and NMC registration and revalidation process.

Other professional development activities included attending industry events, maintaining connections with peers and subscriptions to journals to raise awareness of the best evidence-based care for patients.

Staff explained that they could go the service owner or manager to suggest any service improvements, which were acted on immediately. Service improvements included new wipeable cupboards for storage, carpeted flooring being replaced with wipeable flooring.

While the service had a clinical governance policy, we were told that clinical governance meetings also did not take place.

What needs to improve

While the service could demonstrate a commitment to improvement, it did not have a formal quality improvement plan in place to help structure and record service improvement processes and outcomes. This would allow the service to
measure the impact of change and demonstrate a culture of continuous improvement (recommendation l).

The service did not hold staff meetings. Regular staff meetings should be introduced where all staff meet each other, minutes and action points documented and circulated to all staff (recommendation m).

**Recommendation l**

- The service should develop a quality improvement plan that demonstrates a structured approach to carrying out and recording improvement activities and evaluating the impact of change on the quality of the service.

**Recommendation m**

- This should include staff meetings where all staff meet each other and formally record the minutes of staff meetings. These should include any actions taken and those responsible for the actions. Minutes should be shared with all staff.
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

#### Requirements

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<td>Timescale – immediate</td>
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<tr>
<td></td>
<td>Regulation 3(d)(v)</td>
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<td>The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011</td>
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| **2** | The provider must develop effective systems that demonstrate the proactive management of risks to patients and staff (see page 10). |
|   | Timescale – by 17 November 2021 |
|   | Regulation Regulation 13(2)(a) |
|   | The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011 |
**Domain 5 – Delivery of safe, effective, compassionate and person-centred care (continued)**

### Recommendations

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| **a** | The service should carry out a review of the environment with an appropriate maintenance and redecoration schedule put in place (see page 10).  
Health and Social Care Standards: I experience a high quality environment if the organisation provides the premises. Statement 5.22 |
| **b** | The service should remove all surplus equipment from the sluice room and develop a structured cleaning schedule and update its infection prevention and control policy, in line with Health Protection Scotland’s *National Infection Prevention and Control Manual* (see page 11).  
Health and Social Care Standards: I experience a high quality environment if the organisation provides the premises. Statement 5.22 |
| **c** | The service should develop a structured cleaning schedule and update its infection prevention and control policy, in line with Health Protection Scotland’s *National Infection Prevention and Control Manual* (see page 11).  
Health and Social Care Standards: I experience a high quality environment if the organisation provides the premises. Statement 5.22 |
| **d** | The service should update their medication policy to include that the service uses controlled drugs, the ordering process for medication and who the prescribers are and that medication checklists are being used to ensure that medications are checked regularly (see page 11).  
Health and Social Care Standards: I have confidence in the organisation providing my care and support. Statement 4.14 |
| **e** | The service should ensure that the temperature of the medication fridges are recorded daily (see page 11).  
Health and Social Care Standards: I have confidence in the organisation providing my care and support. Statement 4.14 |
| **f** | The service should develop a programme of regular clinical audits to cover key aspects of care and treatment. Audits must be documented and improvement action plans implemented (see page 11).  
Health and Social Care Standards: 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 (continued)

| g | The service should formally document what aftercare has been provided to aesthetic patients including an out of hours contact number. This would enable patients to be better informed about their care (see page 13). |
| h | The service should accurately record GP details within the surgical patient care record (see page 13). |

Health and Social Care Standards: I am fully involved in all decisions about my care and support. Statement 2.9

Health and Social Care Standards: I have confidence in the organisation providing my care and support. Statement 4.19

## Domain 7 – Workforce management and support

### Requirement

| 3 | The provider must ensure that employment and practicing privileges contracts are introduced for staff working in the service to ensure safe delivery of care, with individual responsibility and accountability clearly identified. Pre-employment checks in line with current legislation and best practice guidance must be carried out (see page 15). |

Timescale – immediate

*Regulation 8, Regulation 12(a)*

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

### Recommendations

| i | The service should ensure that its recruitment policy is updated to outline the pre-employment checks undertaken to help ensure any new members of staff are fit to work at the clinic (see page 15). |

Health and Social Care Standards: My support, my life. I have confidence in the people who support and care for me. Statement 4.24
### Domain 7 – Workforce management and support (continued)

**j** The service should develop and implement a training policy and a formal induction and ongoing training programme for all staff. A process should be implemented to record training effectively (see page 15).

Health and Social Care Standards: My support, my life. I have confidence in the people who support and care for me. Statement 3.14

**k** The service should reintroduce regular staff one-to-ones as part of the staff appraisal process to allow staff the opportunity to discuss progress in their role or any concerns (see page 15).

Health and Social Care Standards: My support, my life. I have confidence in the people who support and care for me. Statement 3.14

### Domain 9 – Quality improvement-focused leadership

#### Requirements

None

#### Recommendations

**l** The service should develop a quality improvement plan that demonstrates a structured approach to carrying out and recording improvement activities and evaluating the impact of change on the quality of the service (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

**m** This should include staff meetings where all staff meet each other and formally record the minutes of staff meetings. These should include any actions taken and those responsible for the actions. Minutes should be shared with all staff (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
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.