Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Announced Inspection Report: Independent Healthcare

Service: Elanic, Glasgow

Service Provider: Elanic Ltd

20 March 2024

NHS SCOTLAND

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1 Progress since our last inspection

What the service had done to meet the recommendations we made at our last inspection on 3 February 2021

Recommendation

The service should ensure that all control measures in place for the management of COVID 19 are reflected in the service's risk assessment documentation.

Action taken

The service had an infection prevention and control policy in place that detailed relevant standard infection prevention and control precautions, including measures relating to COVID-19. Appropriate infection prevention and control precautions and practices were in place.

Recommendation

The service should ensure that all medicines are used, stored and discarded in line with the manufacturer's guidance.

Action taken

We saw appropriate management of medicines. A medicines management policy was in place and relevant audits and checks were carried out.

2 A summary of our inspection

Background

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

Our focus

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

About our inspection

We carried out an announced inspection to Elanic on Wednesday 20 March 2024. We spoke with a number of staff during the inspection. We received feedback from 12 patients through an online survey we had asked the service to issue to its patients for us before the inspection.

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

The inspection team was made up of two inspectors.

What we found and inspection grades awarded

For Elanic, the following grades have been applied.

Direction	*How clear is the service's vision and purpose and how supportive is its leadership and culture?*
Summary findings	**Grade awarded**
Measurable objectives and key performance indicators were used to evaluate the service. A clear leadership structure and clinical governance processes were in place. Structured meetings provided effective team communication. The vision and purpose statement should be shared with patients and staff.	✓✓ Good
Implementation and delivery	*How well does the service engage with its stakeholders and manage/improve its performance?*
Patient feedback was actively encouraged. An audit programme and quality improvement plan supported continuous improvement of the service. Policies and procedures set out the way the service delivered safe care. Processes were in place to manage and reduce complaints, incidents and risks. Patients were kept updated on service information through a monthly newsletter. Information on how patients can make a complaint should be easily accessible.	✓✓ Good
Results	*How well has the service demonstrated that it provides safe, person-centred care?*
The clinic environment and equipment were clean and well maintained with good infection control measures in place. Patient care records were well completed. References should be sought for practicing privileges staff who should also undertake an induction to the service.	✓✓ Good

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

More information about grading can be found on our website at:
Guidance for independent healthcare service providers – Healthcare Improvement Scotland

Further information about the Quality Assurance Framework can also be found on our website at: The quality assurance system and framework – Healthcare Improvement Scotland

What action we expect Elanic Ltd to take after our inspection

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

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

This inspection resulted in no requirements and five recommendations.

Direction	
Requirements	
	None
Recommendation	
a	The service should share its vision and purpose statement with staff and patients (see page 11). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19

Implementation and delivery	
Requirements	
	None
Recommendation	
b	The service should service should ensure that the complaints information for patients is accessible (see page 18). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.20

Results	
Requirements	
	None
Recommendations	
c	The service should complete and submit a self-evaluation when requested by Healthcare Improvement Scotland (see page 22). 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 service should have an induction programme for all new staff, including those working under practicing privileges (see page 22). Health and Social Care Standards: My support, my life. I have confidence in the people who support and care for me. Statement 3.14
e	The service should review the pre-employment procedure and the information requested for those granted practicing privileges in line with the Scottish Government's *Safer Recruitment through Better Recruitment* guidance (2016) (see page 22). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.24

An improvement action plan has been developed by the provider and is available on the Healthcare Improvement Scotland website: Find an independent healthcare provider or service – Healthcare Improvement Scotland

We would like to thank all staff at Elanic for their assistance during the inspection.

3 What we found during our inspection

Key Focus Area: Direction

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

Our findings

Measurable objectives and key performance indicators were used to evaluate the service. A clear leadership structure and clinical governance processes were in place. Structured meetings provided effective team communication. The vision and purpose statement should be shared with patients and staff.

Clear vision and purpose

The service's vision and purpose statement included a commitment to 'excellence, innovation and compassionate patient care' and a dedication to help its patients 'achieve their aesthetic goals with integrity safety and expertise.' We also saw a clear definition of the culture of the service, which included compassion, collaboration and respect.

Aims and objectives of the service were clear and measurable and included:

- excellence in surgical outcomes
- safety and patient wellbeing, and
- patient satisfaction and feedback.

To evidence how well the service was meeting its objectives its performance was assessed against key performance indictors, which included financial, patient satisfaction and safety criteria. Reports of the key performance indicators had been produced and discussed during clinical governance and management meetings.

A business plan was produced detailing actions to meet the planned objectives for the year.

What needs to improve

The service had recently produced a new vision and purpose statement. However, it had not shared this with patients or staff at the time of our inspection (recommendation a).

- No requirements.

Recommendation a

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

Leadership and culture

Staff working in the service included:

- the service manager
- anaesthetists
- nurses
- surgeons
- front of house
- sales, and
- marketing teams.

Some staff members were directly employed and others worked under a practicing privileges agreement (staff not employed directly by the provider but given permission to work in the service).

We saw a clear organisational structure in place, with clear leadership. The service had a leadership statement detailing how standards would be achieved through a defined set of principles.

The service manager was responsible for the clinical governance processes in place to maintain patient safety, such as:

- clinical audits
- patient feedback and complaints management
- reviewing clinical procedures and policies, and
- staff performance and management.

A clinical governance team included senior members of staff. They attended monthly meetings with recorded minutes and a set agenda covering clinical governance items, such as:

- clinical outcomes review
- complaints
- incidents
- infection rates and review
- medicines management, and
- risk register.

Other meetings between staff groups were held to manage the day-to-day operations of the service through structured methods of communication. These meetings included:

- a theatre safety huddle
- monthly management meeting, and
- weekly nurse meetings.

Staff unable to attend the meetings could access meeting minutes and online staff group chats helped to share updates.

A suggestions box was available for staff to provide feedback, suggestions or raise a concern. The service had a whistleblowing policy in place. This policy included information about how staff could raise a concern internally and how to seek external advice and support. For example, staff could seek advice and support from Public Concern at Work or the service's employee assistance programme.

- No requirements.
- No recommendations.

Key Focus Area: Implementation and delivery

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

Our findings

Patient feedback was actively encouraged. An audit programme and quality improvement plan supported continuous improvement of the service. Policies and procedures set out the way the service delivered safe care. Processes were in place to manage and reduce complaints, incidents and risks. Patients were kept updated through a monthly newsletter.

Information on how patients can make a complaint should be easily accessible.

Co-design, co-production *(patients, staff and stakeholder engagement)*
The service's participation policy stated how it would engage with patients to improve their experience. The service sent a survey to patients at different points, such as after their initial consultation, treatment, and discharge. This survey was sent out at different times to assess whether patients' level of satisfaction changed at each interaction with the service.

We saw a patient satisfaction plan in place with improvement actions following feedback, such as:

- establish multiple ways patients can communicate with the service
- implement a dedicated patient coordinator, and
- improve the waiting room area.

Patient feedback had identified an issue with the service's automatic appointment reminder text function not operating correctly. We saw that this was discussed at the clinical governance meeting and measures put in place to resolve the issue.

Changes made as a result of feedback were fed back to patients in the monthly newsletter. Other topics in the newsletter included 'meet the team' and procedures performed in the clinic.

Staff were asked to complete a yearly satisfaction survey and we saw evidence of actions taken as a result of staff feedback about training. A training needs analysis had been produced and another training specific survey was planned. Incentives for working in the service included discounts on treatments for employees, their friends and families and an annual social event. They also had access to an employee assistance programme, which provided support for issues around:

- debt
- law
- relationships
- stress and anxiety, and
- work.

- No requirements.
- No recommendations.

Quality improvement

We saw that the service clearly displayed its Healthcare Improvement Scotland registration certificate and was providing care in line with its agreed conditions of registration.

The service was aware that, as a registered independent healthcare service, it had a duty to report certain matters to Healthcare Improvement Scotland as detailed in our notifications guidance.

Appropriate policies, procedures and processes were in place to deliver safe, person-centred care. Safe operating procedures were documented for all treatments. We saw that senior staff had carried out a ratification process for all policies and procedures to check for accuracy.

A safeguarding policy described the actions staff should take in case of an adult or child protection concern.

A medicines management policy and protocols helped to make sure medicines were managed safely and effectively. Medicines were stored in locked cupboards and fridges and the fridge temperature was monitored to make sure medicines were stored at the appropriate temperature. Emergency medicines were easily accessible and checked monthly.

We saw that the clinic had a laser policy and an agreement in place with a laser protection advisor. The laser protection advisor had written a set of local rules for the laser, which stated that authorised users of laser equipment must complete 'Core of Knowledge' training every 3 years. We saw that the consultants had completed this training in the last 3 years.

We saw a process in place for incident reviews. We were given evidence of one incident review which involved a meeting with relevant staff, a review of documentation and a discussion to establish if anything should have been done differently.

An infection prevention and control policy described the precautions in place to prevent patient and staff harm from avoidable infections. Appropriate products were used to clean equipment and the environment and a cleaning schedule was in place and displayed in each room.

A health and safety management file included an equipment asset log with servicing dates for the equipment and a planned preventative maintenance programme, including:

- air conditioning and ventilation
- fixed electrical wiring and portable appliance testing
- security and fire system and equipment, and
- water safety.

We saw corresponding evidence that the planned maintenance and testing had been carried out for these systems.

An annual fire risk assessment was carried out, fire safety signage was displayed and fire wardens appointed. A water safety risk assessment was carried out and actions documented. Relevant staff had completed legionella awareness training.

A complaints policy detailed the process for managing a complaint and provided information on how a patient could make a complaint to the service to The Independent Sector Complaints Adjudication Service (ISCAS) or to Healthcare Improvement Scotland. We saw evidence that complaints were managed in line with the service's own policy. Complaints were collated in a complaints log and we saw:

- evidence of investigation
- identified areas for improvement, and
- implementation of changes as a result.

A duty of candour policy was in place (where healthcare organisations have a professional responsibility to be honest with people when something goes wrong). The service had published its yearly duty of candour report on its website.

Policies for the management of information were in place. Patient care records were stored on a password-protected electronic database. The service was registered with the Information Commissioner's Office (an independent authority for data protection and privacy rights).

A consent policy detailed how the service would make sure that informed consent was obtained before any treatment took place. We saw the service used bacteriostatic saline to reconstitute the vials of botulinum toxin. This is when a liquid solution is used to turn a dry substance into a specific concentration of solution. The bacteriostatic saline used is an unlicensed product. The use of this, instead of normal saline for reconstitution means that the botulinum toxin is being used outside of its Summary of Product Characteristics and is unlicensed. We were told this provided better pain relief for patients. We saw evidence in the patient care record that the use of unlicensed bacteriostatic saline and the unlicensed use of botulinum toxin had been discussed with patients and that informed consent had been sought and signed by the patient.

When making an appointment on the online system, patients received a consent form with information about the treatment they had booked, including the risks. A medical history questionnaire was given to patients, to be completed before their appointment.

Patients also had a face-to-face consultation with the practitioner before attending their treatment appointment. This allowed the patient a cooling-off period and gave them time to consider the information received before going ahead with treatment. Discussions at the consultations included:

- expected outcomes of treatment
- full medical history
- risks and side effects, and
- aftercare.

Written aftercare information was given to patients following treatment, including a contact number for the practitioner and out-of-hours contact information.

Staff in the service were members of national groups, such as:

- online forums of peers
- the British Association of Cosmetic Nurses (BACN), and
- the British Association of Plastic, Reconstructive and Aesthetic Surgeons (BAPRAS).

This helped the service kept up to date with changes in the aesthetics industry, legislation and best practice guidance.

Policies were in place that detailed safe recruitment and staffing. Staff had received an appropriate level of Disclosure Scotland check to make sure they were safe to work in the service. The service had a process in place for updating the Disclosure Scotland status of staff to make sure they remained safe to work in the service. The service received support from an external agency for human resource such as employment law and policies.

As part of the induction process, new staff become familiar with the service's policies and procedures, as well as completing mandatory training. Induction forms included role-specific competencies, which were signed by a mentor once completed. The service manager monitored completion of ongoing mandatory training. Staff received notifications when a module required completion.

We saw that the service had a process in place to make sure that staff who had been in post for 12 months or more received an annual appraisal and that all staff received regular one-to-one meetings. Staff we spoke with confirmed this.

Staff could complete additional training for personal development. As the service was a small team, they had limited opportunities for progression or changing roles. However, the service planned to expand and we were told this would provide more development opportunities for staff.

What needs to improve

The service's complaints process was not easily accessible to patients. For example, the process was not published on the service's website (recommendation b).

- No requirements.

Recommendation b

- The service should service should ensure that the complaints information for patients is accessible.

Planning for quality

We saw a register of clinical and non-clinical risks in place for risks in the service, such as:

- general health and safety risks for all clinic areas
- risks of procedures such as injectable treatments, and
- use of non-compliant fixtures and fittings.

The risk assessments included processes in place to help manage any risks identified.

As a contingency the service had a formal agreement with a Healthcare Improvement Scotland registered independent hospital to refer patients if required in case of events that may cause an emergency closure of the clinic. This would help make sure patients could continue their treatment plans. Appropriate insurances were in-date, such as public and employer liability insurance.

An annual audit programme helped to review the safe delivery and quality of the service. The findings were documented and an action plan completed, where required and this was discussed with staff during meetings. Audits carried out included those for:

- fire safety
- health and safety
- infection prevention and control
- medicines management (audit carried out with a pharmacist)
- patient care records, and
- staff files.

Quality improvement is a structured approach to evaluating performance, identifying areas for improvement and taking corrective actions. An overarching quality assurance system process was in place and improvement activities were included in a quality improvement plan. The service had a documented process in place for external benchmarking against peers in the industry to identity where improvement could be made.

- No requirements.
- No recommendations.

Key Focus Area: Results

Domain 6: Relationships	Domain 7: Quality control
How well has the service demonstrated that it provides safe, person-centred care?	

Our findings

The clinic environment and equipment were clean and well maintained with good infection control measures in place. Patient care records were well completed. References should be sought for practicing privileges staff who should also complete an induction to the service.

Every year, we ask the service to submit an annual return. This gives us essential information about the service such as composition, activities, incidents and accidents, and staffing details. The service submitted an annual return, as requested.

The clinic environment was modern, clean and well equipped. Equipment was in good condition. Cleaning of the treatment rooms and equipment was carried out between patient appointments, as well as a full clean of the clinic every day. We saw that cleaning checklists were completed each day and appropriate cleaning products were used. All patients who responded to our online survey said they were satisfied with the facilities and equipment in the environment they were treated in. Comments included:

- 'The treatment rooms are clinical, hygienic yet warm. I felt safe to be treated here.'
- 'Always very clean and professional setting.'

Effective measures were in place to reduce the risk of infection and cross-contamination. For example, the service had a good supply of personal protective equipment and alcohol-based hand gel. An appropriate waste management contract was in place and sharps (needles and syringes) were well managed.

The seven patient care records we reviewed had been well completed with detailed information, including documentation of:

- assessment and consultation
- consent form signed by patient and practitioner on day of treatment
- documentation of the discussion about the treatment plan (including the risks and benefits of each treatment offered)
- medicine dosage, batch numbers and expiry dates
- medical history
- patient consent to treatment and to share information with their GP or other relevant healthcare professional where appropriate
- the procedure, and
- the provision of aftercare information.

All patients who responded to our online survey told us they received adequate information about their procedure and felt involved in the decisions about their care. Comments included:

- 'Everything was explained in great detail during the initial consultation and again throughout my experience.'
- 'I felt empowered to make the decision on my terms.'
- 'Fully informed. Frank discussions.'

We reviewed seven staff files, including two files of individuals granted practicing privileges. All seven files were well organised and we saw evidence of clear job descriptions and that appropriate recruitment checks had been carried out, including:

- professional register checks and qualifications, where appropriate
- Protecting Vulnerable Groups (PVG) status of the applicant (this was repeated every 4 years), and
- references for those that the service directly employed.

All employed staff had completed an induction and orientation process, which included an introduction to key members of staff in the service and mandatory training. We were told that new staff were allocated a mentor and the length of the mentorship depended on the skills, knowledge and experience of the new member of staff. We saw evidence of one-to-one meetings with the manager and a documented annual appraisal for the employed member of staff.

Patients told us in our online survey that they had confidence in the service and staff. Comments included:

- ‘Everyone was knowledgeable and professional.’
- ‘The team were great.’
- ‘Knowledgeable, talented and an excellent surgeon.’

What needs to improve

As part of the inspection process, we ask the service to submit a self-evaluation. The questions in the self-evaluation are based on our Quality Assurance Framework and ask the service to tell us what it does well, what improvements could be made and how it intends to make those improvements. While requested, the service did not submit a self-evaluation before the inspection (recommendation c).

We saw no evidence of an induction and orientation process for those staff granted practicing privileges (recommendation d).

While references were in place for permanent members of staff, we found that those staff granted practicing privileges did not have references sought (recommendation e).

- No requirements.

Recommendation c

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

Recommendation d

- The service should service should have an induction programme for all new staff, including those working under practicing privileges.

Recommendation e

- The service should review the pre-employment procedure and the information requested for those granted practicing privileges in line with the Scottish Government’s *Safer Recruitment through Better Recruitment* guidance (2016).

Appendix 1 – About our inspections

Our quality assurance system and the quality assurance framework allow us to provide external assurance of the quality of healthcare provided in Scotland.

Our inspectors use this system to check independent healthcare services regularly to make sure that they are complying with necessary standards and regulations. Inspections may be announced or unannounced.

We follow a number of stages to inspect independent healthcare services.

Before inspections

Independent healthcare services submit an annual return and self-evaluation to us.

We review this information and produce a service risk assessment to determine the risk level of the service. This helps us to decide the focus and frequency of inspection.

Before

During inspections

We use inspection tools to help us assess the service.

Inspections will be a mix of physical inspection and discussions with staff, people experiencing care and, where appropriate, carers and families.

We give feedback to the service at the end of the inspection.

During

After inspections

We publish reports for services and people experiencing care, carers and families based on what we find during inspections. Independent healthcare services use our reports to make improvements and find out what other services are doing well. Our reports are available on our website at: **www.healthcareimprovementscotland.org**

We require independent healthcare services to develop and then update an improvement action plan to address the requirements and recommendations we make.

We check progress against the improvement action plan.

After

More information about our approach can be found on our website: https://www.healthcareimprovementscotland.org/scrutiny/the_quality_assurance_system.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

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