Announced Follow-up Inspection Report: Independent Healthcare

Service: Grand Aura Skin & Wellbeing Clinic, Aberdeen

Service Provider: Grand Aura Limited

26 June 2024

NHS
SCOTLAND

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Contents

1 A summary of our follow-up inspection 4

2 Progress since our last inspection 6

Appendix 1 – About our inspections 14

1 A summary of our follow-up inspection

Previous inspection

We previously inspected Grand Aura Skin & Wellbeing Clinic on 23 November 2023. That inspection resulted in eight requirements and 10 recommendations. As a result of that inspection, Grand Aura Limited produced an improvement action plan and submitted this to us. The inspection report and details of the action plan are available on the Healthcare Improvement Scotland website at: Find an independent healthcare provider or service – Healthcare Improvement Scotland

About our follow-up inspection

We carried out an announced follow-up inspection to Grand Aura Skin & Wellbeing Clinic on Wednesday 26 June 2024. The purpose of the inspection was to follow up on the progress the service has made in addressing the eight requirements and 10 recommendations from the last inspection. This report should be read along with the November 2023 inspection report.

We spoke with the clinic manager during the inspection.

The inspection team was made up of one inspector.

Improved grades awarded as a result of this follow-up inspection will be restricted to no more than 'Satisfactory'. This is because the focus of our inspection was limited to the action taken to address the requirements and recommendations we made at the last inspection. Grades higher than Satisfactory awarded at the last inspection will remain the same. Grades may still change after this inspection due to other regulatory activity.

		Grade awarded
Direction	*How clear is the service's vision and purpose and how supportive is its leadership and culture?*	✓ Satisfactory
Implementation and delivery	*How well does the service engage with its stakeholders and manage/improve its performance?*	✓ Satisfactory
Results	*How well has the service demonstrated that it provides safe, person-centred care?*	✓ Satisfactory

The grading history for Grand Aura Skin & Wellbeing Clinic can be found on our website.

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

We found that the provider had complied with all of the requirements made at our previous inspection. It had also taken steps to act on all of the recommendations we made.

What action we expect Grand Aura Limited 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 no recommendations.

We would like to thank all staff at Grand Aura Skin & Wellbeing Clinic for their assistance during the inspection.

2 Progress since our last inspection

What the provider had done to meet the requirements and recommendations we made at our last inspection on 23 November 2023

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

Clear vision and purpose

Recommendation

The service should ensure a system is in place to make sure its identified aims and objectives are being met.

Action taken

The service had developed a new leadership team formed of the medical director, clinic manager and lead practitioner. This team met every 3 months to discuss the service's aims and objectives and short-, medium- and long-term plans and goals for the service. We saw examples of minutes of these meetings during the inspection.

Leadership and culture

Recommendation

The service should re-introduce a programme of regular staff meetings, including agendas, and a record of discussion and decisions reached at these meeting should be kept.

Action taken

Staff meetings, now known as clinical quality meetings, took place every 3 months, and we saw dates set in the diary for the remainder of 2024 and the beginning of 2025. Staff also met every month. Staff were encouraged to identify training issues and areas of interest to them, and the medical director delivered related training at the meetings.

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

Co-design, co-production *(patients, staff and stakeholder engagement)*

Recommendation

The service should adhere to its participation policy to direct the way it engages with its patients and uses their feedback to drive improvement. This feedback should be audited at agreed set intervals with improvement action plans implemented.

Action taken

The clinic manager now formally reviewed patient feedback every month and fed this information back to the team during staff meetings, as part of a standing agenda item. Patient feedback was also now part of the monthly audit schedule. Responses were collated and an action plan was produced to ensure all responses were reviewed appropriately.

Action plans and action to be taken were documented on the service's quality improvement plan. This was uploaded onto the service's internal intranet system for staff to view.

Quality improvement

Requirement – Timescale: immediate

The provider must ensure that all healthcare professionals employed in the service are not included on the children and adults' lists in the Children and Young People (Scotland) Act 2014 and The Protection of Vulnerable Groups (Scotland) Act 2007.

Action taken

We saw evidence that all members of staff now had Disclosure Scotland Protecting Vulnerable Groups background checks. We also saw that staff's Disclosure Scotland scheme identification numbers were recorded on their personnel files. **This requirement is met.**

Requirement – Timescale: immediate

The provider must ensure that staff have updated personal development plans and receive regular individual performance reviews and appraisals. This includes staff who have practicing privileges and the service manager.

Action taken

We noted that development and review meetings for all members of staff, including staff with practicing privileges, had taken place between March and April 2024. Staff were asked to complete a new personal development template which identified areas of interest, aims and objectives, and had further review meeting dates set. We saw evidence of personal development plans produced following these meetings. **This requirement is met.**

Requirement – Timescale: immediate

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

Action taken

The service had updated its existing risk register and had an audit schedule in place. Risk assessments included health and safety risks, and all aspects of laser treatments and associated risks. This was now discussed as part of the monthly meetings. The risk register was updated every month with an emphasis on areas of concern, and also indicating the risk category and priority of individual risks.

Any adverse patient reactions were now documented electronically by staff. This generated an automatic alert to the clinic manager and was discussed at staff meetings, focusing on the lessons learned. Complaints could also be documented on these electronic forms.

Learning outcomes were reviewed by the medical director and clinic manager. A report was then generated and added to the training and learning development staff folder. Staff could review this information at any time.

Recommendations from any investigations were documented and action plans put in place, identifying the staff member responsible for ensuring plans were updated. A staff memo was also issued. Risk management and reviews were documented and, as a result, could be easily tracked by senior management. Outcomes of risk management were communicated more effectively with staff. This information was included in the senior management team’s annual performance review of the clinic. **This requirement is met.**

Requirement – Timescale: immediate

The provider must notify Healthcare Improvement Scotland of certain matters as noted in the notifications guidance and in specified timeframes.

Action taken

The clinic manager told us they had reviewed Healthcare Improvement Scotland's notifications guidance to ensure they were aware of what should be reported to us. **This requirement is met.**

Recommendation

The service should ensure that all policies reflect Scottish legislation and best practice guidance.

Action taken

We were told that all policies were currently being reviewed to ensure they contained references to the appropriate Scottish legislation and best practice guidance.

Recommendation

The service should develop and implement a system to determine review dates for all its policies and procedures with documented evidence of when reviews are undertaken and what changes or updates were subsequently made.

Action taken

The service had moved to a new human resources system which hosted all relevant documentation, such as policies and procedures, enabling the service to set review dates. The system automatically sent an alert/reminder to the clinic manager. This also advised the manager which members of staff had read or still had to read policies. Staff were also sent individual reminders to review any policies. A new policy detailing the review process for all of the service's policies and procedures was now also in place, and policy review dates were added to the annual audit schedule.

Recommendation

The service should ensure that a system is in place to make sure that staff are subject to ongoing professional registration and indemnity insurance checks.

Action taken

The new human resources system generated a reminder to the clinic manager to review professional registration status and insurance renewal dates for staff.

Planning for quality

Requirement – Timescale: immediate

The provider must develop, implement and maintain a risk register to ensure effective oversight of how the service is delivered.

Action taken

The service had updated its existing risk register, ensuring all risks to patients and staff were included. The register was reviewed every month. We saw evidence of this during the inspection. **This requirement is met.**

Recommendation

The service should develop a more detailed programme of regular audits to cover key aspects of care and treatment such as infection prevention and control, the clinic environment and patient care records. Audits must be documented and improvement action plans implemented.

Action taken

The service had developed an audit schedule with audits now completed on a regular basis by the clinic manager. Results of audits were communicated back to staff during staff meetings. Monthly audits now included:

- patient care records
- lasers
- patient feedback
- infection prevention and control
- incidents/accidents, and
- environmental audits.

Annual audits included:

- staff files
- fire
- health and safety, and
- risk assessments.

Recommendation

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

Action taken

A new leadership team had been formed which included the medical director, clinic manager and lead practitioner. This team met every 3 months to review the quality improvement plan, also known as the 'company goals' document. The service had developed a short-, medium- and longer-term plan which incorporated many areas identified for improvement, for example employing an additional dermatologist to facilitate appointments and treatments for children under the age of 14 years. This plan was also reviewed every year by the leadership team.

Recommendation

The service should develop a contingency plan that sets out arrangements for patient aftercare and follow-up arrangements if the service ceased trading.

Action taken

The service had developed a contingency plan to advise patients at their earliest convenience should it cease to trade business. Patients would be advised of an alternative service to access treatments where and when possible.

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

Requirement – Timescale: immediate

The provider must ensure that detailed patient care records are kept so that safe care of patients can be demonstrated.

Action taken

Patient care records were now being audited every month by the senior practitioner and clinic manager. Staff were given feedback about findings from these audits. We also saw evidence of audits reviewing doctors' and nurses' notes. Laser practitioners were also included in these reviews. This information was also discussed at staff meetings and at supervision sessions with relevant staff as and when required. **This requirement is met.**

Requirement – Timescale: immediate

The provider must review its laser safety arrangements to ensure that:

a) the laser protection advisor has a signed contract in place detailing appointment of this post with the service

b) the laser protection advisor supplies the service with information of their registration with a professional awarding body

c) the local rules are updated annually, and

d) staff's core of knowledge training is updated regularly.

Action taken

The service had a certified laser protection advisor, with a signed contract detailing dates of their contract with the service. All staff operating lasers had updated their core of knowledge training. This was kept on file and reviewed every year by the clinic manager. Local rules to be followed for the safe use of lasers were in place with an annual review date, and this was included as part of the annual audit schedule. **This requirement is met.**

Requirement – Timescale: immediate

The provider must ensure that when products are not used according to the Summary of Product Characteristics that good medicine governance processes are in place, including obtaining informed patient consent.

Action taken

All patient consent forms had now been updated. Before consenting for treatment, patients were now advised that the service used bacteriostatic saline rather than normal saline to reconstitute botulinum toxin (when a liquid solution is used to turn a dry substance into a fluid for injection). This means the product is being used outwith its licensed use. We saw evidence of this consent process in the five patient care records we reviewed during the inspection. **This requirement is met.**

Recommendation

The service should ensure botulinum toxin is used in line with the manufacturer's and best practice guidance, and update its medicines management and consent policy to accurately reflect the processes in place.

Action taken

The service's medicines management policy had been updated. Staff were now aware botulinum toxin should be discarded after use and not kept in the service's medical refrigerator for more than 24 hours.

Appendix 1 – About our inspections

Our quality of care approach and the quality assurance 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.

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: [The quality assurance system and framework – Healthcare Improvement Scotland]

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

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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