

# Where should aesthetic nurses practise?

## An evaluation of national health guidelines

Although non-surgical cosmetic treatments are medical, there is no licensing body for premises where minimally invasive procedures are provided. Despite this, the Royal College of Surgeons recommends that aesthetic practitioners should only treat patients if they believe the environment meets the standard of the licensing body. Chérie Scanlon explores the minefield of aesthetic practice settings in the UK

**N**on-surgical cosmetic medicine sits almost entirely outside the NHS, resulting in a lack of formal guidance on minimum standards for practice settings. This means that treatments such as dermal fillers can be administered anywhere, hence the recent questioning about the suitability of settings where procedures are currently carried out.

For nurses, the patient environment—‘the interface between the patient and the organisation’ (Royal College of Nursing (RCN), 2013a)—underpins their care. It should be ‘a practical and safe area’ to ‘facilitate a patient’s privacy, dignity and recovery’ (RCN, 2013a). However, despite this, for novice non-surgical cosmetic practitioners, the standard for a ‘suitable’ and ‘safe’ environment in which to practice is often perceptibly low. For example, the blandness of the hotel meeting room where the author was ‘trained’ gave no hint of any clinical environmental requirements, and neither did the course content. With their exciting new skills, aesthetic practitioners went off to practise in dental surgeries, beauty salons and domestic settings. At that stage, no practitioner had a clinic to practise in or a client list to service one.

### Importance of operating from a safe premises

Those who venture into non-surgical cosmetic practice must ask themselves



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what the ‘minimum standard’ is for non-surgical cosmetic settings, and what is ‘suitable’ and ‘safe’. During its review of cosmetic interventions, the Department of Health (DH) (2013) proposed a number of overarching objectives for a regulatory framework to ensure high-quality care. Recommendations 7 and 8 state that ‘all practitioners must be registered centrally’ and that entry to said register should be subject to ‘premises meeting certain requirements’ (DH, 2013). Further, recommendation 14 proposed that ‘those training to be non-surgical practitioners should have a clear understanding of the requirement to operate from a safe premises’ and that the ‘code of conduct for those on the register should include an obligation to abide by certain clearly defined minimum standards for premises’ (DH, 2013). To date, the ‘minimum standards’ required for non-surgical cosmetic premises have not been defined.

In February 2014, the DH published its response to the above recommendations, concluding that (DH, 2014):

- ▶ A central register was not found to be required, as many practitioners are already on professional registers
- ▶ By the end of April 2014, a review of the training and skills needed for non-surgical cosmetic procedures will be completed
- ▶ Requirements for premises were not mentioned specifically.

There are several national frameworks that can be used as a resource to determine the suitability of an environment for the safe practice of non-surgical medical cosmetics. The author will explore some relevant ones later on in this article.

### Suitability of domestic settings

*Professional Standards for Cosmetic Practice* (Royal College of Surgeons (RCS), 2013)

was published with a view to harmonise standards among doctors, nurses, dentists and surgeons. It states that ‘practitioners should not undertake any procedures in unlicensed premises such as, but not limited to, *ad hoc* domestic settings’ and practise only ‘if they are satisfied that the premises meet the standards of the licensing body’ (RCS, 2013). However, the Care Quality Commission (CQC) (2013), the licensing body, specifically excluded ‘purely cosmetic interventions’ from its regulation (CQC, 2013). Therefore, there is no licensing body for premises where minimally invasive medical cosmetic treatments are provided, no national guidelines for non-surgical ‘outlets’, and no definitive standards (RCS, 2013). Non-surgical cosmetic treatment providers are not subject to any regulation beyond those of the wider service sector, such as the requirements set down by the Health and Safety at Work Act 1974, enforced by local authority bodies such as Environmental Health and Trading Standards (RCS, 2013).

There are several key questions to ask regarding the statements made by the RCS (2013). For example, what are ‘*ad hoc* domestic settings’ and why are they unsuitable for medical aesthetic practice? What research or evidence underpins this sweeping statement? Some non-surgical cosmetic practitioners insist that environments such as beauty salons are unsuitable because they give the ‘wrong impression’ about the medical nature of the treatments, does that preclude the suitability of the environment on safety grounds? Other aesthetic practitioners have questioned how infection control is managed in domestic settings; those who cannot answer this should not practise in this environment, but does this mean that no one should?



» *Not all domestic settings pose patient safety issues, and not all clinical settings eliminate risk. Other than semantics, what is the difference between one room with a sign saying clinic and another saying salon?* «

In addition, settings frequently chosen for non-surgical cosmetic training purposes are *ad hoc* (e.g. hotels and conference centres). Therefore, could it be argued that patient safety is compromised in favour of a 'higher need', such as the dissipation of knowledge in a conference masterclass, or profit from course fees?

### Patient safety versus profit

There is a major concern in the industry that, in *ad hoc* domestic settings, profit is prioritised over patient safety. Fault is often found with practice that takes place outside of the non-surgical cosmetic clinic; however, opportunities for infection can be identified in all healthcare settings. It is clear that profit should never come before patient safety, as was the case in the Poly Implant Prothèse (PIP) breast implant scandal—a situation in which, if one assumes clinical skill was high in a highly clinical setting, the balance that should have been satisfactory was tipped away from patient safety by the use of poor-quality products. In this case, the physical environment did not impact on the outcome of the equation, but clinical governance may not have been robust enough. The point is that not all domestic settings pose patient safety issues, and not all clinical settings eliminate risk.

### Looking beyond semantics

Other than semantics, what is the definitive difference between one room

with a sign over the door saying 'clinic' and another with a sign saying 'salon'? Is the 'suitable clinical environment' not a dynamic concept, where safety arises from a complex interplay between the specific skills and expertise of each practitioner and characteristics of the environment in which they practise? For example, a highly skilled clinician—one experienced in non-surgical medical cosmetic treatments—in a highly clinical environment—one in which all risks have been identified and addressed for the treatment to be performed—should ensure there is equal consideration for patient safety and profit. On the other hand, a non-medical practitioner or inexperienced clinician in a non-clinical setting—one in which risk has not been managed—may lean more towards profit than patient safety. An algorithm would look like:

► High clinical skill x highly clinical environment = patient safety ≥ profit.

Another example could be a foundation botulinum toxin and dermal fillers course:

► Low clinical skill x non-clinical environment = patient safety ≤ profit.

However, for a conference masterclass, the balance may equalise if clinical skill is assumed to be of a higher level:

► High clinical skill x non-clinical environment = patient safety = profit.

### Managing risk

In the case of a registered community nurse practising non-surgical medical cosmetics, there may also be a reasonable balance between patient safety and profit because the nurse is trained to create a clinical setting, through managing risk, in the patient's home, salon or other *ad hoc* environment. The algorithm for this case would be:

► High clinical skill x highly clinical environment = patient safety ≥ profit.

If risk assessment is undertaken and identified risks are addressed for the treatment to be performed, it could be argued that any place may be a safe environment for practice. Ultimately, if a clinician is competent to work in any particular environment, patient safety will not be compromised. The bottom line is that the practitioner should be aware of the environmental requirements for the treatment to be given and ensure they are met before proceeding. Domestic settings, salons and other '*ad hoc*' environments may therefore be deemed



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safe for practice when all risks have been addressed for the procedure.

### Guidance on premises for patient care

The Health and Safety at Work Act 1974

The Health and Safety at Work Act 1974 is the overarching legislative framework and acts as the basis of British health and safety law. The Act sets out the general duties that employers have towards employees and members of the public, and those that employees have to themselves and to each other. All of these duties are qualified in the Act by the principle of 'so far as is reasonably practicable'—i.e. risks are assessed and sensible measures are taken to address them. The main, essential requirement is to carry out a 'risk assessment', which should be straightforward in a simple workplace, as detailed by the Health and Safety Executive (2011) in *Five Steps to Risk Assessment*. Risk assessment enables identification of relevant risks and simple measures to control identified risks. The law does not expect the elimination of all risk, but it does expect careful examination of what could cause harm to people so that adequate steps can be taken to prevent harm. One is legally required to assess the risks in the



workplace, wherever that may be, so that a plan to control the risks can be put in place.

### Clinical governance

Introduced in 1998, clinical governance placed quality at the centre of NHS reforms. The principles apply equally across the independent healthcare sector. There are five key themes of clinical governance, forming a framework to support clinical judgement and professional self-regulation. Robust systems of clinical governance improve and maintain essential standards of quality and safety, improving patient's experience of care—the central purpose of clinical governance. One of the five themes is 'patient focus', in which good patient care is seen to include 'being safe and comfortable' and 'having confidence in the care environment' (RCN, 2013b).

### Patient safety in primary care

*Seven Steps to Patient Safety for Primary Care* is a best practice guide that was published by the National Patient Safety Agency (NPSA) (2009). It describes seven key areas to address in safeguarding patients, providing hints, techniques and toolkits for the management of patient safety, and a checklist to plan and measure performance (NPSA, 2009). Each of the seven 'steps', the first of which is to build a 'safety culture' (NPSA, 2009), will help ensure that care is as safe as possible, and the right action is taken when things go wrong. The 'steps' will also assist health professionals in meeting clinical governance, risk management and national standards for safety (NPSA, 2009).

### Infection prevention and control

The DH's (2010a) *Code of Practice on the Prevention and Control of Infections* stresses

that providers have a duty to maintain premises that facilitate the prevention and control of infections (DH, 2010a). The standards are comprehensive and could be applied to any clinical environment. The Code also states that it 'may be used as a benchmark standard by providers in the independent sector' who would 'need to take a view on the extent to which the processes set out are followed exactly or are adapted locally' (DH, 2010a). It also states that providers should demonstrate clearly 'that the issues around infection prevention and control and cleaning have been taken into account when making decisions (DH, 2010a).

### Essence of Care

*Essence of Care* (DH, 2010b) provides a structured, patient-centred approach to setting standards for fundamental aspects of care, developing action plans for improvement and audit, and identifying education and training needs. There are 12 benchmarks in *Essence of Care*, including one for the care environment (DH, 2010b).

### Royal College of Nursing

The RCN's (2012) guidance on infection prevention and control highlights essential elements of good practice. Included in this document is advice on 'achieving and maintaining a clean clinical environment'. It also provides a reference to resources which may 'be consulted for new builds and refurbishment projects' to help ensure 'buildings are fit for purpose and comply with the necessary standards' (RCN, 2012).

### Conclusion

The care setting is a critical component of good nursing practice and, although many

would welcome specific guidance for non-surgical premises, it may never come. However, absence of guidance does not preclude the requirement to demonstrate consideration of patient safety. While risk assessment is key to meeting legal requirements, nurses may apply an algorithm to determine the balance between safety and profit in their non-surgical cosmetic practice. ▶ JAN

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