CPSA Clinical and Practice Standards

Overarching Principles

Scope	The Cosmetic Practice Standards Authority (CPSA) Clinical and Practice Standards outline the clinical and practice requirements for non-surgical cosmetic procedures and hair restoration surgery (HRS). Non-surgical cosmetic procedures include the use of: • Botulinum toxin • Skin fillers • Chemical peels and micro needling • Laser, intense pulsed light, light emitting diode (LIPLED) and energy based treatments and • HRS which includes Hair Transplant Surgery by both Strip Follicular Unit Transplant (FUT) and Follicular Unit Extraction (FUE) donor hair harvesting techniques, and Prosthetic Hair Fibre Implantation (PHFI). HRS is recognised as Level 1b invasive cosmetic surgery and • Orphan treatments which do not clearly align with a modality subset and • Novel and untested treatments. Where potential risk is foreseen; CPSA will endeavour to produce a publicly available position statement on newer treatments and those without an evidence base In the future, CPSA will provide guidance based on procedure related data collection and the reporting of adverse events. The CPSA will use this data to identify trends in treatment modalities and

	products, highlighting outlier practice; both poor and outstanding. Standards for the individual modalities have been produced through stakeholder engagement, including: dermatologists, plastic, reconstructive and aesthetic surgeons, aesthetic doctors, dentists, nurses, aesthetic practitioner, the beauty sector, industry experts and professional bodies. Practitioners must provisionally register with the JCCP and can only gain full JCCP registration once they can evidence the standards have been met. Provisional registrants will be evaluated at 18 months to ascertain whether standards have been met or further evidence is required. If standards are met full JCCP registration will occur at 2 years.
Definitions	**Adverse event** An unintended, unexpected or unfavourable event which can result in temporary or permanent outcome. This may include serious injury, deformity, disability and/or death. **Assessor** An experienced practitioner that meets the recognised CPSA Assessor Standards. Their credentials have been scrutinised and benchmarked by a JCCP panel**.** Assessors will evaluate the competence of *Supervisors* (see definition). **Cosmetic procedure** A procedure, with the primary aim of changing physical appearance without direct medical benefit. **Competence** The practitioner's ability to demonstrate appropriate qualifications, training, scientific knowledge, procedural skill, adequate experience and accountability to perform a procedure safely and effectively. The ability to recognise and treat the complications associated with a treatment, including adverse events which may require resuscitation. **Complaint** Where a patient, member of the public or staff expresses dissatisfaction with: the outcome of a treatment, the encounters with practitioners or staff, the standard of the facility; the overall service provided; financial costs of the service. **Compliment** Where a patient, member of staff or member of the public expresses satisfaction and/or thanks for a treatment, the encounters with practitioners or staff, the standards of the facility; the overall service

	provided; financial costs of the service. **Continuous Professional Development (CPD)** The additional relevant educational, training, managerial, leadership and reflective work a practitioner must engage with to ensure practice is professional, up-to-date and progressive. CPD must be presented to an appraiser on an annual basis. **"Cooling off" period** Is the time interval required between the consultation (where risks are explained, patient is appropriately counselled, detailed financial costs are explained) and the decision to proceed with this treatment **Facility** *(or premises)* The establishment and environment where a treatment is delivered. **General Sales List (GSL medicines)** These medicines can be purchased from any retail outlet without a prescription. There are limits on the quantity and strength of medicines that can be supplied. **Health Education England (HEE)** The government arms length body which delivers healthcare training. HEE produced the non-surgical cosmetic and HRS educational and training requirement framework. **Health** The physical, mental and social well-being of an individual. **Oversight** The supervision and responsibility for a known delegated practitioner. **Pharmacy Medicines (P medicines)** These medicines can only be purchased without a prescription but only from a registered pharmacy and are not available for self-selection. **Practitioner** A person who is offering and/or undertaking the procedure(s). **Prescriber** An independent prescriber of prescription only medicines (POMs). The presciber has vicarious liability for their the practitioner who administers the prescription. **Prescription Only Medicines (POMs)** These medicines can only be supplied in accordance with a prescription.

	Professional Statutory Regulatory Body (PSRB) For these Standards includes: General Medical Council (GMC), General Dental Council (GDC), Nursing and Midwifery Council (NMC), Health and Care Professionals Council (HCPC), General Pharmaceuticals Council (GPhC). **Provider** The organisation which employs practitioners and delivers procedures. **Reporting** Is the notification of: an adverse event, negligent practice by a practitioner or provider, a defective health care product or device. Product and device problems must be reported directly with the manufacturer or using the Medicines and Healthcare products Regulatory Agency (MHRA) Yellow Care System. These must be reported to the relevant professional statutory body, regulator and the JCCP register where applicable. **Supervision** Immediately available within the premises, with the ability to intervene in the case of a procedure related complication, adverse event or emergency. • **Direct supervision -** within the procedure room. **Supervisor** An accredited practitioner who has oversight and is accountable for their delegated practitioner: • For Level 6 and 7: Supervisors must be a prescriber regulated by Professional Statutory Regulatory Body, independently assessed by and awarded by a JCCP Assessor (see definition). • Level 4 and 5: Supervisors must be independently assessed and awarded by a *JCCP Assessor* (see definition).
PROFESSIONALISM	
Probity	Practitioners must abide by the CPSA/JCCP Code of Conduct. Practitioners must have strong moral principles and act with honesty and integrity [1-6]. Patient safety and wellbeing must be put first. Practitioners must recognise vulnerable patients and guide them away from treatment if it is inappropriate Practitioners must be honest in financial and commercial dealings with patients. Practitioners must not allow any interests to affect the way that they prescribe, treat, refer or commission services for patients. If practitioners are faced with a conflict of interest, they must be open about the conflict, declaring the interest formally, and

	must be prepared to exclude themselves from decision making [7]. 1. Read the code online. NMC. https://www.nmc.org.uk/standards/code/read-the-code-online/ 2. Act with honesty and integrity. GMC. http://www.gmc-uk.org/guidance/good_medical_practice/honesty_integrity.asp 3. Principle One. Put patients' interests first. GDC. https://standards.gdc-uk.org/pages/principle1/principle1.aspx 4. http://www.hpc-uk.org/aboutregistration/standards/standardsofconductperformanceandethics/ 5. Standards for Pharmacy Professionals 2017 6. Medicines Ethics and Practice – The Professional Guide for Pharmacists 2017 7. Honesty in financial dealings. General Medical Council. http://www.gmc-uk.org/guidance/good_medical_practice/20466.asp
Duty of candour	Practitioners must be open and honest when something has gone wrong with the care, treatment or other services that they provide by: • Informing service users or, where appropriate, their carers, that something has gone wrong; • Apologising; • Taking action to put matters right; and • Making sure that service users or, where appropriate, their carers, receive a full and prompt explanation of what has happened and any lasting effects. **References** 1. Regulation 20: Duty of Candour. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20. http://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour
Efficacy of treatments	• Practitioners must be open and honest about the efficacy of treatments. If little or no evidence is available, practitioners must have a frank discussion around the procedure. • Practitioners must not make ill claims of efficacy to entice patients. • Practitioners must provide effective treatments based on the best available evidence [1]. • When prescribing medications off-license practitioners must be assured and honest of its efficacy [1]. **References:**

	1. GMC - Good practice in prescribing and managing medicines and devices
Multidisciplinary team (MDT) working	• Practitioners must work with colleagues and discuss cases. • Practitioners must work effectively with healthcare professionals to promote effective practice [1]. • An MDT must be consulted prior to carrying out a cosmetic procedure on a child [1]. **Regular meetings** As part of CPD, all practitioners must attend an MDT meeting at least 4 times a year, to facilitate: • Case based discussions • Morbidity/complication review • Review current literature • Present audit or research • Attendees and meeting content must be recorded **References** 1. GMC. Guidance for all doctors who offer cosmetic interventions
Indemnity	• All practitioners must have adequate and appropriate indemnity in place before they start to practice [1][2]. It must be valid in the country of practice. • If supervising other practitioners, this must be included in the supervisor's indemnity. • The practitioner must not act outside their scope of practice and/or indemnity. **References** 1. Insurance, indemnity and medico-legal support. GMC. http://www.gmc-uk.org/doctors/information_for_doctors/insurance_and_indemnity.asp 2. Professional indemnity arrangement. NMC. https://www.nmc.org.uk/registration/staying-on-the-register/professional-indemnity-arrangement/
PRE-EMPLOYMENT CHECKS	
Practising privileges	A practitioner must present information to a provider prior to starting practice and notify them immediately of any changes.

	A provider should use the principles set out by the Association of Independent Healthcare Organisations Practising Privileges Principles [1]. The provider must be assured that the practitioner provides evidence adequate of: 1. Up to date Curriculum Vitae (CV) 2. Valid degrees and qualifications 3. At least two references (at least one referee must be regulated by a PSRB) 4. Professional license (if applicable) 5. Evidence of professional good standing 6. Any sanctions on PSRB license, which impacts upon practise or supervision (if applicable) 7. Valid appraisal (and revalidation where required) 8. Has been cleared by the Enhanced Direct Barring Services (DBS) Check 9. Adequate indemnity to practice and /or supervise 10. Adequate occupational health and immunisation history 11. The procedures performed are within scope of practise and insurance 12. Is adequately trained and qualified to perform the procedures stated **References** 1. Association of Independent Healthcare Organisations Practising Privileges Principles**.** https://aiho.org.uk/689-aiho-practising-privileges-principles
Disclosure and Barring Services (DBS)	• All practitioners must have a cleared contemporaneous Enhanced DBS check [1]. **References** 1. DBS checks (Previously CRB checks) https://www.gov.uk/disclosure-barring-service-check/overview
Good standing of practitioner	• A practitioner must be able to demonstrate they are of good standing • The provider must ensure that their practitioners are of good standing. • If a practitioner is regulated by a Professional Statutory Regulatory Body (PSRB), the provider must ensure there are no sanctions that would prevent the practitioner from working. • A practitioner who has been ‘struck-off’ from their respective PSRB Register is by default, unable to meet the CPSA

	Standards and therefore cannot enter the JCCP register.
OCCUPATIONAL HEALTH	
Immunisation history	**Immunisations for practitioners involved in direct patient care** All practitioners must be up to date with the following immunisations: (Providers must have an assurance process in place). • Diphtheria • Tetanus • Polio • Measles, mumps and rubella (MMR) Measles and rubella • It is vitally important to avoid transmitting measles or rubella to vulnerable groups. • Satisfactory evidence is having received two doses of a positive antibody test. Other selected vaccines, as recommended below: • BCG – healthcare workers who may have close contact with infectious patients • Hepatitis B – healthcare professionals who may have direct contract with patients' blood or blood-stained body fluids e.g. from sharps • Influenza – healthcare workers directly involved in patient care, who should be offered influenza immunisation on an annual basis to protect staff and reduce transmission to patients • Varicella (Chickenpox) – susceptible healthcare workers who have direct patient contact. Those who have **not** had a definite history of chickenpox or shingles should have a blood test and given vaccination unless immune. [1][2] **Non-clinical staff in healthcare setting** This includes non-clinical ancillary staff that may have social contact with patients but are not directly involved in patient care, such as receptionists. All staff must be up to date with routine immunisations:

	• Diphtheria • Tetanus • Polio • Measles, mumps and rubella (MMR) Hepatitis B vaccination would only be necessary if a risk assessment of the employee's role concludes that they are at risk of injury from blood-contaminated sharp instruments, or of being deliberately injured or bitten by patients. Annual influenza vaccine is not routinely recommended for this group. [1][2][3] **References** 1. Health and Safety at Work Act (HSWA) 1974. http://www.legislation.gov.uk/ukpga/1974/37/contents 2. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. http://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents 3. The Control of Substances Hazardous to Health (COSHH) Regulations 2002. http://www.legislation.gov.uk/uksi/2002/2677/regulation/7/made
WORKPLACE HEALTH, SAFETY and WELFARE	
Workplace health, safety and welfare policy	A written policy must be in place when there are greater than 5 employees demonstrating: • A commitment to workplace health, safety and welfare • Who is responsible • What arrangements are in place • Consultation with employees allowing them to participate in health and safety • Employers have access to competent health and safety advice and assistance
Risk assessment and control	A provider must be able to demonstrate: • Risk assessments have taken place • Significant risks have been identified • Any significant findings and details of any groups identified as being at risk been recorded (this is optional where there are fewer than 5 employees)

	• Control measures been identified and put in place as a result of the risk assessments • Risks and control measures directly relate to the occupations and activities carried out in the workplace • Systems in place to control general and clinical waste • Risks and control measures explained to employees and others • Risk assessments are regularly reviewed
Accident, incidents and first aid	A provider and/or practitioner must be able to demonstrate: • Adequate arrangements for first aid materials have been made • Adequate arrangements for trained first aid persons have been made • Accidents, incident and first aid episodes are recorded in a logbook • Learning occurs after events • All legally reportable accidents, incidents and ill-health be reported to the enforcing authority and will they be investigated to enable remedial action to be taken
Staff induction and training	Providers must demonstrate: • Health and safety information, instruction and training given to all new employees • Ongoing health and safety information, instruction and training provided • Health and safety information, instruction and training recorded • The effectiveness of health and safety information, instruction and training assessed, and is the assessment recorded
Personal protective equipment (PPE) and clothing (C)	Providers must demonstrate: • PPE/C provided, free of charge, to employees/practitioners as determined through risk assessment • Training and information on the safe use of PPE/C provided to all employees/practitioners • Proper use and storage of PPE/C enforced • PPE/C maintained and replaced
Fire safety	Providers and practitioners must ensure the premises is safe from fire according to the Regulatory Reform (Fire Safety) Order 2005: a short guide to making your premises safe from fire [1].

	Providers must demonstrate: • A named person(s) for emergencies • A fire log/record book kept • A means of raising the alarm and fire detection in place • Appropriate means of fighting fire in place • Effective means of escape in place including unobstructed routes and exits • Fire-fighting equipment, preventive measures and emergency arrangements maintained, including through tests and practise drills • Evidence of risk assessment complete which identifies risks, hazards and control measures **References** 1. Regulatory Reform (Fire Safety) Order 2005: a short guide to making your premises safe from fire. https://www.gov.uk/government/publications/making-your-premises-safe-from-fire
Safe and healthy working environment	Providers must demonstrate: • The premises (structure, fabric, fixtures and fittings) safe and healthy (suitable, maintained and kept clean) • The working environment (temperature, lighting, space, ventilation, noise) an appropriate safe and healthy one • welfare facilities (toilets, washing, drinking, eating, changing) provided as appropriate and maintained • There is access to a dedicated hand wash sink that must be for hand washing only. The sink must not be dual purpose e.g. a kitchen or bathroom sink • Multiple use equipment and devices cleaned or decontaminated between use • Single use and single person devices are not re-used or shared • There are appropriate laundry facilities and supplies of clean linen/towels sufficient for each treatment/procedure and for additional use for modesty reasons as required • Substances which fall under the Control of Substances Hazardous to Health Regulations 2002 in a suitable storage with safety data sheet [1] • Exposure to hazards from physical, chemical and biological agents adequately controlled • Facilities are provided to ensure modesty and privacy appropriate to the treatment/procedure

	References 1. Control of Substances Hazardous to Health Regulations 2002. www.hse.gov.uk/cossh
Employer liability and insurance	Providers must demonstrate: • Professional Indemnity and Public Liability insurance current and other relevant insurances in place as appropriate to the business undertaking • Employers liability insurance current if appropriate to the business • They can account for practitioners when they work away from the employer's own premises or when employees are placed with another employer / site
Annual reviews	Providers must demonstrate: • Health, Safety and Welfare annual review • An annual review of practitioner competencies and scope of practice • Employed practitioners have undergone an annual review of CPD and formal appraisal
Workplace violence	• Providers must safeguard staff against workplace violence and follow the World Health Organisation Framework Guidelines for Addressing Workplace Violence in the Health Sector [1]. **References** 1. World Health Organisation Framework Guidelines for Addressing Workplace Violence in the Health Sector http://www.who.int/violence_injury_prevention/violence/activities/workplace/en/
Security	Providers must demonstrate: • A security policy • Ensure patients are safe • Locks and alarms should be available to safeguard against intruders and to keep patients and staff safe. • The premises are risk assessed for potential security breaches • Security breaches are reported and learnt from

	• For larger providers of concern security personnel may be required
Medical device storage	Providers must demonstrate: • They meet the regulatory standards for particular medical devices • Hazardous chemicals shall be labelled and stored in accordance with recognized standards.
Compressed gases	Compressed gas cylinders must be stored and handled in a safe manner according to the British Compressed Gas Association Medical Gases guidance. **References** 1. British Compressed Gas Association Medical Gases guidance. http://www.bcga.co.uk/pages/index.cfm?page_id=29
Electricity at work	A practitioner must comply with Electricity at Work Regulations [1] and electrical appliances should undergo Portable Appliance Testing [2]. **References** 1. The Electricity at Work Regulations 1989. http://www.hse.gov.uk/pubns/priced/hsr25.pdf 2. Portable Appliance Testing (PAT). https://www.pat.org.uk/
Needlestick injuries **Body fluid or blood exposure**	The practitioner and/or provider must adhere to the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 [1] which provides advice on: • Safe use and disposal of sharps • Training requirements • Procedures for responding to a sharps injury **Training courses** • Safe sharps handling must be formally trained on the accredited courses **Preventative measures**

	Preventative measures should be put in place, such as: • A comprehensive needlestick injury policy must be in place • Adequate staff training • Sharps disposal procedures • PPE and clothing readily available • Workplace risk assessments • Using safety-lock or retractable needles where possible [2] **First aid treatment** • If the mouth or eyes are involved, they should be washed thoroughly with water • If skin is punctured, free bleeding should be gently encouraged and the wound should be washed with soap or chlorhexidine and water, but not scrubbed or sucked • If there is any possibility of HIV exposure, urgent advice should be sought about the relative indications for anti-retroviral post-exposure prophylaxis [3] **Reporting** In some circumstances, needlestick injuries must be reported to RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 [4]. Practitioners and providers must familiarise themselves with the Regulations. **References** 1. Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. http://www.hse.gov.uk/pubns/hsis7.htm 2. Needlestick injuries. The point of preservation. Royal College of Nursing 2009. https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/publications/2009/february/pub-003313.pdf 3. Managing the risk of sharps injury. NHS Employers. http://www.nhsemployers.org/~/media/Employers/Documents/Retain%20and%20improve/Health%20and%20wellbeing/Managing%20the%20risks%20of%20sharps%20injuries%20v7.pdf 4. RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013. http://www.hse.gov.uk/riddor/
SUPERVISION and ACCOUNTABILITY	
Supervision	All practitioners will need some element of supervision at the

principles	beginning of their practice, unless deemed an Independent Practitioner (those practitioners who are on a GMC Specialist Register in a subspecialty with training in non-surgical cosmetics and procedures are included in annual appraisal, or those who can demonstrate independence to a JCCP Panel). This proposal is not an attempt to restrict practice but is an attempt to promote high levels of ***Clinical Professionalism***; safeguarding the patient and practitioner. • The time and level of supervision is stipulated depending on modality, HEE level, prescriber-status and professional background of the practitioner (see *Supervision Matrix)* • *Supervisors* must be independently assessed and awarded by a JCCP Assessor • *Supervision* means immediately available within the premises, with the ability to intervene in the case of a procedure related complication, adverse event or emergency • *Direct supervision* means within the procedure room, which is required for practitioners. This is required • See *Supervision Matrix* for modality, HEE level and practitioner background requirements
Provider accountability framework	A provider must demonstrate: • An accountability framework is in place and recognised by all staff, knowing their line manager and how to escalate concerns • At least one 'Board member' or senior employee must be regulated by a Professional Statutory Regulatory Body • A provider induction takes place for all employees – delivering corporate vision and strategy, organisational values and reinforcing ethical code of practice • Line managers are easy to identify and readily available to support employees professionally and pastorally
EMERGENCY CARE	
Resuscitation requirements	Providers and practitioners must have effective arrangements in place to provide adequate and appropriate equipment, facilities and personnel to ensure that patients receive immediate attention if they become acutely unwell. **Adult basic life support (BLS) and automated emergency defibrillation (AED)** [1] All practitioners, providing any modality of treatment, regardless of HEE level must be trained in BLS and the use of an Automated

External Defibrillator (AED). BLS must be refreshed on an annual basis.

If an AED is not immediately available on the premises, practitioners must know where the nearest available AED is located. AED locations can be found by entering a postcode at www.heartsafe.org.uk [2].

Anaphylaxis

The recognition and treatment of anaphylaxis must be integrated into all modality training pathways.

Emergency medicine and equipment must be regularly checked and recorded to be functioning and in-date. A practitioner must have access to:

- Maintained oxygen supply and a mask
- Adrenaline auto injector for intramuscular injection
- The anaphylaxis treatment algorithm (Resus Council or equivalent)
- Any other emergency medicine deemed appropriate based on risk assessment

All practitioners must be able to recognise and treat anaphylactic shock. Practitioners must be able to:

- Position patient appropriately
- Administer intramuscular injection (using an auto injector) of adrenaline 500 micrograms 1:1000 concentration
- Administer oxygen

Sedation

- If administering sedation, practitioners must assure that the appropriate numbers of skilled staff are available
- Practitioners must follow the Royal College of Anaesthetists Guidelines for the Provision of Anaesthesia Services (GPAS) Guidance on the Provision of Sedation Services 2016 [4] and the Academy of Medical Royal Colleges, Safe sedation practice for healthcare procedures [5]

References

1. Adult basic life support and automated external defibrillation https://www.resus.org.uk/resuscitation-guidelines/adult-basic-life-support-and-automated-external-defibrillation/
2. Heartsafe®. http://www.heartsafe.org.uk/
3. Resus Council – Emergency Treatment of Anaphylactic Reaction. https://www.resus.org.uk/anaphylaxis/emergency-treatment-of-anaphylactic-reactions/

	4. Guidelines for the Provision of Anaesthesia Services (GPAS) Guidance on the Provision of Sedation Services 2016. http://www.rcoa.ac.uk/gpas2016 5. Academy of Medical Royal Colleges. Safe sedation practice for healthcare procedures. http://www.rcoa.ac.uk/document-store/safe-sedation-practice-healthcare-procedures-standards-and-guidance
PATIENT SAFETY	
Patient safeguarding	• All practitioners require Level 2 in Adult Safeguarding [1] • Those in a provider setting but without clinical contact require Level 1 Adult Safeguarding [1] • If providing care to children additional child safeguarding qualification are required **References** 1. Safeguarding adults. http://www.e-lfh.org.uk/programmes/safeguarding-adults/
MEDICINES	
Medicines management	When carrying out activities related to medicines; safety, security, legal requirements and local environmental regulations must be considered at all times. Practitioners must act within the legal framework provided by Human Medicine Regulations 2012 [1] and must comply with the Nursing and Midwifery Council "Standards for Medicines Management" [2] Practitioners must never administer any medication that has not been prescribed, or that has been acquired over the internet without a valid prescription [2].The exception to this is in the case of emergency – see details below. **Standard Operating Procedures (SOPs)** 1. SOPs should be in place covering all aspects of the medicines process. 2. There must be evidence that practitioners have read and understood the SOPs. 3. SOPs should be regularly reviewed and updated. **Training** 1. Competency based training covering all aspects of the processes relating to medicines should be in place. 2. Training records should be maintained. **Prescription** Prescribers must practice in-line with the Royal Pharmaceutical

	Society “A Competency Framework for all Prescribers” [3]. **Administration** POMs must only be administered against a valid prescription written by a: *(a) a doctor;* *(b) a dentist;* *(c) a supplementary prescriber;* *(d) a nurse independent prescriber; or* *(e) a pharmacist independent prescriber.* It is good practice for all medicines, including P and GSL medicines, to be prescribed in order to maintain clear records. Following administration appropriate records should be made in the patients notes. **Stock** Where medicines are held as stock they must be: 1. Procured through recognised wholesalers 2. Administered against a valid prescription 3. Stored securely and in the correct environment as recommended by the manufacturer 4. Audited at regular intervals 5. Recorded appropriately when administered **Disposal** Medicines waste should be stored securely until disposal. Suitable arrangements for the disposal of medicines and medical devices must be in place. The Department of Health ‘Management and disposal of healthcare waste (HTM 07-01)’ guidance should be followed [4]. **Emergency Medicines** Those medicines listed in **Schedule 19** of the Human Medicines Regulations may be administered without a prescription for the purpose of saving life in an emergency [1]. Medicines stocked for the purpose of emergency use must be risk assessed. The practitioner must be competent to administer the medicines. See “Resuscitation Requirements” above. **Controlled Drugs (CDs)**

	The Misuse of Drugs Regulations 2001 place additional controls on medicines that could be misused. [5] Controlled drugs may be subject to: 1. Additional prescription writing requirements 2. Additional storage requirements 3. Additional record keeping requirements 4. Home Office license requirements Mechanisms for linking with NHS England lead controlled drug accountable officers and local controlled drugs intelligence networks must be in place. [6] **Specific medicines** <u>Topical local anaesthesia</u> These products must be used in accordance with the manufacturer's guidance. Over the counter doses must not be exceeded unless there is a prescription. Patients must not be asked to: • Stock pile medicines • Exceed recommended doses and/or recommended surface area coverage <u>Botulinum toxin A</u> • Practitioners must comply with MHRA Guidance [7] • Prescription must be face-to-face after thorough clinical assessment [2] [7] [8] • Current recommendations state there must be one vial, per patient per patient episode. **<u>References</u>** 1. Human Medicines Regulations 2012. http://www.legislation.gov.uk/uksi/2012/1916/contents/made 2. Nursing and Midwifery Council Standards for Medicines Management. https://www.nmc.org.uk/standards/additional-standards/standards-for-medicines-management/ 3. Royal Pharmaceutical Society. A Competency Framework for all Prescribers. https://www.rpharms.com/resources/frameworks/prescribers-competency-framework 4. Health Technical Memorandum 07-01: Safe management of healthcare waste. Department of Health. 2013. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167976/HTM_07-01_Final.pdf 5. Misuse of Drugs Regulations.2001. http://www.legislation.gov.uk/uksi/2001/3998/contents/made

	6. Controlled Drugs: Safe Use and Management. 2016. https://www.nice.org.uk/guidance/ng46/chapter/recommendations#administering-controlled-drugs 7. MHRA guidance on Supply and administration of Botox®, Vistabel®, Dysport® and other injectable medicines in cosmetic procedures. https://www.sps.nhs.uk/articles/mhra-guidance-on-supply-and-administration-of-botox-vistabel-dysport-and-other-injectable-medicines-in-cosmetic-procedures/ 8. Guidance for doctors who offer cosmetic interventions. General Medical Council. 2016. http://www.gmc-uk.org/Guidance_for_doctors_who_offer_cosmetic_interventions_210316.pdf_65254111.pdf
INFECTION CONTROL and ENVIRONMENT	
Infection control principles	**Infection Prevention Society Clinical Practice Process Improvement Tools** Practitioners must ensure they comply with the following Infection Prevention Society Clinical Practice Process Improvement Tools: • Standard precautions [1] • Hand hygiene [2] • Hand Hygiene Observation Tool [3] **Invasive surgical procedures** • Theatre asepsis [4] • Scrub procedures [5] and • Infection Prevention Practice Across The Surgical Pathway OneTogether Infection Assessment Toolkit [6] **Decontamination of surgical equipment** Hair restoration surgery providers and practitioners must conform to the Decontamination of Surgical Equipment: Healthcare Technical Memorandum 01-01 [7]. Equipment must be decontaminated as per manufacturer's guidance. Single use items must not be re-used. **References** 1. Infection Protection Society. Process Improvement Tools (PIT). Standard precautions. http://www.ips.uk.net/index.php/download_file/view/591/264/2

	64/ 2. Infection Protection Society. Process Improvement Tools (PIT) Hand hygiene http://www.ips.uk.net/index.php/download_file/view/585/264/264/ 3. Infection Protection Society**.** Process Improvement Tools (PIT). Hand hygiene Observation Tool. http://www.ips.uk.net/index.php/download_file/view/614/264/264/ 4. Infection Protection Society. Process Improvement Tools (PIT). Theatre asepsis. http://www.ips.uk.net/index.php/download_file/view/704/264/264/ . **5.** Infection Protection Society**.** Process Improvement Tools (PIT). Scrub procedures. http://www.ips.uk.net/index.php/download_file/view/590/264/264/ 6. OneTogether Infection Assessment Toolkit. Infection Prevention Practice across the Surgical Pathway http://www.ips.uk.net/index.php/download_file/view/4168/2903/ 7. Decontamination of Surgical Equipment (Healthcare Technical Memorandum 01-01). https://www.gov.uk/government/publications/management-and-decontamination-of-surgical-instruments-used-in-acute-care
Infection control – procedure room	**Clinical hand wash sink** [1] • Dedicated for hand washing only (not instrument decontamination or body fluid discharge) • Plug must not be used to allow for hand washing under running water • Integral back outlet the sink surround e.g. grout/splashback must be intact and easy to clean • Situated near patient/service user i.e. in the room if invasive procedures performed or in adjacent room • Hand washing sinks must be supplied with liquid soap from a clean dispenser, disposable paper towels and a black bag waste bin. Alcohol rub must be available for staff in the clinic room (but not at sink) • Sinks ideally should be operated by lever action (e.g. elbow) or sensor taps (with single self-draining spout). If elbow taps are not available disposable towels can be used to switch of the taps • A clinical hand wash sink must be accessible and should not be sited behind curtain rails TMV3-approved thermostatic mixing valve (either fitted directly to tap or integral within it, in accordance with Health Technical Memorandum 04-01)

	Visitor/service user hand wash sink [1] • Must be present in the toilet areas • As above except hand drying may be by air drier or disposable paper towels (not fabric towel) **Flooring** [1] • No carpet in any area where clinical procedures are performed or where there is a risk of body fluid spillage • The floor must be easily cleaned (a wooden floor is acceptable if sealed) • Place an absorbent pad on the floor if the wound is oozing heavily **Furniture and horizontal work surfaces** [1] • All surfaces and furniture including chairs must be smooth (no deep chips and scratches), easy to clean. Surfaces that can be contaminated with body fluid must be able to tolerate chlorine releasing solution (10,000ppm of av.chlorine) • Work surfaces must be free from extraneous items and clutter **Clinical waste** • The practitioner must comply with the Department of Health Healthcare Technical Memorandum 07-01: safe management of healthcare waste [2] **Sharps** [1] • **Sharps Boxes** - Boxes for the disposal of scalpels, needles or any other sharps must comply with BS 7320 and UN3291.The sharps box lid colour code is: • **Purple** – for sharps contaminated with cytotoxic or cytostatic drugs • **Orange**- sharps waste not contaminated with any drugs/chemicals • **Yellow**- sharps waste contaminated with any drugs/chemicals **Clinical waste - bags** [1] • **Waste bags**- **Black** – for non-hazardous waste • **Orange** - infectious waste with no chemical contamination include all blood soiled waste • **Yellow** - infectious waste with chemical contamination • **Tiger stripe waste** – offensive waste but not known to be infection risk **Decontamination** [1] • **Couch and seating** for examining patients must be easy to clean (fluid impermeable material, no splits or tears). Fresh

	blue disposable roll must be placed on the couch for each patient. At the start and end of each clinic, wipe the couch with sanitizing wipes. Also clean with detergent if visibly soiled or used by a known infected patient. It must also tolerate disinfectants to decontaminate blood stained fluids • **Dignity blanket** - provide a single use disposable dignity blanket or machine launder reusable linen after each patient. • **Pillows** must be covered to make them impermeable to fluids. Wipe pillow with sanitising wipe at the start and end of each clinic and wash with detergent if visibly soiled. Disposable pillow cases rather than linen cases should be used if a pillow case is required • **IT equipment in procedure room** - a wipeable keyboard should be used. The keyboard should tolerate wiping with a sanitizing wipe at the beginning and end of each clinic and if obviously soiled • **Blood pressure cuffs –** wipe with a sanitizing wipe after each use and protect from body fluid contact **Buckets** [1] • Must be lined with a single use disposable liner (e.g. single use waste bag) before filling with water, to prevent contamination of the bucket • **Do not fill the bucket directly from a hand washing sink or kitchen sink**. If no other clean water source is available fill the bucket in these areas using a clean jug filled from the kitchen tap/hand washing sink) • After use, discard the bucket fluid into a **sluice type out let** (ie not hand wash sink). A sluice type outlet includes a slop hopper, toilet in a non-inpatient area or cleaners sink • If a toilet has to be used it must be cleaned with a sanitising wipe after each bucket emptying • Staff must wear disposable gloves, aprons and face protection when decanting body fluids, followed by hand washing • The lid must be closed when flushing the toilet to reduce aerosol spread. If more than one toilet available in the clinic then limit the discarding of fluid to one toilet and keep it out of action for the duration of the clinic. To clean out the bucket with a sanitising wipe, store bucket dry **Privacy screens** [1] • Must be wipeable with a sanitizing wipe or detergent and hot water • Non-wipeable screens must be able to be laundered in a washing machine. Wipe/launder screens if visibly soiled, if used for patients with a known infection and at least 6

	monthly **Storage** [1] • Store clean supplies in a clean, dust protected area (e.g. box, covered trolley or cupboard) • Clean supplies and used supplies must be stored and transported in separate containers • Clean and dirty areas should be kept separate and the workflow patterns of each area should be clearly defined. • The design and finish of ancillary areas should facilitate good cleaning • They should have facilities for hand-hygiene and sufficient storage for supplies and equipment **Cleaning schedule** [1][3] • **Immediately:** All spills and body fluid contamination must be cleaned immediately with a 1% chlorine releasing solution • **Daily**: Floors, chairs, tables, hand wash containers, waste receptacles, toys, toilets, sinks, examination couch, low surfaces, treatment area – may need additional cleaning if clinics run 'back to back' • **Weekly**: door handles, switches, internal glazing, high surfaces • **Monthly:** Dust walls and ceilings, radiators, ventilation grilles • **6 monthly**: external glazing, curtains/blinds • **Yearly:** Wash walls and ceiling **References** 1. Appendix 7.4: Generic treatment room standard. Aseptic Technique and Clean Technique 2. Healthcare Technical Memorandum 07-01: safe management of healthcare waste. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167976/HTM_07-01_Final.pdf 3. National Standards of Cleanliness in the NHS 2007
Clinical waste	The practitioner must comply with the Department of Health Healthcare Technical Memorandum 07-01: safe management of healthcare waste [1]. **References** 1. Healthcare Technical Memorandum 07-01: safe management of healthcare waste. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167976/HTM_07-01_Final.pdf

Procedure room size, layout and equipment	The clinical area should be organised so that dirty and clean procedures and processes are clearly separated to reduce the cross contamination. **Size** • The room should be greater than 12m² • Sufficient size that ensures required staff (are able to move freely and there is access to three sides of the operating couch. **Hand wash basin** • Designated clinical hand wash basin must be available. • Large enough to contain splashing and enables the correct hand wash technique to be performed • Ideally the clinical hand wash basin should be fitted with elbow or sensor operated taps • Wall mounted liquid soap dispenser • Wall mounted alcohol rub dispenser • Wall mounted and paper towel dispenser • Surgical hand scrub must be available in a pump operated dispenser. It is preferable to have this wall mounted • Foot operated waste bin for disposal of paper towels • Nailbrushes if used for completing a surgical hand washing technique at the beginning of the session must be single use and disposed of immediately after use • Splash backs should be impermeable and smooth. **Furniture, fixtures and fittings** • Furniture, fixtures and fittings must be clean, intact and constructed of an impermeable material that allows easy and frequent cleaning and able to withstand chlorine base solution **Couch** • Free standing adjustable couch • Covering intact and made of impervious material to allow cleaning. • Step-stool available **Sharps bins** • Sharps bins must be immediately available in the room and preferably wall mounted. **Storage** • The room should contain the minimum amount of equipment to reduce the accumulation of dust and allow easy cleaning. • Equipment and consumables should be stored off the floor. • Equipment should be stored in a cupboard to reduce risk of environmental contamination.

	Flooring • Must be impervious to moisture and withstand cleaning • Intact washable floor covering (non-slip) **Walls** • Must be impervious to moisture and withstand cleaning. • Intact washable walls. • Posters laminated to facilitate cleaning. **Windows/Blinds/Curtains** • Ideally have obscured glass • Blinds if used must be impervious to moisture and withstand cleaning **Ventilation** • Mechanical or natural ventilation **Lighting** • Moveable spot lighting that is easy to clean **Privacy** • Room with solid partitions and a door that offers privacy. • Doors lockable without vision panels **Emergency equipment** • Equipment, emergency packs and sterile swabs should be available to tamponade bleeding • Resuscitation trolley should be available with access to an AED (if no direct access providers/practitioners must know where the nearest AED is available). Necessary emergency drugs and adjuncts required for CPR immediately available • For sharp local anaesthetic and sedation cases, cardiovascular monitoring equipment should be available during and after the treatment. Oxygen should be available **Patient safety** • The practitioner and/or provider should ensure the safety of the patient during treatment • No patient should be left unattended during or immediately after treatment. The staff member left with a patient must be adequately trained to deal with unexpected events
Waiting room	• There should be a designated waiting room with seating available • The area should be uncluttered, clean and well lit • If there is a designated area for administrative tasks, this should maintain patient confidentiality and be safe for

	employees
EDUCATION and TRAINING	
Training	A practitioner performing aesthetic medical treatments should be trained in the respective treatment by an accredited training provider that meets the CPSA Standards requirements. Training should not only include practical skills, but build and test against a solid understanding of: • Basic sciences • Evidence based treatment that informs decision making • Skin anatomy • Skin and systemic physiology • Pathology (see below) • Immunology (see below) • Pharmacology and the specific mechanics of a treatment Recognition, diagnosis and management of complications related to the treatments. Complications of treatments: immediate and late should be taught and recognised. Severe adverse event pathophysiology (including, but not limited to: allergic reactions, anaphylaxis, medicine toxicity, vasovagal syncope) must be taught, including recognition, resuscitation skills and escalation to a higher care setting. Adequate baseline knowledge is required to minimize inappropriate treatment or misdiagnosis. Familiarity of common skin and systemic pathologies, which may cause increased risks associated with a treatment: Benign skin conditions • Infections: Abscess, Cellulitis • Benign tumours: Cysts, lipomata, seborrheic keratosis • Benign pigmented diseases • Other skin conditions: Acne, eczema, psoriasis Skin cancers • Basal cell carcinoma • Squamous cell carcinoma • Melanoma Burns • Recognition • Pathophysiology • Assessing depth and size

	• Immediate response • Referral Systematic diseases • Diabetes • Cardiovascular disease • Pulmonary disease • Diseases requiring anticoagulation • Disease that increase the bleeding risk • Autoimmune disorders • Scarring including keloid and hypertrophic Assessing skin • Fitzpatrick skin types • Ageing skin • Assessment of skin quality Training must also include: • Psychology • Medical ethics • Consent • Professional behaviours • Indemnity • Occupational health requirements • Sharps management Training should be theoretical and a practical, and is evaluated with formal assessments. Practical skills should be developed over a recognised period of time of mentorship.
PATIENT JOURNEY	
Patient consultation	**Identifying practitioners** • Practitioners must identify themselves through introduction and a name badge • True title and credentials must be offered on request. • Practitioners must ensure they are not using a title or prefix which is incorrect or misleading • Other practitioners involved in the procedure and care should be forthcoming to the patient, stating their name, role, qualifications and expertise • It must be clear to the patient who the practitioner providing the treatment is, if there will be assistants and if it is a training case consent must be acquired **Language and translator** • The language used should avoid jargon, be accessible, appropriate and in lay-terms where required

	• If there is a noticeable language barrier, arrangements for a translator should be made **Initial consultation** • Must be in person, face to face with an appropriately trained practitioner • Must not be with an industry representative selling a product. • The consultation should not be delegated to unqualified staff who are unable to perform the procedure and cannot carry out the consent process • Practitioners may need to offer a 2nd (and more if required) consultation prior to embarking upon treatment, especially for more invasive procedures **History and examination** 1. Confirmation of patients identify including: name, date of birth, sex, address and next of kin 2. Contact details should be recorded 3. A unique patient identifying number should be generated. 4. Assessment and documentation of a patient's general health status to check feasibility of treatment 5. Assess and document specific aesthetic concerns 6. Assess and document past medical history 7. Assess and document past psychological/psychiatric history 8. Assess and document aesthetic history 9. Assess and document assess and document allergies 10. Assess and document any evidence of body dysmorphia 11. Assess and document patient expectations 12. Assess and document skin quality, type and local condition 13. Assess and document skin disease 14. Use diagrams and annotate discussion 15. Assess and refer for /request relevant blood tests, if necessary 16. Assess and refer for /request other relevant investigations 17. If in any doubt with capacity and consent process, get further opinion from a medical colleague/supervisor 18. If the patient is diagnosed with dysmorphia no aesthetic medical treatments shall be performed 19. Inform the patient of and document the financial implications. 20. The consultation is the start of the consent process and counselling must be documented; highlighting risks and benefits **Follow up consultations** • Follow up must be offered to all patients. • Face to face is recommended • If video consultation is used it must be deemed safe to do so by the supervisor. • A mechanism must be in place to identify those patients who

	need an emergency face-to-face review and make this available at short notice. **Patient information** • Information should be provided after initial consultation and read during the cooling off period, with ample opportunity to ask questions before the procedure. • The practitioner should provide information to the patient who is up to date, accurate, understandable, realistic, truthful and not misleading. • Practitioners should counsel patients on the aims of treatments, benefits, risks, potential adverse effects, alternatives **Efficacy of treatment** • The practitioner must provide background information and the evidence of treatments and devices on request • If there is no evidence available or it is weak; the practitioner must relay this information honestly to the patient **Managing expectations** • The practitioner must inform the patient of the expectations of a treatment and devices used, ensuring they are aligned with the patient's. • These must be compared to alternative options, including other modalities of treatments, techniques, drugs, agents and devices. • The practitioner must articulate the comparable result of doing nothing and present this in a balanced way **Cooling off** • The practitioner must offer the patient time to digest information, weigh up the risks and benefits of treatment, reflect and ask additional questions before embarking upon treatment (refer to 'cooling off').
Photographs	• Photos are recommended pre and post procedure • The patient must give written consent to have photos taken and stored • At least two views must be taken • Enhanced before and after photos must not be used as advertising material • Intended outcomes must be realistic and photos must not be used as an enticing marketing tool • Honest and realistic limitations of the treatment must be explained to the patient

Psychological/ Psychiatric concerns	The practitioner must be aware of and be able to screen for psychological concerns and/or psychiatric illness. For such patients a referral for a psychological/psychiatric professional is advised prior to commencing cosmetic treatment. This includes training and awareness of Body dysmorphia disorder (BDD). If you are unable to refer directly to these services the patient should be referred to see their GP.
Cooling off	The cooling off period is a minimum time frame that should be used between consultation and treatment. The time frame depends on the level of invasion and risk of a procedure. This is specified for each modality and must be offered to every patient. Practitioners must offer patients time to think before agreeing to go ahead with treatment [1]. **<u>References</u>** 1. Guidance for doctors who offer cosmetic interventions. www.gmc-uk.org/guidance/ethical_guidance.28687.asp
Consent	A patient must give permission before they receive any type of medical treatment, test or examination. This must be done on the basis of an explanation by the practitioner [1]. Consent should be an ongoing process from first consultation to the day of the treatment. Written consent must be gained prior to the treatment taking place. For consent to be valid: • The patient must be competent. • The patient must have sufficient information to make a choice. • The patient must be able to give their consent freely [2]. **Consent process should include** 1. Details of intended outcomes 2. Limitations, risks, alternative treatments and result of doing nothing 3. Commonly occurring and serious but rare complications should be fully explained and understood 4. Recovery period, time required off work, what to avoid and for how long (off-work, keeping dry etc.) 5. Confirm the patient is able to retain, understand and explain the planned treatment, benefits, risks and alternative outcomes 6. Claiming below average or low rate of complication should

	not be used to entice patients 7. Known rates of complications should be documented if known as a whole number i.e.1 in 100 8. Written information shall be in addition to, and not replaced an informative discussion 9. Both parties must sign the informed consent form 10. The practitioner should ensure that the patient is informed of the limitation, implications and potential complications of the aesthetic medical treatment before booking 11. No money should be exchanged for the procedure until the patient has gone through the first aspect of consent which includes fully understands the limitation, implications and potential complications of the treatment, with the exception of previously declared non-refundable deposit 12. No treatment should occur without completion of consent 13. Treatment for patients under the age of 18 years should be only in exceptional circumstances with a documented medical assessment 14. The consent form signed by both parties, understandable and legible **References** 1. Consent to treatment. www.nhs.uk/conditions/consent-to-treatment/pages/introduction.aspx 2. Consent – the basics. www.medicalprotection.org/uk/resources/facstsheets/england-factsheets/uk-eng-consent-the-basics
Safe timing of treatments	Practitioners should advise on lifestyle modification around the time of a procedure. If the risk of a procedure could be reduced by losing weight, smoking cessation, or improving a concurrent medical/skin condition including psychological state this should be made explicitly clear to the patient. Practitioners should consider age, skin quality, patient expectations and realistic achievable outcomes when counselling a patient for a procedure. Practitioners should consider the patient's psychological state when considering treatment, and not proceed with a procedure if concerns are uncovered.
Patient correspondence	The patient is entitled to view their notes and should receive correspondence relating to a treatment. The practitioner must provide access to patient records according to The Freedom of Information Act 2000 request [1].

	Access to written information about a condition and procedure should be given to the patient. The information given should be clear and honest; and must not involve any marketing tactics to entice the patient The identification, speciality, affiliation and qualification of a practitioner who performs the treatment must appear clearly and accurately on all formal communications with the patient. Cancellation policies should be clear to the patient before they embark upon treatment and before any payment is made. A full refund of treatment fees shall be given if any pre-payment is made when the cancellation is within the "cooling off" period. Further arrangements are at the practitioner/clinics discretion but shall be clearly explained and set out in writing to patients. **References** 1. How to make a freedom of information (FOI) request. www.gov.uk/make-a-freedom-of-information_request/the-freedome-of-information-act
Out of hours and emergency cover	Patients should be given an emergency contact number for the provider or practitioner in the case of emergency. Emergency out of hours care should be provided by the practitioner involved in the treatment, unless there are clear arrangements made with a nominated covering practitioner. Cross cover should be provided by a practitioner who is appropriately trained and of a similar level of expertise. For higher risk treatments a formal handover of the patient is required.
Discharge, follow-up and patient satisfaction	• Patients must receive a discharge document after a procedure outlining aftercare and follow-up if required • A guidance document outlining the treatment performed, the aftercare required and how to recognise complications should be issued • Dressing advice (if required) should be issued • An emergency contact number must be provided • When and where to seek emergency care should be outlined. • It is best practice for the practitioner to follow up their own patients • If patient has late concerns about the result, the patient is entitled to see the practitioner who performed the treatment • A patient feedback survey should be carried out before discharge and/or on follow up (also see complaints and

	compliments)
MEDICAL RECORDS and INFORMATION GOVERNANCE	
Documentation of medical records	Medical records should be managed according to the Academy of Medical Royal Colleges' Standards for the clinical structure and content of patient records [1]. **References** 1. Standards for the clinical structure and content of patient records: https://www.rcplondon.ac.uk/projects/outputs/standards-clinical-structure-and-content-patient-records
Confidentiality	Patient confidentiality must be in line with Confidentiality: NHS Code of Practice [1]. **References** 21. Confidentiality: NHS Code of Practice https://www.gov.uk/government/publications/confidentiality-nhs-code-of-practice
Information governance	Information governance must be aligned with Records Management Code of Practice for Health and Social Care 2016 [1]. **References** 1. Records Management Code of practice for Health and Social Care 2016. https://digital.nhs.uk/media/1158/Records-Management-Code-of-Practice-for-Health-and-Social-Care-2016/pdf/Records-management-COP-HSC-2016
Data protection	Practitioners should comply with the Data Protection Act and should refer to the Information Commissioner's Office (ICO) Guide to data protection [1]. Practitioners or the place of employment must be registered with the ICO. Practitioners should also comply with NHS Digital: Cyber and data security policy and good practice in health and care [2] **References** 1. Information Commissioner's Office Guide to data protection. https://ico.org.uk/for-organisations/guide-to-data-protection/ 2. NHS Digital: Cyber and data security policy and good

	practice in health and care. https://digital.nhs.uk/cyber-security/policy-and-good-practice-in-health-care
CONTINUAL PROFESSIONAL DEVELOPMENT (CPD) and APPRAISAL	
CPD	The practitioner must engage with CPD. The number of credits required will be stipulated specifically by the modality. This should be evidenced at annual appraisal to maintain current level of practice or progress.
Audit and quality improvement	Practitioners must evaluate their own practice against recognised standards. This process should facilitate quality improvement. If areas of improvement are identified, a plan should be made to implement change and re-audit performance. Quality improvement should not be regarded as a static process and the practitioner should take every opportunity to improve of enhance their practice. A relevant audit or QI project must be presented as evidence for annual appraisal.
Management and Leadership	Where possible, practitioners should engage with management and leadership opportunities. Such commitments can be used to demonstrate CPD as part of the appraisal purposes.
Complaints	Complaints must be handled according to Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 16 Receiving and acting on complaints [1]. All practitioners should engage with patients to facilitate a clear patient complaints process. Information on how to complain should be made readily available. There must be a process to acknowledge a complaint and formally reply within 28 days. A practitioner should identify themes and trends in complaints. Complaints should be recorded and closed when resolved. If unable to resolve in-house an independent external process should be offered. Learning should be generated and recorded, which should facilitate quality improvement. **References** 1. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 16 Receiving and acting on complaints. http://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-16-receiving-

	acting-complaints#guidance
Appraisal	Appraisal is a requirement to enable practitioners to carry out the duties they are employed to perform as set out by the Health and Social Care Act [1]. All practitioners must be subject to a formal annual appraisal outlining their CPD and future professional development. **References** 1. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18: Staffing. www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-18-staffing#full-regulation
FEES and ADVERTISING	
Fees	Details of fees charged, including the possibility of any additional costs should be provided, and the patient should be aware of the extent of follow up and aftercare required [1]. Fees and billing should be transparent from the beginning of patient contact. A detailed written quote should be provided. The patient should not be deceived with hidden fees. Longer term financing packages must be clear. If a practitioner advised multiple treatments; this must be made explicitly clear prior to embarking upon treatment. Financial implications for complications must be explicit. Financial discounts must not be used to entice patients to have multiple treatments or a 'package deal'. Patients must be informed of the terms and conditions of a deposit, whether it is refundable or non-refundable and any time limitations associated. **References:** 1. Review of the Regulation of Cosmetic Interventions. April 2013. www.gov.uk/government/uploads/system/uploads/attachment_data/file/1922028/Review_of_the_regulation_of_cosmetic_interventions.pdf

Advertising	Advertising must not make false claims or be materially misleading. Nor should it be irresponsible. Practitioners must comply with The Advertising Standards Authority [1]. Marketing must be prepared with a sense of responsibility to patients and society as a whole [1]. The Codes contain specific rules that govern the provision of physically invasive treatments. Guidance has been developed to ensure that practitioners' advertising is compliant with the Codes [2]. If you have any concerns about advertising you may submit an enquiry via the online CAP Copy Advice form here. Practitioners and providers must ensure: 1. Advertising and marketing must be legal, truthful and socially responsible. 2. Free consultation should not be used as a coercive marketing tool. 3. No models should be used either in advertising or marketing. 4. Media, web and blogs must be transparent and accurate. If this task is delegated to others, there must be credible oversight. 5. The status/qualification of the practitioner must be clearly stated. 6. Practitioner's qualifications must not be falsified and should not be misrepresented. 7. A commission based system for referring professionals of patients should not be used. 8. Patient testimonials must be verified, traceable and unpaid. **References** 1. Cosmetic Interventions: Social Responsibility. www.asa.org.ukcosmetic-interventions-social-responsibility.html 2. Help notes on cosmetic interventions. https://www.cap.org.uk/Advice-Training-on-the-rules/Help-Notes/Cosmetics-interventions-marketing.aspx#.V_96cDbrti4
Adverse events, incident reporting and evaluation of compliance	It is the responsibility of a practitioner to collect information specific to the procedure. The JCCP register will also have access to a database to record procedure and practitioner information. This is to provide a central database to help identify outcome trends related to procedures and products, and demonstrate outlier practice. Adverse events associated with medicines and medical devices must be reported to the MHRA via the Yellow Card Scheme [1]. Adverse events and incidents should also be locally recorded, discussed and learning generated in a formal recorded discussion.

	The incidents should be reported, reflected upon, learning identified and quality improvement encouraged. The practitioner and/or provider should be aware of national alerts cascaded down from the Central Alerting System (CAS) [2] to ensure they are delivering effective, current and safe treatments to patients. The provider/practitioner must provide evidence that these alerts have been acted upon. A system should be in place to identify patients who may be directly affected by these alerts. Regular, formal and recorded review of currently offered treatments, techniques and equipment should be carried out. If products/treatments are discontinued the practitioner and/or provider is responsible to notify new patients requesting a specific treatment. Periodic evaluation of legal changes, regulatory requirements and best practice should take place. This should be recorded and documented. **References** 1. Yellow Care Scheme. yellowcard.mhra.gov.uk 2. Central Alerting System (CAS). www.cas.dh.gov.uk/Home.aspx
MEDICAL TOURISM	
Medical tourism and travelling long distance for treatment	Patient/practitioner medical tourism, resulting in travelling long distances to give or receive treatment is not routinely advised. If unavoidable the practitioner must make the patient aware of the implications of long distance travel in terms of the post-treatment phases and follow up, even for minimally invasive/low risk procedures. Practitioners must advise the patient how they plan to manage even minor complications or dissatisfaction with a treatment. Practitioners must avoid organising initial consultation and follow-up local to the patient to facilitate medical tourism for the treatment. Practitioners must encourage and make follow up available where possible. Clear documentation should outline discussions explaining the difficulties associated with distance and highlight a plan in the case of dissatisfaction and complications. This must be taken into consideration during the consenting process and presented as a risk disclosure document that is signed by the patient.

	The risks of treatments and travelling long distances before and after should be explained. Practitioners must not endorse or recommend an insurance scheme whereby complications may be handed over to third parties. These act to entice patients by making a dangerous treatment more attractive but no less dangerous; Practitioners must inform patients if they are travelling long distance to provide treatment.
CONFERENCES, EXHIBITIONS and MOBILE WORKING	
All overarching standards apply	The overarching clinical and practice standards must be met and the modality specific standards. The provider must also ensure: • There a named person responsible for health and safety at the venue • Indemnity insurance current and other insurance in place as appropriate to the business undertaking • Specific risk assessments been carried out and significant risks identified • Demonstration volunteers have gone through an adequate cooling off and consent process • Demonstration volunteers have given additional consent for: educational purposes, research purposes (where applicable) photographs, videos, live streaming and other mediums of recording.