Laser and Light Ltd

Inspection report

1 Church Gate Mews
Loughborough
LE11 1TZ
Tel: 01509266882

Date of inspection visit: 20 April 2021, 26 April 2021, 27 April 2021, 12 May 2021
Date of publication: 14/06/2021

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Inadequate

Overall summary

This service is rated as Inadequate overall. Laser and Light Ltd was last inspected in January 2015, but it was not rated as this was not a requirement for independent health providers at that time. Since April 2019, all independent health providers are now rated, and this inspection was undertaken to provide a rating for this service.

The key questions are rated as:

Are services safe? – Inadequate

Are services effective? – Inadequate

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Inadequate

We carried out an announced comprehensive inspection at Laser and Light Ltd on 20 April 2021 as part of our inspection programme.

Laser and Light Ltd provides treatment of acne to patients as well as mole and skin tag removal and injectable botulinum toxin for the treatment of migraines and hyperhidrosis.

This service is registered with CQC under the Health and Social Care Act 2008 in respect of some, but not all, of the services it provides. There are some exemptions from regulation by CQC which relate to particular types of regulated activities and services and these are set out in Schedule 1 and Schedule 2 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Laser and Light Ltd provides a range of non-surgical cosmetic interventions, for example dermal fillers and laser therapies which are not within CQC scope of registration. Therefore, we did not inspect or report on these services.

Our key findings were:

- Care records did not always contain full information on what medicines and treatment had been provided.
- Policies and procedures were not always up to date and relevant to the service.
- Not all staff had the appropriate level of training for safeguarding.
- Consent was not always recorded for each procedure.
- Patient feedback was positive about clinical care and treatment experience.
- The service was supportive of patients' needs and patients were able to access the service.
- Leaders were not always aware of issues within the service such as ineffective policies and lack of access to safety alerts and updates.
- Out of date equipment was found within the service. There was no clear system for monitoring stock expiry dates.
- There was no evidence of improvement within the service as there had been no clinical audits, significant events or complaints.

The areas where the provider **must** make improvements as they are in breach of regulations are:

Overall summary

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

Dr Rosie Benneyworth BM BS BMedSci MRCGP
Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team was led by a CQC lead inspector**.** The team included a CQC specialist adviser and a member of the CQC medicines team.

Background to Laser and Light Ltd

Laser and Light Ltd is a service intended to provide treatment to private patients in relation to skin conditions such as acne and mole or skin tag removal. The service also provided injectable services for the treatment of migraines or hyperhidrosis.

Laser and Light Ltd is located at 1 Church Gate Mews, Loughborough, Leicestershire, LE11 1TZ and is registered with the CQC to provide the regulated activities of diagnostic and screening procedures, surgical procedures and treatment of disease, disorder or injury.

Consultations are by prior arrangement via telephone or online via email. The service is open from 9am to 5.30pm on Mondays, Tuesdays, Thursdays and Fridays and 9am to 3pm on Wednesdays and Saturdays.

The service was run by a sole doctor, supported by a part time nurse, a laser nurse (not a Nursing and Midwifery Council registered nurse) and three administrative staff.

How we inspected this service

We inspected Laser and Light Ltd on 20 April 2021 and completed interviews carried out remotely on 26 and 27 April 2021. Before visiting we reviewed a range of information we hold about the service and asked the service to send us a range of information. This included information about policies and risk assessments, staff members and audits. Laser and Light Ltd also provided additional information on the site visit and via email following the inspection.

Due to the coronavirus pandemic we were unable to utilise comment cards at this inspection.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Inadequate

Are services safe?

We rated safe as Inadequate because:

We found the service did not always have clear systems to keep people safe as:

- Care records did not always contain full information on what medicines and treatment had been provided and if past medical histories had been assessed.
- Out of date equipment was found within the service. There was no clear system for monitoring stock expiry dates.
- Not all staff had the appropriate level of training in safeguarding.
- Policies and procedures were not always up to date and relevant to the service.
- There were no reported significant events in the service.

Safety systems and processes

The service did not always have clear systems to keep people safe and safeguarded from abuse.

- The service had safeguarding policies for adults and children. Policies clearly outlined the safeguarding lead within the service. The policies were not specific to the service as they referenced other guidance documents which were not available and referenced local guidance which was not relevant to the area that the service was located in. The adult policy stated that the doctor would be responsible to refer cases to the local authority if necessary, however there was no information to suggest referring cases to the local authority in the child safeguarding policy. The policy stated that any abuse should be documented on a log however we were told by staff there was no log within the service. Staff told us that safeguarding concerns would be logged within the patient records however we were not clear on where it would be highlighted on the patient record for other staff members to be aware of.
- The registered manager told us that children under the age of 18 were not seen in the service. However, some policies indicated that children would be seen, and staff informed us that children had been treated in the service. Following the inspection, we were told that children under the age of 18 were only seen for treatments which were not part of the regulated activities.
- Staff had received safeguarding training however we did not see an appropriate level of training for the doctor in relation to adult and child safeguarding.
- Staff we spoke said they felt confident to report concerns to the doctor.
- The provider's policy was to complete Disclosure and Barring Service (DBS) checks for all staff. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- At the time of our inspection there was an infection control policy however it did not include details of general cleaning, audit requirements, training requirements and who was responsible for oversight of infection prevention and control.
- There was a risk assessment for infection prevention and control, however it did not include all risks and actions required to promote adequate infection prevention. We were told there had been no infection control audit completed.
- Following our inspection, we were provided with evidence of updated procedures which included an infection control audit.
- During our onsite inspection, we were given cleaning schedules for the service relating to the kitchen and toilet daily cleaning rota. Staff told us of other cleaning tasks they performed, such as cleaning door handles, but told us this was not recorded anywhere. Following the inspection we were sent cleaning schedules for the treatment rooms and reception area which included documentation of the other cleaning which took place within the service. The service's policy stated that this cleaning was to be documented and reported to the doctor at the end of each clinic session, however there was no evidence of this.

Inadequate

Are services safe?

- The service had cleaning products for use within the building however we did not always see Control of Substances Hazardous to Health (COSHH) information sheets for these. For example, bleach was required within the service however this did not have a safety sheet. A COSHH data sheet for bleach was sent following the inspection. We also saw that a disinfectant called barbicide was used for cleaning within the service, however the safety information was not being followed as it had been decanted into a spray bottle.
- The provider had completed a risk assessment for legionella within the premises however it did not provide assurance that all risks had been fully assessed. There was no information on precautions that staff were taking regularly.
- The provider ensured that facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.
- We found out of date equipment within the service including needles, syringes and scalpels. These items were not separated from items which were in date. The provider told us these items were not routinely used and would not have been for use on patients. We did not see evidence of a process for checking stock to ensure it remained in date and suitable for use.
- The provider carried out environmental risk assessments, which took into account the profile of people using the service. The provider had completed further environment risk assessments in relation to the coronavirus pandemic relating to cleaning and infection control standards between patients.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There was an effective induction system for staff tailored to their role.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example sepsis.
- The service held emergency medicines appropriate to their activity which were in date and accessible to staff.
- The service had a policy regarding the safe handling of sharps however this included treating needlestick injuries with iodine. There was no iodine available within the service and the registered manager was not aware that the policy stated this. Following our inspection, the service provided us with evidence of an updated policy which reflected the current sharps procedures which did not refer to the use of iodine.
- There were appropriate indemnity arrangements in place.

Information to deliver safe care and treatment

Staff did not always have the information they needed to deliver safe care and treatment to patients.

- The care records we saw were not always fully completed and did not always include necessary information to deliver safe care and treatment, for example past medical history. It was not always possible to know what medicines had been used or what dose had been administered to patients.
- We saw evidence of the service sharing information with other agencies however the patients or their GP's were not always included in results. Following the inspection, we were told that the patients GP would be sent results directly from the hospital. It was not clear in the patient records if the patients had received results of tests.
- The service did not have a system in place to retain medical records in line with Department of Health and Social Care (DHSC) guidance in the event that they cease trading.
- At the time of our inspection the service was not signed up to the Information Commissioner's Office for the storage of photos within patient records. However, the provider rectified this following the inspection and we saw evidence of this.

Safe and appropriate use of medicines

Inadequate

Are services safe?

The service had some systems for appropriate and safe handling of medicines, however storage systems for medicines kept people safe.

- The systems and arrangements for managing medicines and emergency medicines minimised risks.
- The medicines management policy for the service was not up to date. The policy had been created in 2019 and used out of date clinical guidance and referred to activities not undertaken by the service. Following the inspection, we received an updated copy of the medicines management policy.
- The service did not have a formulary of which they would prescribe from however we were told that the British National Formulary (BNF) would be used. We were told that controlled drugs would not be prescribed (controlled drugs are medicines which have additional controls due to their risk of misuse and dependence). We were also told that they would not prescribe medicines requiring additional monitoring beyond the remit of Laser and Light Ltd and would rarely prescribe oral antibiotics.
- Staff prescribed, administered and supplied medicines to patients however we did not see evidence to confirm if these were were given in line with legal requirements and current national guidance. Records did not always provide full details of what medicines were used and what dose was given. We were told the process for labelling medicines which were dispensed however were not able to see any completed evidence of this.
- The service verified identity of patients via payment methods.
- We found medicines were stored securely with access restricted to authorised individuals including medicines which required refrigeration. Medication fridges had temperature monitoring recorded efficiently.
- The registered manager was intending to expand the service to include slimming services using injectable medicines, however this was not in place at the time of our inspection.

Track record on safety and incidents

- There were risk assessments in relation to safety issues however these did not always give actions and timelines for actions.
- The service had a fire policy and a recently completed risk assessment. The fire policy referenced what staff and patients should do in the event of a fire alarm, however staff confirmed there was no fire alarm at the service.

Lessons learned and improvements made

At the time of our inspection, there were systems in place for when things went wrong however no incidents had taken place.

- There was a policy for recording and acting on significant events. Staff understood their duty to raise concerns and report incidents however there were no incidents which had been reported at the time of our inspection. Staff we spoke with did not always understand what constituted a significant event.
- The provider was aware of the requirements of the Duty of Candour but had not had any occasions to implement it.

We were told that the provider acted on alerts received relating to medicine thefts or counterfeit medicines. At the time of our inspection, the service was not receiving safety alerts or drug safety updates and was unaware of any recent recalls or alerts relating to medicines or equipment which they used in their service. The registered manager told us during our inspection this would be rectified. Following the inspection we were showed evidence of some safety alerts being received however the doctor was not aware of the system at the time of the inspection and we could not be assured that safety alerts had been acted on appropriately.

Inadequate

Are services effective?

We rated effective as Inadequate because:

- The provider could not demonstrate how it kept staff up to date with evidence-based practice.
- There was no evidence of quality improvement audits being completed.
- Patient records were did not always contain full details of the patients history, and include full details of treatment provided by the service.
- Consent was not always obtained for each procedure.

Effective needs assessment, care and treatment

The provider could not evidence they had systems to keep clinicians up to date with current evidence-based practice.

- The provider could not evidence how they kept clinicians up to date with current evidence-based practice, for example in the removal of moles and skin tags. The doctor was not able to demonstrate that she kept up to date with guidance in relation to dermatology and mole removal. From the records we reviewed there was no evidence that clinicains were not working outside of evidence based practice.
- Following the inspection, we issued the provider with a section 64 letter requesting evidence of training and competencies in relation to the aspects of care provided at the service. The provider responded in line with the section 64 request where we were provided with evidence of the skills to be able to complete mole or lump removal. However, we did not see an audit of minor surgery which would be standard practice.
- The provider assessed patients' immediate and ongoing needs however the records we reviewed did not always contain enough information to give a full account of treatments or diagnosis.
- We saw no evidence of discrimination when making care and treatment decisions.
- Arrangements were in place to treat follow up patients.

Monitoring care and treatment

The service was not actively involved in quality improvement activity.

- The service could not demonstrate improvement as a result of audits. The service collected data annually on a number of patient appointments which included complaints and patient satisfaction, however they were not able to show how this information had been acted on to improve care. We were given an audit in relation to aesthetic medicine however we were unable to see how this related to the service and what impact it had on patients of the service.

Effective staffing

Staff did not always have the skills, knowledge and experience to carry out their roles.

- The doctor was registered with the General Medical Council (GMC) and we were provided evidence of her qualifications required to undertake the treatments she was delivering. .
- The provider had an induction programme for all newly appointed staff.
- There was evidence of training required by the provider being completed for staff, however we did not see appropriate safeguarding training for clinicians. We were told that clinical staff had completed basic life support training in their other roles however the provider had no evidence or assurance of this training.

Inadequate

Are services effective?

- The provider had some records of staff vaccination status however this could not be seen for all patient facing staff. The records we did see did not contain the full list of vaccinations required and we did not see risk assessments for those staff with gaps in vaccination records. The service was not following their own policy which stated that all medical staff should have been vaccinated for Hepatitis B within 5 years.
- Staff reported they were encouraged and given opportunities to develop during appraisals.

Coordinating patient care and information sharing

Staff did not always work well with other organisations, to deliver effective care and treatment.

- From records we saw, it was not always clear if past medical history or allergy status had been reviewed. We were told that before providing treatment, doctors at the service ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines history.
- The service would share details of patient care if the patient had been referred to the service via GP. However, for other appointments, information was not always shared with the patient's GP. We saw evidence of information being shared appropriately with a GP regarding antiviral prescribing.
- The provider had not risk assessed the treatments they offered.
- There was no evidence the service monitored the process for seeking consent appropriately.

Supporting patients to live healthier lives

Staff were consistent and proactive in empowering patients and supporting them to manage their own health and maximise their independence.

- Where appropriate, staff gave people advice so they could self-care.
- Where patients' needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Consent to care and treatment

The service did not obtain consent to care and treatment in line with legislation and guidance.

- Records we reviewed did not always show consent being obtained for every procedure the patient had received. The provider's consent form did not contain evidence of the risks and benefits of the care and treatment being provided. We did not see any evidence in the patient records that risk factors were identified and discussed with patients.
- From patient records, we cannot be assured that patients were supported to make decisions about care as discussions of risks and benefits of treatment was not documented. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

Good

Are services caring?

We rated caring as Good:

- Patient feedback was positive about clinical care and treatment experience.
- Staff were able to give examples of ways they have supported people within the clinic with additional needs.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- The service sought feedback on the quality of clinical care patients received. We saw nine completed patient satisfaction questionnaires, where seven were positive and two were neither positive nor negative. There was no information on why patients did not report positive feedback.
- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

- Staff told us interpretation services were available for patients who did not have English as a first language. Patients were also told about multi-lingual staff who might be able to support them.
- Information leaflets were available to help patients be involved in decisions about their care.
- We were not able to get patient feedback at this time via comment cards due to the ongoing pandemic, however we noted patients' comments and feedback were positive regarding the way staff treated patients.
- Staff communicated with people in a way that they could understand.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect.
- Staff knew that if patients wanted to discuss sensitive issues or appeared distressed, they could offer them a private room to discuss their needs.

Good

Are services responsive to people's needs?

We rated responsive as Good because:

- The service was supportive of patients' needs and patients were able to access the service.
- There was information on how to complain available but at the time of our inspection, no complaints had been received.

Responding to and meeting people's needs

The service organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The provider understood the needs of their patients.
- The facilities and premises were appropriate for the services delivered.
- Reasonable adjustments had been made so that people in vulnerable circumstances could access and use services on an equal basis to others. For example, patients who had visual impairments were supported to use the service and given additional time during appointments to ensure they were comfortable and given all necessary information.

Timely access to the service

Patients were able access care and treatment from the service within an appropriate timescale for their needs.

- Patients had timely access to initial assessment and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised such as patients who may have reacted to previous treatments and needed to be reviewed by the doctor.

Listening and learning from concerns and complaints

There was no evidence available to review complaints.

- Information about how to make a complaint or raise concerns was available. At the time of our inspection, no complaints had been received.
- The service had a complaints policy and procedures in place. However, we did not see any evidence of analysis of trends or lessons learnt from individual concerns or complaints due to none being received.

The complaints policy outlined that complainants would be informed of any further action that may be available to them should they not be satisfied with the response to their complaint.

Inadequate

Are services well-led?

We rated well-led as Inadequate because:

- Leaders were not always aware of issues within the service such as ineffective policies and the absence of safety alerts or drug safety updates.
- The service did not have an effective governance structure.
- The services policies were not reflective of systems and processes which were in place. Leaders at the service were not aware of this.
- There was no evidence of quality improvement within the service due to a lack of clinical audits being completed.
- Leaders were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.

Leadership capacity and capability

- The lead clinician was knowledgeable about some issues and priorities relating to the quality and future of services. However, they did not understand all the challenges of providing safe and effective care for example, policies not being up to date, systems for safety alerts and training requirements for staff.

Vision and strategy

The service had a clear vision and strategy to promote good outcomes for patients.

- There was a vision and a set of values which staff all worked towards.
- The lead clinician told us the service did not treat patients under the age of 18. Staff members told us that patients under 18 had been seen for treatment when accompanied by an adult. The service's safeguarding children policy stated that acne treatment was available for patients under the age of 18. Following the inspection, we were told that children under the age of 18 were only seen for treatments which were not part of the regulated activities

Culture

The service had a culture of high-quality sustainable care.

- Staff felt respected, supported and valued. They were proud to work for the service.
- The service focused on the needs of patients.
- Staff told us they could raise concerns and were encouraged to do so.
- There were processes for providing all staff with the development they needed. This included appraisal and career development conversations. All staff had received annual appraisals in the last year.
- The service actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

There was no clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were not always clearly set out, understood and effective.

Inadequate

Are services well-led?

- The provider was not always aware of systems within the service which were not effective or up to date.
- The service policies were not being followed within the service and included incorrect information. The provider was not aware of this at the time of our inspection but told us following our inspection they would update them. We received some evidence of updated policies.
- It was not clear who was responsible for monitoring performance and how the service assured themselves that they were operating as intended.
- The service submitted data or notifications to external organisations as required.
- There were arrangements in line with data security standards for the availability and confidentiality of patient identifiable records however we did not see a policy regarding storage of data. At the time of our inspection the service was not registered with the information commissioner's office for the storage of photographs, however the provider rectified this immediately and we saw evidence of this.
- The registered manager told us that children under the age of 18 were not seen in the service. However, some policies indicated that children would be seen, and staff informed us that children had been treated in the service.

Managing risks, issues and performance

There were not always clear processes for managing risks, issues and performance.

- The process to identify, understand, monitor and address current and future risks to patient safety were not always effective.
- Performance of clinical staff could not be demonstrated through audit of their consultations, prescribing and referral decisions.
- Leaders did not have oversight of safety alerts or drug safety updates.
- We did not see any evidence of systems to improve and impact on quality of care and outcomes for patients as there were no clinical audits completed.
- The provider did not have a business continuity plan in place at the time of our inspection. Staff could tell us how they would deal with major incidents.

Appropriate and accurate information

The service did not always have appropriate and accurate information.

- There was no evidence of the service using performance information it received.
- There was no evidence that quality and sustainability were discussed in relevant meetings.

Engagement with patients, the public, staff and external partners

- The service encouraged and heard views and concerns from patients. We did not see evidence of the service acting on feedback however the feedback we saw was positive.
- Staff were given opportunities to give feedback and staff reported they felt confident to do this.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There was no evidence of systems and processes for learning, continuous improvement and innovation.

- At the time of our inspection the service had not received any complaints or had any incidents.

Inadequate

Are services well-led?

The audit that we were provided with did not show any improvement or actions which had been taken.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The service did not have effective governance arrangements in relation to policies and procedures being relevant to the service. • There were not effective systems to ensure that patients' records included all information needed in order to provide safe treatment. • Systems in place for obtaining consent from patients were not effective. • Training records were not always available. • There were no systems to show any quality improvement within the service. • Improve systems for monitoring stock equipment to assure expiry dates are not breached.