Avenfield Limited

London Slimming Centre

Inspection report

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Overall summary

We carried out a focused inspection on the 25 April 2018 to ask the service the following key question: **Is the service safe?**

Our findings were:

Is the service safe?

We found that this service was providing safe care in accordance with the relevant regulations.

Background

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the service was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

CQC previously inspected this service on the 25 April 2017 and asked the provider to make improvements regarding the safety of the service. We checked this as part of this focussed inspection and found that this had been resolved.

The London Slimming Centre is a slimming clinic located on Edgware Road in North West London. The clinic consists of a reception room and a consulting room on the first floor of 406 Edgware Road. It is very close to Edgware Road tube station, and local bus stops. Parking in the local area is limited and the building is not wheelchair accessible.

The clinic provided slimming advice and prescribed medicines to support weight reduction. It is a private service. It is open for walk in or booked appointments all day on Mondays, Tuesdays, Wednesdays (until 3pm), Thursdays, and Saturday mornings.

Our key findings were:

- The provider had taken steps to ensure that all medicines dispensed to patients were labelled appropriately and relevant patient information was provided.
- The provider should continue to review arrangements regarding the use of chaperones and any associated training that may be required.
- The registered manager had received training in the safeguarding of both adults and children.
- The provider now had an emergency risk assessment document. However, this had not been translated into a procedure for staff to follow in the event of an emergency.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found that this service was providing safe care in accordance with the relevant regulations.

The provider had taken steps to ensure that all medicines dispensed to patients were labelled appropriately. In addition, any relevant patient information was provided. The provider had also taken steps to ensure that the registered manager was trained in the safeguarding of adults and children.

London Slimming Centre

Detailed findings

Background to this inspection

We undertook a focussed inspection of London Slimming Centre on 25 April 2018. This was because the service had been identified as not meeting legal requirements and regulations associated with the Health and Social Care Act 2008 during our inspection on 25 April 2017. The regulatory requirements the provider needs to meet are set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We had found that three of these requirements had not been adhered to. Specifically:

- The provider did not provide chaperone training to staff.
- The provider had not ensured that all medicines dispensed to patients were labelled appropriately and that any relevant patient information was provided.
- The provider had not ensured that the registered manager was trained in the safeguarding of adults and children.

We issued a requirement notice in respect of these issues and found arrangements had significantly improved when we undertook a follow up inspection of the service on 25 April 2018. We inspected the practice against one of the five questions we ask about services: **is the service safe?**

This inspection was led by a CQC Pharmacist Specialist and supported by another member of the CQC Medicines Optimisation Team. We looked at records from the provider on the day of inspection.

Are services safe?

Our findings

Safety systems and processes

At the previous inspection, there was a sign in the waiting area that explained that a chaperone could be provided on request. However, at this inspection, the sign had been removed. We were told that although staff had not received any chaperone training, a chaperone had never been requested. In addition, the doctor said that chaperone training would be sought. (Although it was unlikely that a chaperone would be requested due to the nature of the service.)

At the previous inspection, the registered manager had not had any safeguarding training. At this inspection, the registered manager had received training in the safeguarding of both adults and children.

Risks to patients

At the previous inspection, the provider did not have a formal risk assessment detailing how emergencies would be managed. Staff had not had any formal first aid training. At this inspection, there was an emergency risk assessment which detailed the emergency equipment kept at the clinic. There was no emergency protocol explaining what staff needed to do in these circumstances. However, we were told that as a doctor was always on site, they would take responsibility for managing any medical emergencies.

Safe and appropriate use of medicines

At the previous inspection, we found areas where improvements should be made relating to the information provided to patients on the use of off label and unlicensed medicines. (Unlicensed medicines' refers to both medicines with no UK licence, and those being used outside of the terms of their licence (commonly referred to as 'off-label') At this inspection we found that this had been resolved. The provider had a sign which explained that phentermine and diethylpropion were unlicensed medicines and the implications of this. The registered manager and doctor on duty told us they made patients read the sign before the consultation started and to seek further medical opinion if concerns arose. In addition, the patient information leaflets that were supplied included information that alerted patients that these medicines were unlicensed.

In addition to appetite suppressants, doctors also prescribed a medicine that blocked fat absorption. At the previous inspection, the provider had not ensured that medicines dispensed to patients were labelled appropriately and that relevant patient information was provided. At this inspection we found that these issues had been resolved. When medicines were prescribed by the clinic doctor they were supplied in labelled containers. The label contained the name of the medicine, instructions for use, the patient's name and date of dispensing. A patient information leaflet was also supplied.