Discover Laser Ltd

Discover Laser

Inspection report

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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?	Requires Improvement
Are services well-led?	Inadequate

Summary of findings

Overall summary

Discover Laser Ltd. is an independent health clinic. They are registered to provide diagnostic and screening procedures, services in slimming clinics, surgical procedures and treatment of disease, disorder or Injury. The treatments provided by the clinic which fall into the scope of regulation includes the treatment of excessive sweating, slimming clinics, acne treatment and Mohs micrographic surgery. The clinic also provides a range of other aesthetic services which are not regulated.

We carried out this unannounced comprehensive inspection of Discover Laser Ltd. on the 12 and 13 January 2022 as part of our continual checks on the safety and quality of healthcare services. We issued two section 29 warning notices as we found that the service was required to make significant improvements within Regulation's 12 and 17 of the Health and Social Care Act 2008.

Details for the surgery service inspected can be found later within the report, a summary of the safe, effective, caring, responsive and well led is below.

We rated it as inadequate because:

- The service did not always provide mandatory training in key skills to all staff and did not always make sure everyone completed it. Managers could not demonstrate that all staff had up to date training on how to recognise and report abuse. The service did not always have effective systems in place to monitor infection prevention and control measures effectively. The service did not have an effective system to ensure equipment was kept secure and were suitable for the purpose for which they were being used. Staff did not complete and update risk assessments for each patient and did not evidence that they removed or minimised risks. The service did not have enough staff to keep up with the demand of the service to provide the right care and treatment. The service could not always demonstrate that staff had the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Staff did not always keep detailed records of patients' care and treatment. The service did not demonstrate they had systems and processes in place to safely prescribe, administer, record and store medicines. This exposed patients to a potential risk of harm. The service did not manage patient safety incidents well. Staff did not recognise and report incidents and near misses. Managers did not investigate incidents and did not provide evidence that they shared lessons learned with the whole team. Managers did not ensure that actions from patient safety alerts were implemented and monitored.
- The service did not always provide up to date care and treatment guidance and policies based on national guidance and evidence-based practice. Managers did not check to make sure staff followed guidance. We were concerned that the service did not have effective systems and processes in place to monitor the effectiveness of care and treatment. They did not always use the findings to make improvements. They did not always achieve good outcomes for patients. The service did not always make sure staff were competent for their roles. Managers did not always appraise staff's work performance and did not always hold supervision meetings with them to provide support and development. Doctors and staff worked together as a team but did not always demonstrate that they worked to benefit patients.
- The service could not demonstrate that they were always inclusive and took account of patients' individual needs and preferences. The service could not always demonstrate that they made reasonable adjustments to help patients access services. The service did not monitor and report on patients receiving care and treatment in a timely manner.

Summary of findings

It was not always easy for people to give feedback and raise concerns about care received. The service did not always treat concerns and complaints seriously, they did not evidence that they investigated them and shared lessons learned with all staff. The service did not always include patients in the investigation of their complaint. The service did not have a system for referring unresolved complaints for independent review.

- Leaders did not always have the capacity, skills and abilities to run the service. They did not always understand and manage the priorities and issues the service faced. Leaders did not operate effective governance processes, throughout the service. Team meetings were not always recorded effectively and did not demonstrate that discussions had been undertaken for staff to learn from the performance of the service. Leaders did not use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues and did not identify actions to reduce their impact. The service did not always collect reliable data and analyse it. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The service could not demonstrate that data or notifications were not always consistently submitted to external organisations as required. Leaders could not demonstrate that the service was continuously improving.

However:

- The service kept equipment and the premises visibly clean. Staff used equipment to protect patients, themselves and others from infection. Staff managed clinical waste well. The service made sure patients knew who to contact to discuss complications or concerns. Records were clear, up to date, stored securely and easily available to all staff providing care.
- Staff ensured that patients were not without food or drinks for long periods. Staff assessed and monitored patients regularly during their treatment to see if they were in pain and gave pain relief in a timely way. Patients could contact the service seven days a week for advice and support after their surgery. Staff supported patients to make informed decisions about their care and treatment. They understood how to support patients.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff provided emotional support to patients to minimise their distress. They understood patients' personal, cultural and religious needs. Staff supported patients to understand and make decisions about their care and treatment.
- People could access the service when they needed it and received the right care. They were focused on the needs of patients receiving care.
- Leaders were visible and approachable in the service for patients and staff. The service had a vision for what it wanted to achieve and a strategy to turn it into action. Staff felt respected, supported and valued. Staff at all levels were clear about their roles and accountabilities.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Inadequate 	We rated it as inadequate. See summary above for details.

Summary of findings

Contents

Summary of this inspection

Background to Discover Laser

Discover Laser Ltd. had not been inspected and rated since 2013. At our last inspection we rated the provider as 'met this standard' in our previous methodology, which consisted of;

- Consent to care and treatment
- Care and welfare of people who use services
- Cleanliness and infection control
- Staffing
- Complaints

How we carried out this inspection

During our inspection we spoke with a variety of staff including the registered manager, managing director, aesthetic support staff and patients attending the service for procedures. We reviewed patient records and other information provided by the service.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The service must ensure that the directors satisfy all the requirements set out within the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for fit and proper persons (Regulation 5 (3)).
- The service must ensure that persons providing care and treatment have the qualifications, competence, skills and experience to do so safely (Regulation 12 (2)(c)).
- The service must ensure that any complaint must be investigated, and necessary and proportionate action must be taken in response to any failure identified by the complainant or investigation (Regulation 16 (1)).
- The service must ensure that they establish and operate an effectively accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons (Regulation 16 (2)).
- The service must ensure that they maintain securely an accurate, complete and contemporaneous record in respect of each service user, including of the care and treatment provided to the service user and of decisions taken in relation to care and treatment provided (Regulation 17 (2)(c)).
- The service must ensure that they evaluate and improve their practice in respect of processing information referred to in sub-paragraphs (a) to (e). (Regulation 17 (2)(f)).

Action the service SHOULD take to improve:

- The service should store equipment in cleanable containers to ensure the prevention of infection.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Inadequate	Inadequate	Good	Requires Improvement	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Good	Requires Improvement	Inadequate	Inadequate

Inadequate

Surgery

Safe	Inadequate
Effective	Inadequate
Caring	Good
Responsive	Requires Improvement
Well-led	Inadequate

Are Surgery safe?

Inadequate

We rated it as inadequate.

Mandatory training

The service did not always provide mandatory training in key skills to all staff and did not always make sure everyone completed it.

Staff did not always receive and keep up to date with their mandatory training. Mandatory training compromised of eight of the 11 recommended core skills for health; these included health and safety, fire safety, manual handling, personal protective equipment, infection control, safeguarding, equality and diversity and resuscitation.

The staff files did not always include mandatory training for clinical and non-clinical staff. We were provided with a mandatory training list which included the eight annual mandatory training courses, one of the seven staff listed had completed their mandatory training in 2021. Mandatory training was last completed for all staff in 2020. We requested but did not receive evidence of all staff mandatory training records. There was no record in the staff files that the medical staff with practicing privileges had completed their mandatory training. We were concerned that managers did not always ensure staff had completed mandatory training in key skills.

We were told that medical staff had psychodermatology training which was specialist training on recognising and promoting a multidisciplinary approach to patients with mental health concerns related to the impact of a skin disease. However, the service could not demonstrate evidence that medical staff received training in psychodermatology.

Safeguarding

Staff did not always understand how to protect patients from abuse and the service did not always work well with other agencies to do so. Managers could not demonstrate that staff had up to date training on how to recognise and report abuse.

We were told that aesthetic therapy staff and medical staff received online level one adults and children's safeguarding training on how to recognise and report abuse. This was not always aligned with the intercollegiate documents for adult

safeguarding and children's safeguarding, which recommends clinical staff should have at least level three safeguarding training for children and adults. We requested but did not receive evidence that all staff, including medical staff working at the service, received training specific for their role on how to recognise and report abuse. We were concerned that staff may not be able to recognise and report abuse if required.

Staff would refer any safeguarding concerns to the registered manager. We reviewed the protection of children and vulnerable adults' policy on site and found it to be dated 2019. The policy was one page and did not contain detailed information about how to make an adults or children's safeguarding referral. We were concerned that this did not allow staff access to details about how to make a safeguarding referral. Following the site visit, we requested further evidence and were sent an updated policy dated 2021 and a standard operating procedure (SOP) with no date; these did contain information about how to make a referral and who to refer to. However, these were not available to staff during the inspection.

The service did not always ensure safety was promoted in recruitment practices for staff. We reviewed seven staff files, which included checks for both newly appointed and established appointments. Not all files included two references;

- One of the seven staff files reviewed had two references.
- Two of the seven staff files had one reference.
- The other four staff files did not have any references.

Staff files did not always consist of evidence that staff had the right to work in the United Kingdom, three of the seven staff employed had evidence of proof of eligibility to work in the UK. Staff files did not contain evidence of the recruitment process undertaken. Five of the seven employed staff had contracts of employment in their staff file.

The service did not keep records of the interview process within the staff files for medical staff with practising privileges. This is not aligned with the services practicing privileges policy.

The service did not always promote safety during recruitment of staff and ongoing checks of disclosure and barring service (DBS) checks We found that DBS checks were not all undertaken for the purposes of employment at Discover Laser Ltd. DBS checks were not always repeated once staff members were in post. Seven out of twelve staff members had DBS checks that were more than three years old, one dating back to 2008.The Discover Laser Ltd. recruitment and selection policy did not identify what the frequency of DBS should be. This meant people who used the service were at risk of potential harm as the provider could not be assured of the current DBS status of the staff.

Cleanliness, infection control and hygiene

The service did not always have effective systems in place to monitor infection prevention and control measures effectively. They kept equipment and the premises visibly clean but did not provide evidence of cleaning undertaken. They did not always have suitable furnishings which could be cleaned. Staff used equipment to protect patients, themselves and others from infection.

The service and clinical areas were observed to be clean and well maintained. We saw storage of various sterile equipment including syringes, forceps and scissors in non-washable fabric boxes. This posed a risk of infection prevention and control.

Daily cleaning was outsourced to a private company. We were provided with a weekly cleaning schedule which consisted of the cleaning expected each day. However, we did not see evidence that cleaning was undertaken. We were told checklists for evidence of cleaning were not undertaken, but leaders would observe the service once a week to check cleanliness.

Inadequate

Surgery

During inspection we saw an audit checklist that included infection prevention and control and hand hygiene audits which identified they were to be completed every six months. We saw the last infection prevention and control audit was undertaken in September 2021, which was within six months. This showed hand hygiene audits had been completed for all staff in June 2021.

Staff followed infection control principles including the use of personal protective equipment (PPE) and national COVID-19 guidance.

We were told that staff cleaned equipment after patient contact but did not use labels to show when equipment was last cleaned. However, we did observe staff cleaning equipment between procedures.

The service did not require a contract for the decontamination of surgical instruments as the equipment used for minor surgeries performed were single patient use and were disposed of appropriately.

Environment and equipment

The service did not always have an effective system to ensure equipment was kept secure and were suitable for the purpose for which they were being used. This meant there was a risk of harm to people using services, those close to them and staff. Staff managed clinical waste well.

Discover Laser Ltd. had an intercom system and remote-control access for entry into the clinic and one-way access into the leisure centre next door. This prevented patients and visitors from the leisure centre walking into Discover Laser Ltd. without an appointment, which created privacy for patients.

Discover Laser Ltd. consisted of two separate waiting rooms, and had six other rooms; a histology laboratory, cleaning cupboard, kitchen, medicines and equipment storeroom, changing and clinical waste room and office. In addition, there were six clinical rooms; two consulting rooms and four procedure rooms. Each procedure room was allocated a dedicated treatment and piece of equipment, for example a dermal room or a minor operations room. This provided consistency for patients and staff and prevented equipment from being moved around the clinic.

The service did not always have effective systems to ensure the premises and equipment were kept secure and were suitable for the purpose for which they were being used. This meant there was a risk of harm to people using services, those close to them and staff.

Medicines were stored together with cleaning materials, which included cleaning equipment, sterile equipment and medicines. This meant that if there was a spillage of cleaning equipment this could contaminate medicines potentially causing harm to patients.

The most recent environmental risk assessment was completed in April 2017 which included the control of substances that are hazardous to human health (COSHH) risk assessments. The site risk assessment included aspects unrelated to the clinic setting, including comments relating to forklift trucks, diggers, lorries and rats. We were concerned that staff did not understand the risks at the service and this meant staff could not ensure appropriate actions were taken to mitigate the risks. After our inspection, we were told this document was not the services document it was created by a cleaning contractor. The service provided an environmental risk assessment and a COSHH risk assessment for each item within each room.

Inadequate

Surgery

We were provided with a risk assessment dated 25 February 2020 which contained generic hazards which included personal injury from incorrect manual handling techniques, slips and trips, fire and electric shocks. We saw that the storage cupboard was very cramped making it difficult for staff to access the emergency equipment quickly should an emergency situation arise. We were concerned that the service was not maintaining a suitable storeroom space in relation to storage of equipment.

During our inspection, we saw that the service was not maintaining, checking and auditing their emergency equipment. We saw adrenaline and chlorphenamine in the emergency bag which was out of date. The audit checklists were not completed. Although when requested evidence after our inspection the service sent emergency equipment checklists dated October, November and December 2021. We were concerned that the checks were not always completed effectively to remove out of date equipment so that emergency equipment was safe to use if required.

However, the service had suitable facilities to meet the needs of patients.

Staff disposed of clinical waste in a large yellow wheelie bin. The clinical waste wheelie bin was stored in the locked female changing room and storeroom. This was in line with the Health Technical Memorandum 07-01 from the department of health regarding 'the safe management of healthcare hazardous waste'.

We saw evidence of the duty of care transfer note for the safe disposal of controlled waste which was in line with 'the safe management of healthcare hazardous waste' memorandum 07-01. We saw the service did not always undertake a six-monthly clinical waste audit, the last one completed was 25 February 2020.

The service had enough suitable equipment to help them safely care for patients. We saw evidence of portable appliance testing (PAT) and regular servicing for all equipment.

The medicine fridge did have the temperature checked daily when the clinic was open and was documented to be within recommended limits.

Assessing and responding to patient risk

Staff did not complete and update risk assessments for each patient and did not evidence that they removed or minimised risks. Not all staff were trained in a process to act upon patients at risk of deterioration. The service made sure patients knew who to contact to discuss complications or concerns. There was not a clear system for referring patients for psychological assessment before starting treatment, if necessary.

Staff did not complete formal risk assessments for each patient. The service sent a health questionnaire to the patients prior to their arrival and consultation, this included patient concerns, medical history, cosmetic history, social history, drug history and allergies. The medical staff would review the questionnaire at the consultation appointment where any risks would be discussed regarding the surgery or procedure required.

We requested evidence of the exclusion criteria for minor operations, Mohs micrographic surgery (surgically removing skin cancer with laboratory assessment while the patient waits), Isotretinoin, and hyperhidrosis provided at the service. The provider sent a list of exclusion criteria that did not contain all the exclusions relevant for the procedures being undertaken and did not reflect the exclusion criteria within the consent forms. We were concerned that treatments such as Isotretinoin or Roaccutane did not contain information about the exclusion criteria for pregnancy or breast feeding, having liver impairment and reduced doses in kidney disease. Therefore, it was not clear which patients may not have been suitable for each treatment at the service.

Inadequate

Surgery

Psychological assessments were being undertaken in the form of a questionnaire and medical staff had received training in psychodermatology. Medical staff completed psychological assessment for patients by using a questionnaire, built into the electronic record system, which assessed anxiety, depression and/or body dysmorphic disorder.

The service could not demonstrate a clear pathway for patients who may benefit from further psychological assessment or input by a suitably trained professional the service provided us with a psychological assessment standard operating procedure and pathway dated 2022. This did not contain details regarding what would constitute a minor, moderate or more severe mental health concern and did not specify who would be the most appropriate professional or service to refer to if there were any concerns. The provider could not demonstrate a clear pathway for patients that may benefit from further psychological assessment or input by a suitably trained professional.

The service did not always ensure compliance with the World Health Organisation (WHO) surgical checklist five steps to safe surgery for all surgical procedures carried out. After our inspection we were provided with the service's minor surgery policy which stated that the "WHO checklist steps, where applicable to a minor surgical procedure, are embedded in our electronic patient record system". We reviewed three patient's medical records and observed four minor surgeries and there was photographic evidence of checking the right site of surgery but there was no evidence that the service was ensuring counting in and counting out of equipment. We were told by the registered manager there was no form of surgical checklist or local safety standards for invasive procedures (LocSIP) that was based around the WHO checklist. The service was not compliant with their own policy and we were concerned that there was a risk of harm to people using services by not being complaint to the WHO checklist.

We did not see any evidence that any vital signs or observations (pulse, blood pressure, oxygen saturations, respirations or temperature) were taken on patients prior to treatment, during treatment or after treatment of any procedures at the service. Although it is not a required standard for superficial planned procedure in otherwise healthy individuals, we reviewed one patients medical records who had received weight loss treatment for seven months who did not receive any observations throughout their treatment despite having significant underlying health conditions. Where relevant, patients were not having their observations undertaken during any procedures. We were concerned that unwell, or deteriorating, patients with underlying health conditions may not be recognised or actions taken to respond to this.

We were provided with a written process of the training for non-clinical staff in the recognition of a deteriorating patient. If a patient was unwell at the service non-clinical staff would escalate to the medical staff in the service and call 999 if instructed to do so. We requested but did not receive evidence of training.

During the inspection, the provider could not evidence any weight loss policy or procedure to ensure patients were safe to be treated. We saw two patient's records which did not include evidence of the prescription. One patient record had evidenced a notification to the patient's GP regarding the prescription of the medicine. The service did not document and monitor outcomes for patients who were treated for weight loss surgery despite one of the patients being treated monthly over a seven-month period. We were concerned that there was not effective monitoring of these patient during their treatment to ensure patients were not being put at risk of harm.

Staffing

The service did not have enough medical and support staff to keep up with the demand of the service to provide the right care and treatment. The service could not always demonstrate that staff had the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed but did not have enough staff with the right skills to adjust staffing levels and skill mix to keep up with demand.

Inadequate

Surgery

The service did not always have enough medical staff to keep up with the demand for the services provided. The service had one permanent medical staff who was also the registered manager and two medical staff who were consultant dermatologists with practicing privileges. The registered manager told us that the service was requiring a second permanent member of the medical staff.

Managers were aware that there was a risk to the service and that the waiting list was getting longer. Managers had considered that they needed to engage a doctor or nurse prescriber to support the diary and patient demand but did not give any detail to how this would be achieved, but they did include a timeframe. We were concerned that the demand for the service was expanding quickly without enough suitably trained staff to support the service and there was no evidence of the active recruitment to the post.

Sickness rates for all staff were low. The service had low turnover rates for staff. Managers did not use locums when they needed additional medical staff.

Records

Staff did not always keep detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Patient records were stored securely in the electronic computer system and all staff, including those with practising privileges, could access them easily. Each patient had an identification number specific to them to ensure all records for that patient were stored in one patient electronic file.

When patients were discharged from the service after surgery, the patient and GP received a letter through the post containing information and photographs of the treatment received.

Patient records were not always comprehensive, but all staff could access them easily. Patient records did not contain the of name and dose of medicines given. There was evidence of a photograph of the back of the medicine vial with a batch number and expiry date, but this did not contain name and strength of medicine or the dose given. This will be discussed further in the medicines section.

Medicines

The service did not demonstrate they had systems and processes in place to safely prescribe, administer, record and store medicines. This exposed patients to a potential risk of harm.

We were concerned about the safe management, prescribing and dispensing of medicines. The service's medicines policy, dated 2021, stated that the service "does not dispense medicines to patients to take home…but some prescribed medicine might be stored and issued to patients from the premises". We saw 16 boxes of medicines prescribed and stored for patients who were not in the building.

The service did not have effective systems and process in place to prescribe, administer and document medicines given within the service. The service held a 'black book' to reference all medicines that were dispensed within the service. This documented that only three medicines had been prescribed and given within the service in the last year. There was no documentation of dose, route, reason or who gave the medicine.

There was ineffective monitoring of medicines in stock. The service could not demonstrate any audits of the medicines to ensure they were not misused and not past their expiry date. We saw four boxes of medicines, including emergency

medicines, that were past their expiry date. We requested evidence of stock checks of medicine and were only provided with the emergency grab bag checks. This did not show effective monitoring of all medicines in stock. This was not aligned to the management of medicines policy which stated the service reinforces its safe and secure handling of medicines with proactive audit and review.

The Discover Laser Ltd. drug formulary contained Diazepam 4mg tablets, however the provider's record of administration "black book" identified that preparations of 5mg Diazepam was being given to patients. Therefore, the drug formulary was not consistent with the medicines being given.

Staff did not always complete medicines' records accurately. The service did not effectively ensure there was clear documentation of medicines that were prescribed and given within the three patient electronic records reviewed. There was a photograph of the medicine bottle used with the batch number and expiry date, but the records did not always include the name of the medicine, strength, dose, route and reason for administration. This was not aligned with the provider's management of medicines policy.

Staff did not store and manage all medicines safely. Medicines, including diazepam, were not always kept in a locked cupboard or storeroom. The storeroom was accessible to anyone within the premises. This was not in line with the provider's management of medicines policy.

Staff did not always carry out routine safety checks of emergency equipment which included oxygen and the emergency grab bag which included adrenaline and chlorphenamine for use in anaphylactic reactions. During inspection we saw the checklist in the emergency grab bag was blank and we found out of date medicines in the emergency grab bag. After our inspection, we were provided with three checklists for the emergency grab bag for October, November and December 2021. We were concerned that there were not effective systems in place to manage, remove and dispose of out of date medicines which could pose a risk to patients if out of date medicines were given in an emergency.

There were insufficient systems and processes in place to adequately dispose of medicines, including the disposal of incorrectly prescribed medicine and medicine past its expiry date. The registered manager told us they were in the process of looking for an overseas charity to donate unusable medicines to. However, there was no current system in place which meant out of date medicines or medicines prescribed to individual patients were being stored in the storeroom that was not locked during the daytime.

Incidents

The service did not manage patient safety incidents well. Staff did not recognise and report incidents and near misses. Managers did not investigate incidents and did not provide evidence that they shared lessons learned with the whole team. Managers did not ensure that actions from patient safety alerts were implemented and monitored.

Staff and managers, we spoke with did not know what constituted an incident and how to report them.

We were told by the leaders that no incidents had occurred, been reported or investigated. However, whilst on inspection we identified incidents that would meet the provider's recording of incidents policy criteria for incidents. These included medicine incidents and adverse reactions following thread lift procedures. This meant the service was not investigating incidents or learning lessons to prevent occurrences and make improvements.

Inadequate

Surgery

On the day of our inspection, the 'recording of incidents' policy was dated 2019 and due to be reviewed in October 2020. The policy stated staff should "report any incident to the registered manager who will be responsible for recording and if necessary, reporting incidents. It identified that accident record forms will be kept in custody of the registered manager".

After our inspection we were sent an incident reporting policy, dated 2021. This was different to the policy seen during the inspection which meant staff did not have access to an up to date incident reporting policy. Staff did not raise concerns and report incidents and near misses in line with the service's up to date policy.

Managers did not investigate incidents thoroughly. The service did not provide evidence that changes had been made as a result of feedback on investigations. Following the inspection, on 17 January 2022, the service provided a document named "incident reports" which listed patient identification number, date of incident, brief details and remedy. However, there was no evidence the incident reporting policy was followed as there was no lessons learnt identified and no evidence of any investigations taking place.

The service did not have effective systems and processes to recognise and report medicine incidents safely. We saw multiple antibiotics prescribed for single patients stored within the storeroom, the reason given for this prescription was not documented. The registered manager told us this had been an accidental order of too many boxes. The registered manager told us on 14 January 2022 that no incident form had been completed, there had been no formal incident review and subsequent lessons learnt had not been recorded. We were concerned that staff may not have appropriate training to recognise and report medicine incidents which could prevent effective formal investigation and lessons learnt across the service.

Are Surgery effective?

Inadequate

We rated it as inadequate.

Evidence-based care and treatment

The service did not always provide up to date care and treatment guidance and policies based on national guidance and evidence-based practice. Managers did not check to make sure staff followed guidance.

Staff did not always have access to follow up-to-date policies to plan and deliver high quality care according to best practice and national guidance. During inspection we saw 10 policies that were out of date with and did not always reference national guidance. We requested copies of the policies and were provided with 20 policies; three policies were out of date. The resuscitation policy, managing complaints and concerns policy, and incidents policy had been updated from when we reviewed these during the inspection. The risk management policy was provided but this was not available to staff while on inspection. We were concerned that up to date policies were not always available to staff.

The service could not demonstrate that pre-operative assessment included a comprehensive psychiatric history and discussion with people about body image before surgery. In the three medical records reviewed, there was evidence of a psychological assessment split into three scores anxiety scale, depressive scale and body dysmorphic disorder (BDD) scale. We requested but did not receive evidence of the psychological checklist used.

The service did not ensure all staff had access to a comprehensive standard operating procedure (SOP) and process regarding assessment of patient's mental health prior to surgery. The service provided their SOP for psychological

assessments, dated 2022. The SOP did not consist of how to interpret the scores in the psychological assessment or who the service would refer to if a patient required specialist care. We were concerned that staff did not have access to a standardised process within the service regarding psychological assessments and ongoing referrals to external psychiatric specialists when required.

The service did not always ensure there was no discrimination, including on the grounds of protected characteristics under the Equality Act (2010), when making care and treatment decisions. The equal opportunities policy and prevention of disability policies did not include detail regarding processes to support patients with protected characteristics to make care and treatment decisions. However, the prevention of disability policy stated, "adaptations and modifications will be made to allow use of the service by patients having disabilities". We requested but did not receive evidence of how the service was supporting patients with disabilities.

The service used technology to aid in accurate record keeping. The service had an electronic computer system and used electronic portable tablets to allow for accurate and contemporaneous record keeping of the care and treatment provided. The service used photographs to document before and after images of patient surgeries.

The service ensured care was managed in accordance with NICE guidelines [NG45] "routine preoperative tests for elective surgery" as the procedures undertaken at the service were minor and did not require any preoperative tests according to the NICE guidance.

The service managed care in accordance to the NICE guidance [NG125] for surgical site infections. The service used recommended skin preparation for patients and staff, and the service provided wound care information to patients after their procedures.

The service did not undertake audit using the Royal College of Surgeons audit tool that covered key aspects of the pre-operative and consultation prior to surgery.

Nutrition and hydration

Staff ensured that patients were not without food or drinks for long periods.

Patients had access to hot and cold drinks from the service and these were offered regularly.

Hot and cold food was available from the leisure centre next door which could be delivered into the service. The external company had a choice of six sandwiches available, some being fish, meat and vegetarian. The service did request if anyone had any dietary requirements in advance of their appointments.

Pain relief

Staff assessed and monitored patients regularly during their treatment to see if they were in pain and gave pain relief in a timely way.

Patients received pain relief soon after requesting it.

Staff did not always prescribe, administer and record pain relief accurately. We saw that not all medicines given were prescribed and recorded accurately within the patient's records.

Inadequate

Surgery

Patient outcomes

We were concerned that the service did not have effective systems and processes in place to monitor the effectiveness of care and treatment. They did not always use the findings to make improvements, they did not always achieve good outcomes for patients.

The service did not always participate in relevant national clinical audits due to the limited national audits available. The service participated in the British College of Aesthetic Medicine (BCAM) yearly audit review of services provided which showed a list of;

- One treatment provided for hyperhidrosis (excessive sweating)
- Four thread lift treatments were provided and three of these had adverse events
- The service provided 50 minor surgeries and no evidence of adverse events

The service had been providing Mohs micrographic surgery for nine months but had not undertaken an audit to monitor patient outcomes despite this being a new procedure to the service. They did not have relevant benchmarking data for the procedure. We were concerned that managers did not have oversight of this service and did not have effective systems and processes in place to monitor patient outcomes.

We were told that outcomes for patients were positive, consistent and met expectations. However, managers and staff did not carry out a comprehensive programme of repeated audits to check improvement over time. Managers were not able to demonstrate audits to monitor and improve patients' outcomes. Managers did not use information from audits to improve care and treatment. Improvement was not checked and monitored. We were concerned that the service did not accurately monitor and improve outcomes for patients to ensure that they were providing safe care and treatment, which could cause a risk to patient care.

Managers did not monitor or audit whether staff followed the guidance and policies. We requested safety monitoring and benchmarking data. The service stated that they benchmarked against similar providers through the British College of Aesthetic Medicine's annual audit which showed;

- 34% of services who responded provided minor surgeries, which included Discover Laser Ltd. In 2021, nationally there had been an 88% decline in minor surgeries during the COVID-19 pandemic. There had been no reported adverse events.
- We were told thread lift treatments had not been provided at the service since 2019.The BCAM review which included data from 2019 to 2021 showed that the provider performed four thread lift procedures and had three adverse events recorded. No benchmarking evidence was provided as the service subsequently decided not to perform thread lift procedures.
- The service performed one hyperhidrosis, excessive sweating, treatment in the last 12 months. No adverse events were recorded. No benchmarking data was provided from any other source.

Competent staff

The service did not always make sure staff were competent for their roles. Managers did not always appraise staff's work performance and did not always hold supervision meetings with them to provide support and development.

The service did not always demonstrate that staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Inadequate

Surgery

Managers gave all new staff a full induction tailored to their role before they started work. The service provided an induction policy and procedure that was seen on site. It consisted of a comprehensive induction checklist which included training, team meeting details and induction sessions.

Managers did not always support staff to develop through yearly, constructive appraisals of their work. We saw an appraisal plan which showed that of the five staff listed, one had their appraisal completed in 2021. The five staff listed had last all had a completed appraisal in 2019. The managing director did not have a recent record of an appraisal, the last had been completed in 2013. We were concerned that staff were not always given one to one time to support, improve and develop. However, we acknowledged that the service was closed for seven months in 2020 and closed for three months in 2021.

Medical staff with practising privileges did have documented that appraisals had been seen in their staff files. Copies of the appraisals were not in the staff files and did not include the date when the appraisal was completed. The appraisals were not completed at the service but elsewhere in their main job roles. We were concerned that managers did not ensure the doctors with practising privileges had supervision meetings to provide support and development for the services provided. Managers did not always support aesthetic therapy staff and medical staff with practising privileges to develop through regular, constructive supervision of their work. We saw evidence that one of the five aesthetic therapy staff had supervision within the staff files and this was in 2013.

Managers identified training needs for their staff had but did not always give them the time and opportunity to develop their skills and knowledge. See the records within the mandatory training section of the report. Staff had the opportunity to discuss training needs with their manager at annual appraisals and were supported to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. We saw training certificates for three of the five therapy staff that had completed a specialist course to assist with medical procedures. We were told that each member of staff had training from medical staff within the service in September 2021 and undertook a day attachment to a local GP clinic to assist with minor operations. We did not see evidence of competency assessments within the staff files. We requested but did not receive evidence of competency documents. We were concerned that staff did not always have competency assessed, documented and reviewed appropriately.

We saw aesthetic therapy staff had completed a phlebotomy study day in July 2021. We were provided with a certificate of attendance to the study day. We were told that the member of staff had undertaken two days at a local GP surgery to assist with the phlebotomy clinic taking blood under supervision and worked under medical supervision to complete her portfolio. However, we did not see evidence of a competency document within the staff files reviewed. We requested but we were told that the member of staff was still working under supervision and had not been fully signed as competent.

We did not see evidence that the service had appropriately trained staff working within the Mohs micrographic surgery laboratory. We were told that the service was ensuring staff had training but did not always evidence the skills, training and experience within their staff files.

Multidisciplinary working

Doctors and staff worked together as a team but did not always demonstrate that they worked to benefit patients. The service could not demonstrate that they supported each other to provide good care.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. However, team meetings were not always minuted and did not always show actions to be taken to show how effective they were.

Inadequate

Surgery

The service's standard operating procedure did not demonstrate how staff referred patients for mental health assessments when they showed signs of mental ill health or depression.

The service shared information with the patient's general practitioner (GP), when the patient gave consent to do so.

Seven-day services

Patients could contact the service seven days a week for advice and support after their surgery.

The service was open six days a week from 10am until between 4pm and 7pm dependent on the day.

The service provided urgent help and advice available at any time (24-hour / seven days a week) following discharge but it was not always provided by medical staff immediately. An urgent help and advice telephone line was available on the service's website and was given to patients prior to discharge. Overnight the help and advice telephone was held by medical staff. However, during working hours patients would contact the service and non-clinical staff answered the telephones. There was no formal training or process involved in understanding if a concern was clinically urgent but staff would refer to medical staff for advice.

Health promotion

Staff supported patients to make informed decisions about their care and treatment. They understood how to support patients. However, the service could not demonstrate that they followed national guidance and ensured that patients gave consent in a two-stage process with a cooling off period of at least 14 days between stages.

Staff provided patients with relevant information and gave them time prior to the treatment to ensure patients made informed decisions about their care and treatment. During our inspection, we observed staff complete a comprehensive re-confirmation of consent with patients prior to treatment. The staff ensured that patients fully understood the care and treatment planned before signing the consent form.

Consent

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

The registered manager informed us there was exclusion criteria for each procedure on the relevant consent form. The service sent us the consent forms for the procedures provided. The consent forms for Mohs micrographic surgery and minor surgeries contained eight "potential factors that might impact your suitability for the chosen treatment". We were concerned that the information in the consent forms were not always specific to each individual patient's treatment and could be seen as generic.

Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records. The service would send an electronic copy of the consent form to the patient to allow prior reading and understanding of the consent to their surgery or treatment. It was sent with details regarding the proposed treatment and the cost.

Inadequate

Surgery

Are Surgery caring?

Good

We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We heard and observed staff speaking with a patient regarding the care required and that they had a young person with them. The staff were understanding that in some circumstances the service may have to be flexible to help patients receive treatment but also did an informal risk assessment that the young person was safe to be left in the waiting area while their parent had treatment.

Staff kept patient care and treatment confidential. We saw that patients were treated in individual rooms with the door closed to ensure confidentiality. We observed interactions with patients that were caring and supportive.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff described how they provided care for patients who had sensitive personal needs and differing cultural backgrounds and how they provided personalised support for these patients.

Emotional support

Staff provided emotional support to patients to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed staff speaking with patients on the telephone and in person and they showed understanding of each patient's situation and provided reassurance when required.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff told us about a patient who did not have the expected outcome of their treatment. We were told how staff were empathetic and were able to sensitively relieve the worries about the treatment process. Staff offered an apology and were able to show understanding of the emotional impact this had on the patient, and the patient continued with their treatment.

Understanding and involvement of patients and those close to them

Staff supported patients to understand and make decisions about their care and treatment.

Staff made sure patients understood their care and treatment. Staff talked with patients in a way they could understand. We observed staff explaining and discussing the procedure to patients prior to starting the treatment and found that patients were given time to understand their care and treatment.

Inadequate

Surgery

We requested but did not receive evidence of staff using communication aids where necessary.

Patients could give feedback on the service and their treatment and staff supported them to do this. There was evidence that patients provided feedback on their website.

Are Surgery responsive?

Requires Improvement

We rated it as requires improvement.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. The service supported the wider healthcare system and local to plan care.

Managers planned and organised services so they met the needs of the local population. The service has ensured that the services provided are aligned to the needs of the local population. The service is extremely busy and the medical doctors are seeing on average 40 patients a week.

Facilities and premises were appropriate for the services being delivered.

The service did not have systems in place to help care for patients in need of additional support or specialist intervention. Managers did not always make sure staff and patients could get help from interpreters or signers when needed. The service preferred to allow relatives and carers into the services to assist with translation when required, as they told us they did not want to incur unwanted extra costs for patients. We requested but did not receive evidence that staff had access to communication aids or registered interpreters to help patients become partners in their care and treatment. Guidance from NHS England states that spoken language interpreters should be registered with the National Register of Public Service Interpreters and should have training in medical terminology in order to communicate information effectively. We were concerned that this could lead to patients not fully understanding their treatment, which could lead to harm.

The service had developed a Mohs micrographic surgery service to treat patients with skin cancer. These patients had been seen by the doctors with practicing privileges in the NHS and had histology results confirming cancer diagnosis. There was a lack of evidence of referral process or referral documentation within the patient records. Therefore, the service could not demonstrate evidence of the delivery and patient outcomes of the service as it had not been audited to date, despite being in place for nine months.

Meeting people's individual needs

The service could not demonstrate that they were always inclusive and took account of patients' individual needs and preferences. The service could not always demonstrate that they made reasonable adjustments to help patients access services.

We requested but did not receive evidence on how the service was meeting the information and communication needs of patients with a disability or sensory loss. We did not see that the service had information leaflets available in languages spoken by the patients and local community.

Inadequate

Surgery

The service had good wheelchair access throughout the service. The service did not have any stairs and had no steps into the service. The service did have access to an accessible toilet within the service.

Patients were given a choice of food and drink to meet their needs. The external company had a choice of six sandwiches available, some being fish, meat and vegetarian. The service did request if anyone had any dietary requirements in advance of their appointments.

The service could not demonstrate a clear pathway for patients that may benefit from further psychological assessment or input by a suitably trained professional, for further information please refer to the assessing and responding to patient risk section of the report.

Access and flow

People could access the service when they needed it and received the right care. However, the service did not monitor and report on patients receiving care and treatment in a timely manner.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Managers monitored waiting times daily and told us that this was evidenced by live diary entries on the clinical management diary system. We were told that average waiting times from consultation to treatment was from four to six weeks for minor operations and Mohs micrographic surgery unless the patient preferred to wait outside of this timescale. We requested but did not receive evidence that the service was monitoring and reporting the average waiting time from consultation to treatment.

Managers and staff worked to make sure patients did not stay longer than they needed. The service did not have overnight facilities and would ensure patients were discharged safely on the same day of treatment. After some procedures the medical staff would contact a patient at home in the evening to ensure they were recovering well after their procedures.

Learning from complaints and concerns

It was not always easy for people to give feedback and raise concerns about care received. The service did not always treat concerns and complaints seriously, they did not evidence that they investigated them and shared lessons learned with all staff. The service did not always include patients in the investigation of their complaint. The service did not have a system for referring unresolved complaints for independent review.

Patients did not always know how to complain or raise concerns. There was no evidence of how to complain on their website. The service did not clearly display information about how to raise a concern in patient areas. We requested but did not receive evidence of the discharge letter and advice after their procedures.

Staff understood the policy on complaints and knew how to acknowledge complaints. Managers did not formally investigate complaints and did not identify themes. We requested evidence during our inspection and we were told that they did not keep a record of complaints, outcomes, lessons learnt and actions taken. This was not in line with the provider's managing complaints and concerns policy, 2021.

Leaders shared an example of a recent complaint raised by a patient. They told us how the situation was managed sensitively but were able to resolve the patient's complaint.

Inadequate

Surgery

Managers told us they shared feedback from complaints with staff at staff meetings. We were told during inspection, that the learning was shared during team meetings but outcomes and actions taken were not always documented. However, we did not see evidence of this in the staff meeting minutes. We were concerned that systematic changes and learning from complaints was not always embedded effectively.

The service could not demonstrate that patients received feedback from managers after the review into their complaint. We were told by leaders that patients received feedback through email about their complaint. However, we received a record of the complaints, actions taken and response and this did not evidence that the service responded and undertook duty of candour, if appropriate.

After our inspection the service provided a list of complaints, titled incident report 2021, which included 13 complaints and incidents ranging from March 2021 until December 2021. The document contained the date of the incident, description and resolution for each complaint. At the end of the document there was a list of four learning points however these did not include any learning to prevent incidents or complaints re-occurring. We were concerned that the provider was not always monitoring, learning and sharing learning from complaints, which could lead to similar complaints.

Are Surgery well-led?

Inadequate

We rated it as inadequate.

Leadership

Leaders did not always have the capacity, skills and abilities to run the service. They did not always understand and manage the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills.

The service opened in 2008 and the two directors had been in place since the service opened. The service consisted of the registered manager and the managing director.

The registered manager was the medical director for the service. The registered manager was a qualified general practitioner, had a Business and Technology Education Council (BTEC) diploma in lasers and light, post graduate certificate (PG Cert) in cosmetic medicine, a master's degree (MSc) in non-surgical facial aesthetics and a post graduate diploma (PG Dip) in clinical dermatology. The registered manager had responsibility for any clinical decisions within the service, was the appraiser for any medical staff, except those with practising privileges and was the responsible officer which included medicines management within the service. We were concerned that the registered manager had a busy service with limited clinical support and was undertaking busy clinic lists while in the service. We were concerned that this gave limited capacity for clinical oversight of the service.

The managing director had significant experience of management and business but not within healthcare services until this role. The managing director had a large portfolio and managed the day to day running of the service. The managing director's duties consisted of implementation of the business strategy and finance management, preparing and managing reputations with stakeholders, creating business plans and reports, ensuring the service adhered to health and safety legislation, managing complaints as well as managing and leading employees. We were concerned that this was a large portfolio and gave limited capacity within the role and there was a large reliance on her work.

Inadequate

Surgery

The service did not demonstrate that they had considered succession planning. We were aware that they had only one permanent doctor within the service who was also the registered manager. There had been a previous doctor within the service but incidents that the service was actively recruiting a further doctor to help with capacity. Managers had identified this as a risk but had not clearly articulated how they would action this risk.

We found that the Fit and Proper Person Procedure was not fit for purpose and the files were not in line with the requirements of the regulation.

There is a requirement for providers to ensure that directors are fit and proper to carry out their role. This included checks on their character, health, qualifications, skills, and experience. During the inspection we carried out checks to determine if the service was compliant with the requirements of the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014).

We reviewed the two director files. Both files included two references but some were personal references. Original documents and photocopies of original documents could be seen such as degree certificates.

As discussed within the safeguarding section of the report, the service did not always promote safety during recruitment of staff and ongoing checks of disclosure and barring service (DBS) checks.

We did see that both directors had the right to work in the UK. There was a contract of employment within the files reviewed. Not all directors had an up to date yearly appraisal. The files did not contain a yearly self-declaration, made by the directors, to confirm they remained fit and proper.

The service used a mixture of paper and electronic staff files to store information for the fit and proper persons requirements.

We were concerned that the service did not have robust systems and processes to ensure compliance with the fit and proper persons requirements.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The directors and staff had a clear vision which was ‘patient before profit’ at Discover Laser Ltd. The ethos was to promote skin health and general well-being in a warm, safe and welcoming environment. While on inspection we felt that the service and staff understood and was applying the vision on a day to day basis.

The service did have a business plan and strategy which focussed on sustainability of services. This reflected the vision and ensured patient experience was paramount.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients and their families could raise concerns without fear.

Inadequate

Surgery

The staff we spoke with during inspection felt supported valued and respected. The service had a close family unit feel, most of the staff employed had been friends or had known the directors in past employment. We had concerns that this could lead to staff feeling that they could not raise concerns.

The service focussed on the needs of the patients receiving care and treatment. The service relied on patient experience and word of mouth to promote their services. We could see that they were a busy service and the patients were confident and happy with the care and treatment provided.

Managers ensured that staff were given opportunities to develop in their careers but the service could not always demonstrate the records of competencies achieved.

Governance

Leaders did not operate effective governance processes, throughout the service. Staff at all levels were clear about their roles and accountabilities. Staff had regular opportunities to meet. However, team meetings were not always recorded effectively and did not demonstrate that discussions had been undertaken for staff to learn from the performance of the service.

We issued a section 29 warning notice stating that the service was failing to ensure that they had effective systems or processes established and were operating effectively to comply with the requirements of the 2014 Regulations.

Systems and processes were not regularly reviewed and improved. Leaders ensured that policies and procedures were followed. Some of the Discover Laser Ltd. policies were generic and contained information which did not apply to the service. Other policies and standard operating procedures did not contain pertinent information, had past the specified review date, or did not have review dates recorded. This included but was not limited to:

- There were five Discover Laser Ltd. policies which referenced the “provider’s board”. We were informed at the time of our inspection that you do not have a provider board. However, this does not provide evidence of a functioning and effective board. This included the incident reporting policy, risk assessment policy, managing complaints and concerns policy, responding to concerns policy and the medical appraisal policy.
- The Discover Laser Ltd. clinical governance policy references another service provider’s name.
- The standard operating procedure for local anaesthesia and weight management do not include a date when approved or for review.
- According to the Discover Laser Ltd. practising privileges policy, dated 2019, copies of a written agreement for doctors with practicing privileges should be kept, an interview record and two references. We looked for these documents in the staff files and did not see evidence that these were kept in accordance with the policy.
- We saw 22 policies, five of these policies were out of date and past their review dates.

We were concerned that leaders were not always aware of what was included in their polices and did not ensure they were being adhered to, as discussed within the incidents section of the report.

Staff at all levels were clear about their roles and they understand what they are accountable for. Staff had regular opportunities to meet. However, team meetings were not always recorded effectively and did not demonstrate that discussions had been undertaken for staff to learn from the performance of the service. We were told by leaders that the weekly meetings were very informal to encourage staff to participate. We requested copies of the weekly staff meeting minutes and the clinical governance, quality and safety meeting minutes.

The notes of meetings reviewed identified, you do not discuss the monitoring of safety and quality or relevant national guidelines in your clinical governance or team meetings.

Inadequate

Surgery

Clinical governance meetings were not held regularly or consistently. When asked to provide minutes of clinical governance meeting minutes, the service provided a one A4 summary document which identified meetings had taken place in June 2020, November 2020 and November 2021. This did not identify the date the meetings had taken place, who was present or the detail of what was discussed, it provided a list of discussion areas. However, managers ensured that staff unable to attend read the records of the meetings and signed the meeting record. We were concerned that there were not effective governance and management structures in place to ensure that safe care and treatment was being provided.

We requested but did not receive a systematic programme of clinical and internal audit to monitor quality and operational processes. There was no auditing around referral of patients for Mohs micrographic surgery as they had only been undertaking this procedure less than a year. The registered manager told us that an audit was due after one year of offering the procedure. We were concerned that there was no oversight of the Mohs micrographic surgery process by the leaders.

The service did not ensure that the doctors signed a fitness to practice declaration and did not have records of two suitable professional references. Written agreements with the practitioners with practising privileges were not kept within the staff files. This was not in line with the services practising privileges policy.

The service had service level agreements with local services. The service had service level agreements with two local laboratories for their histology testing, which included transport of histology samples. There were arrangements in place for removal of clinical waste with external contractors under a service level agreement.

Management of risk, issues and performance

Leaders did not use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues and did not identify actions to reduce their impact. The service had plans to cope with unexpected events.

The service did not ensure there were processes in place to manage current and future performance. Leaders were unable to evidence how they were assured of quality and safety because there were limited audit processes in place. Therefore, there was limited oversight of quality and safety control measures and subsequent actions taken.

- The service confirmed that the use of Isotretinoin, which is a high-risk drug for women of child-bearing age, had not been audited.
- Leaders told us cleaning audits were not completed and a visible check was completed but this not evidenced.
- Within the folder supplied to the inspection team during inspection, the last hand hygiene audit was undertaken in 2019. However, after our inspection we were provided with a hand hygiene audit, completed for all staff, in June 2021.
- As discussed within the patient outcomes section of the report, the service had been providing Mohs micrographic surgery for nine months but had not undertaken an audit, despite this being a new procedure to the service.

We were concerned that leaders did not have the oversight of procedures being carried out at the service and could not demonstrate that these procedures were being carried out safely which could potentially cause harm to patients.

The service did not ensure there were effective assurance systems and that performance issues were escalated appropriately through clear structures and processes. Within the incident and complaint report that was provided after the inspection we saw two incidents where suspicious lesions in lower leg were observed while being treated for other

reasons. The resolution was that the suspicious lesions were removed. These incidents were later confirmed to be pre-malignant lesion and a melanoma. We were concerned that there were not effective systems and processes to monitor and escalate incidents appropriately. The incident report did not contain enough information to ensure learning took place to prevent the likelihood of reoccurrence.

The service did not have robust arrangements for identifying, recording and managing risks, issues and mitigating actions. During inspection, we found that processes to minimise the likelihood and impact of risks on people who use services, were not identified, consistently embedded or monitored effectively. There were inconsistencies in the Discover Laser Ltd. risk assessment policy. We were provided with two different policies, one whilst on site and one the following day. The policy which was provided on site was dated 2019 and the one provided the following day was dated 2021. The updated policy contained information about the process for recording incidents, including the likelihood and level of impact each risk had. However, we found this policy was not being adhered to as there was no risk register and there was no objectives or action plan following the SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis. After our inspection, we were provided with a business plan which did include an action plan but it did not contain SMART (specific, measurable, attainable, relevant and time bound) plans that were specific to the risks. Which was not aligned with the providers policy.

Leaders confirmed there was no provider risk register, which was not in line with the Discover Laser Ltd. 'risk assessment and management' policy. Leaders confirmed that they undertook a SWOT analysis of the business instead of a risk register. This did include the risk, a risk rating, person responsible, date achieved by and subsequent actions to mitigate the risk. This was not in line with the provider policy.

The Discover Laser Ltd. risk assessment policy demonstrated the robust assessment of risk and escalation through the discover laser's governance processes to the service's board. During the registered manager's interview, we requested details on the provider board as stated within their policies but were told that it consisted of the registered manager and managing director. We were told that they would have informal meetings to discuss risks and actions. However, we were concerned the service could not demonstrate an effective and functioning board.

Information Management

The service did not always collect reliable data and analyse it. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

The service did not have any data management systems in place to monitor quality or patient outcomes to monitor service delivery. We requested but did not receive evidence on patient outcomes and quality monitoring.

The service did not have effective arrangements to ensure that information was used to monitor, manage and report on quality and performance. Managers could not demonstrate that they were improving services from people's views of the care and treatment provided at the service. We requested but did not receive evidence of the improvements made after complaints.

The service could not demonstrate that quality and sustainability received sufficient coverage in relevant meetings. The services meeting minutes provided were not comprehensive and could not demonstrate that sustainability and quality were discussed during meetings.

The service did not use information technology systems to effectively monitor and improve the quality of care. The service did not demonstrate clear and robust service performance measures, which are reported and monitored. We requested but did not receive evidence of the records audits.

Inadequate

Surgery

Engagement

Leaders did not always actively and openly engaged staff to plan and manage services.

Leaders engaged with staff on a weekly basis to plan and manage the service. However, this was not always minuted and monitored to ensure actions discussed were implemented.

Learning, continuous improvement and innovation

All staff were encouraged to continually learn but leaders could not demonstrate that they were continuously improving services.

Leaders told us that they encouraged staff to learn during their weekly staff meetings and through developing staff skills in phlebotomy, Mohs micrographic surgery laboratory technicians and to assist with minor surgeries. However, leaders did not monitor services provided and could not demonstrate that they were continuously improving services.

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 Services in slimming clinics	Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors The service must ensure that the directors satisfy all the requirements set out within the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for fit and proper persons (Regulation 5 (3)).

Regulated activity	Regulation
Surgical procedures Diagnostic and screening procedures	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The service must ensure that any complaint must be investigated, and necessary and proportionate action must be taken in response to any failure identified by the complainant or investigation (Regulation 16 (1)). The service must ensure that they establish and operate an effectively accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons (Regulation 16 (2)).

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service must ensure that they maintain securely an accurate, complete and contemporaneous record in respect of each service user, including of the care and treatment provided to the service user and of decisions taken in relation to care and treatment provided (Regulation 17 (2)(c)).

This section is primarily information for the provider

Requirement notices

The service must ensure that they evaluate and improve their practice in respect of processing information referred to in sub-paragraphs (a) to (e). (Regulation 17 (2)(f)).

Regulated activity	Regulation
Surgical procedures Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service must ensure that persons providing care and treatment have the qualifications, competence, skills and experience to do so safely (Regulation 12 (2)(c)).

This section is primarily information for the provider

Enforcement actions

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
Treatment of disease, disorder or injury Surgical procedures Diagnostic and screening procedures Services in slimming clinics	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The service was failing to comply with Regulation 12(1), Safe care and treatment, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that the service was failing to comply with this regulation because:** 1. The service was not effectively or appropriately assessing and managing the risks to service users who are receiving care and treatment. 2. The service was failing to ensure that they had sufficient infection prevention and control measures to mitigate the risks of infection. This exposed patients to a potential risk of harm. 3. The service could not demonstrate that they had systems and processes in place to safely prescribe, administer, record, store and dispose of medicines. This exposed patients to a potential risk of harm. 4. The service was not identifying or investigating incidents appropriately to ensure the health, safety and welfare of people using services. This meant the risk of incidents happening again was not reduced. 5. The service did not have an effective system to ensure the premises and equipment were kept secure and were suitable for the purpose for which they were being used. This meant there was a risk of harm to people using services, those close to them and staff.

Regulated activity	Regulation
Diagnostic and screening procedures Services in slimming clinics Surgical procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

Treatment of disease, disorder or injury

The service was failing to comply with Regulation 17, (1), Good governance, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that the service was failing to comply with this regulation because:

1. The service was failing to ensure that they had effective systems or processes established and operating effectively to comply with the requirements of the 2014 Regulations.