The Cosmetic Clinic

Inspection report

Unit 8, North Lynn Business Village
Bergen Way, North Lynn Industrial Estate
King's Lynn
PE30 2JG
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www.ukcosmeticclinic.co.uk

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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	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Overall summary

This service is rated as Requires improvement overall.

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Requires improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires improvement

We carried out an announced comprehensive inspection at The Cosmetic Clinic, Unit 8 North Lynn Business Village, Bergen Way, North Lynn Industrial Estate, King's Lynn, Norfolk PE30 2JG. The inspection was undertaken to rate the service as this was the first inspection since registration with CQC.

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. The service provides surgical and non-surgical cosmetic treatments, some of which are in-scope such as non-surgical polydioxanone (PDO) thread lifts, joint injections and non-surgical orthopaedic consultations, and some treatments which are out of scope such as beauty treatments.

The Medical Director is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Our key findings were:

- The service did not have wholly effective systems and processes in place to keep people safe.
- We saw evidence that clinicians assessed needs, but care and treatment was not always delivered in line with current legislation, standards and guidance.
- Staff treated patients with compassion, respect and kindness and involved them in decisions about their care.
- The service organised and delivered services to meet patients' needs. It took account of patient needs and preferences.
- There were clear responsibilities, roles and systems of accountability to support good governance and management, but these were not always effective.

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

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

(Please see the specific details on action required at the end of this report).

Overall summary

The areas where the provider **should** make improvements are:

- Review post-operative written information so it is in a format which patients will easily understand.
- Review the consent process to ensure all necessary information is recorded.
- Review the whistleblowing policy to promote freedom to speak up.

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

Chief Inspector of Hospitals and Interim Chief Inspector of Primary Medical Services

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a nurse specialist adviser.

Background to The Cosmetic Clinic

- The name of the registered provider is GlowmedP Ltd.
- The service operates from Unit 8, North Lynn Business Village, Bergen Way, North Lynn Industrial Estate, King's Lynn, Norfolk PE30 2JG.
- The provider has an additional location at 226 Dogsthorpe Road, Peterborough, Cambridgeshire, PE1 3PB. No regulated activities are provided from this location and hence this was not inspected.
- The provider first registered as Glowmed Ltd with the CQC in August 2019. The name was subsequently changed to GlowmedP Ltd and a new registration commenced in May 2022.
- The provider is registered to provide the regulated activities: diagnostic and screening procedures, surgical procedures and treatment of disease, disorder or injury and is registered to provide these services to adult patients only. The service provides a range of cosmetic treatments, most of which are out of scope. However, the service does offer non-surgical polydioxanone (PDO) thread lifts, joint injections and non-surgical orthopaedic consultations which require registration under the regulated activities of diagnostic and screening procedures, surgical procedures and the treatment of disease and disorder as they are carried out by a listed healthcare professional. The provider informed us that around 20 patients are treated for regulated activities per month.
- The clinic is situated in a two-storey building on a business park. There is free parking at this clinic.
- The service is open Mondays and Fridays 8.30am to 5:30pm and Tuesdays and Thursdays from 9am to 5pm.
- The provider's website is https://www.ukcosmeticclinic.co.uk/

How we inspected this service

Before the inspection, we asked the provider to send us some information, which was reviewed prior to the site visit. We also reviewed information held by the CQC on our internal systems.

During the inspection, we spoke with members of staff who were present, including the Registered Manager and two other members of staff. We made observations of the facilities and service provision and reviewed documents, records and information held by the service

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.

Requires Improvement

Are services safe?

We rated safe as Requires improvement because:

- The service did not have all the systems necessary to keep people safe and safeguarded from abuse.
- There were some systems in place to assess, monitor and manage risks to patient safety.
- The service had some systems in place for appropriate and safe handling of medicines.

Safety systems and processes

The service did not have wholly effective systems necessary to keep people safe and safeguarded from abuse.

- The provider conducted safety risk assessments. It had appropriate safety policies, which were regularly reviewed and communicated to staff. Staff received safety information from the service as part of their induction and refresher training. The service had systems to safeguard vulnerable adults from abuse.
- Whilst the service only treated adults over 18 years of age, the identification of patients was not being checked to verify the age of the patient.
- The provider carried out some staff checks at the time of recruitment. The service's recruitment policy stated that references needed to be obtained. However, we looked at records for two staff members who were involved in the provision of regulated activities, neither of which had any written documentation of references being obtained. The provider informed us that references had been obtained for these staff members, but the records had been destroyed. After the inspection, we were shown evidence of one reference obtained for a staff member who had been recently recruited but was no longer working at the service and also references for a second member of staff.
- Disclosure and Barring Service (DBS) checks were not always undertaken at the time of employment by the service. (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). The service did not have a DBS policy and one member of staff had a DBS certificate dated 2018 which related to a previous employment. We saw, however, that this staff member had signed an annual declaration to the provider stating there had been no change to their status. All staff had to complete the annual declaration.
- The provider was not able to evidence that all the required immunisation checks were completed as we saw one member of staff, who was involved in the provision of regulated activities, had not received any Hepatitis B vaccinations. There was no associated risk assessment undertaken by the provider for this staff member. The provider was aware of this and informed us that vaccinations will be arranged.
- All staff received up-to-date adult safeguarding and safety training appropriate to their role. No child safeguarding training had been completed but the provider informed us this was due to the service not treating children. Staff who acted as chaperones were trained for the role and had received a DBS check. Patients were requested not to be accompanied by any persons under the age of 18 years old.
- There was an effective system to manage infection prevention and control (IPC). We saw that annual audits were carried out and we were told that bimonthly random checks were also carried out. These, however, had not been documented.
- The service had completed a Legionella risk assessment and were adhering to the recommendations. Hence temperature monitoring was being carried out on a six monthly basis.
- 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.

Risks to patients

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

Requires Improvement

Are services safe?

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective induction system for staff although this was not always documented.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention.
- When there were changes to services or staff the service assessed and monitored the impact on safety.
- There were appropriate indemnity arrangements in place.
- There were suitable medicines and equipment to deal with medical emergencies which were stored appropriately and checked regularly. However, we found two adrenaline autoinjectors (EpiPens) in the emergency kit; one of which was the incorrect dose for adults. We also saw that two adrenaline ampoules were stored in a plastic sleeve along with three hyaluronidase ampoules which is not an emergency medicine. This could result in an incorrect dose or medicine being administered to a patient in an emergency. We saw that there was an Automated External Defibrillator for use in an emergency but there was not a spare set of adhesive pads.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Safe and appropriate use of medicines

The service had some systems in place for appropriate and safe handling of medicines.

- The systems and arrangements for managing medicines minimised risks. The service kept prescription stationery securely.
- Although the provider was the only clinician prescribing medicines, they had not carried out any antibiotic audits to ensure prescribing was in line with best practice guidelines for safe prescribing. We found that the first choice of antibiotics which the service prescribed did not adhere to national guidance.
- We saw evidence that medicines that required refrigeration were stored in the premises' refrigerator. We saw that the fridge temperature was being taken and documented once a day. However, there was no evidence of refrigerator temperature ranges or a system to monitor this. The cold chain policy did not include what actions to take if the temperatures went out of the recommended temperature range.

Track record on safety and incidents

The service had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The service monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

Requires Improvement

Are services safe?

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events. However, we were unable to view any significant event analysis as we were told that none had arisen from regulated activities.
- There were adequate systems for reviewing and investigating when things went wrong. We were told that discussion of these clinical incidents occurred at regular practice meetings.
- The provider was aware of and complied with the requirements of the Duty of Candour.

Requires Improvement

Are services effective?

We rated effective as Requires improvement because:

- We saw evidence that clinicians assessed needs but care and treatment was not always delivered in line with current legislation, standards and guidance.
- The service obtained consent to care and treatment in line with legislation and guidance, but this was not documented.
- We saw that post-operative written advice was lacking in detail.

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence based practice. We saw evidence that clinicians assessed needs but delivered care and treatment which was not always in line with current legislation, standards and guidance (relevant to their service).

- We found that the first choice of antibiotics which the service prescribed did not adhere to national guidance.
- Patients' immediate and ongoing needs were fully assessed. Where appropriate this included their clinical needs and their mental and physical wellbeing.
- Clinicians had enough information to make or confirm a diagnosis.
- We saw no evidence of discrimination when making care and treatment decisions.
- Arrangements were in place to deal with repeat patients.
- Staff assessed and managed patients' pain where appropriate.

Monitoring care and treatment

The service was involved in quality improvement activity but did not always use the information to make improvements.

- The service used some information about care and treatment to make improvements and we saw some evidence that improvement had been made through the use of completed audits. For example we saw a thread-lift audit completed in 2021 which highlighted that recovery for patients sometimes took longer than advised by the manufacturer. As a result of this feedback, the information given to patients was adjusted and improved. However, we saw that a previous audit on consent carried out in October 2019 had identified where improvements could be made but these had not been implemented. Additionally, we found that antibiotic audits had not been carried out in order to ensure that the service was following national guidance in respect of appropriate prescribing.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- All staff were appropriately qualified. The provider had an induction programme for all newly appointed staff, but this was not always documented.
- Relevant professionals (medical and nursing) were registered with the General Medical Council (GMC)/ Nursing and Midwifery Council and were up to date with revalidation.

Coordinating patient care and information sharing

Requires Improvement

Are services effective?

Staff worked together, and worked well with some other organisations, to deliver effective care and treatment.

- Patients received coordinated and person-centred care. Staff referred to, and communicated effectively with, some other services when appropriate. For example, when necessary, the provider liaised with local plastic surgeons or vascular surgeons to ensure best treatment for patients.
- Before providing treatment, the doctor at the service ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines history.
- The provider told us that patients were asked if treatment information could be shared with their GP but this was not documented. The provider told us that they did not routinely share information with the patients' GP.

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. However, written post-operative advice was not written in language that patients would easily understand.

- Where appropriate, staff gave patients post-operative verbal advice so they could self-care. However, the written advice given to patients following a thread lift which is a regulated activity, was not clear. The generic leaflet was not written in language that patients would easily understand. For example, it used words such as a jimjibang and a tudeuk. In addition it did not contain any information regarding pain relief or contact details for the service.
- 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 obtained consent to care and treatment in line with legislation and guidance, but this was not always correctly documented.

- Staff understood the requirements of legislation and guidance when considering consent and decision making. However, they were not following current legislation and guidance as they were not verifying the age of patients prior to treatment to ensure informed consent.
- We saw evidence that all patients had signed a consent form, however, the consent form did not have a patient identifier present, nor was it signed by the practitioner.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The service monitored the process for seeking consent appropriately. We saw that an audit of consent forms had been completed in October 2019 which identified that consent forms were not being fully completed. However, this had not resulted in any change or improvement.

Good

Are services caring?

We rated caring as Good because:

- Staff treated patients with kindness, respect and compassion.
- Staff helped patients to be involved in decisions about care and treatment.
- The service respected patients' privacy and dignity.

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 that a patient survey had been carried out in August 2022. This feedback was predominantly for non-regulated activities and had not yet been evaluated.
- Feedback from patients was positive about the way staff treated people.
- 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.

- We were told that interpretation services were available for patients who did not have English as a first language. However, there were no notices in the reception areas, including in languages other than English, informing patients this service was available.
- For patients with learning disabilities or complex social needs, family or carers were appropriately involved.

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 organised and delivered services to meet patients' needs. It took account of patient needs and preferences.
- Patients were able to access care and treatment from the service within an appropriate timescale for their needs.
- The service did not take complaints and concerns seriously.

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 and improved services in response to those needs.
- The facilities and premises were appropriate for the services delivered.

Timely access to the service

Patients were able to 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.
- Referrals and transfers to other services were undertaken in a timely way. For example the provider would liaise with a plastic surgeon if it was felt that a superior result would be obtained elsewhere.

Listening and learning from concerns and complaints

The system in place did not evidence that the service took complaints seriously.

- Information about how to make a complaint or raise concerns was not available. There was no complaints information on the service's website, nor in the waiting areas. We did see a practice complaints procedure but there were different versions available which contained slightly different information. Information regarding how to escalate a complaint was evident in one version, but this was not evident in the other version which was printed out by reception.
- The provider told us that they had received no complaints regarding regulated activities, so we were unable to fully evaluate this procedure or to assess if the service had learned lessons from complaints.

Requires Improvement

Are services well-led?

We rated well-led as Requires improvement because:

- The whistle blowing procedure could be improved.
- There were clear responsibilities, roles and systems of accountability to support good governance and management, but these were not always effective.

Leadership capacity and capability;

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.

Vision and strategy

The service had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The service monitored progress against delivery of the strategy.

Culture

The service had a culture of high-quality sustainable care but the whistle blowing procedure could be improved.

- Staff felt respected, supported and valued.
- The service focused on the needs of patients.
- Openness, honesty and transparency were demonstrated when responding to incidents. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff told us they felt supported in their work. However, some staff were unsure about what a whistle blower was or how they could raise a concern. We were shown the service's whistle blowing policy which named the service owner as the first point of contact and a relative (who also worked in the service) as the second point of contact. No other possible points of contact were mentioned. This could discourage a staff member from whistle blowing if it concerned the owner or their relative.
- There were processes for providing all staff with any development opportunities. This included appraisals. All employed staff had received an annual appraisal in the last year. They were given protected time for professional development.
- There was an awareness of the safety of all staff.
- Whilst there was an equality and diversity policy dated July 2022, no training in this area had been undertaken by staff. After the inspection, the provider showed us that one member of staff had completed this training in January 2022.
- There were positive relationships between staff and teams.

Governance arrangements

Requires Improvement

Are services well-led?

There were clear responsibilities, roles and systems of accountability to support good governance and management, but these were not always effective.

- Structures, processes and systems to support good governance and management were set out, but these were not always followed.
- Staff were clear on their roles and accountabilities.
- Leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.
- Clinical audits were being carried out, some of which had a positive impact on the quality of care and outcomes for patients. We saw a consent audit which was completed in 2019 which identified that consent forms were not being correctly completed. This was still the case at our inspection, hence in this example, no change to services had been introduced as a result of the audit which would have improved patient care.
- The information used to monitor performance and the delivery of quality care was accurate and useful.
- The service submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Managing risks, issues and performance

There was some clarity around processes for managing risks, issues and performance.

- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety.
- Leaders had oversight of safety alerts.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance.

Engagement with patients, the public, staff and external partners

The service involved patients to support high-quality sustainable services.

- The service encouraged and heard views and concerns from patients and acted on them to shape services and culture. Staff feedback was received verbally during appraisals.
- There were systems to support improvement and innovation work.

Continuous improvement and innovation

There was evidence of systems and processes for continuous improvement and innovation.

- There was a focus on continuous learning and improvement.
- During annual appraisals, leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

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
Treatment of disease, disorder or injury Surgical procedures Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 How the regulation was not being met: Some systems and processes were not operated effectively in order to mitigate risks to the health and safety of staff and service users receiving care and treatment. In particular: • To ensure complaints information for patients is readily available and accessible and includes information regarding the escalation process. • To ensure that staff had received the appropriate immunisations. • To verify the identity of service users to ensure all patients were over the age of 18 years. • To ensure all recruitment checks were completed, including DBS checks. • To ensure care was being provided in line with standards and make improvements through the use of relevant audits. • To improve the system and process to provide medicines required in case of an emergency.