Illuminate Skin Clinic

Inspection report

50 Churchill Square
Kings Hill
West Malling
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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	Good
Are services safe?	**Good**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Requires improvement**

Overall summary

This service is rated as Good **overall.**

The key questions are rated as:

Are services safe? – Good Are services effective? – Good Are services caring? – Good Are services responsive? – Good Are services well-led? – Requires improvement

We carried out an announced comprehensive inspection at Illuminate Skin Clinic as part of our inspection programme.

Illuminate Skin Clinic is an independent healthcare provider based in West Malling in Kent. The service provides an aesthetic cosmetic service, as well as private treatments for skin and other conditions.

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 and of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Illuminate Skin Clinic provides a range of non-surgical cosmetic interventions, for example aesthetic treatments which are not within CQC scope of registration. Therefore, we did not inspect or report on these services.

The service manager was the registered manager at the time of the inspection. 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.

Twelve people provided feedback about the service, however, it was not clear which of these patients had received services relating to our regulated activities. Feedback was positive, with people reporting that staff were caring, understanding and professional. People described the service as being of a high standard.

Our key findings were :

- The provider did not have a system for receiving and acting on safety alerts.
- The provider had a system for identifying and managing risks. However, not all risks had been effectively managed.
- The service did not have reliable systems for appropriate and the safe handling of medicines, as there was no process for regular medicines audits and no process for calibration of the temperature gauge of the medicines fridge.
- The service demonstrated some quality improvement activity. However, clinical audits were not routinely carried out.
- There were gaps in training records for staff.
- The service was offering a cervical screening service at the time of inspection but there was no evidence of training or up to date clinical skills practice for the sample taker. However, following the inspection we were told that this service had ceased while under review.
- Staff treated people with kindness, respect and compassion.
- The needs and preferences of individual patients were taken into account.
- Leaders had the capacity and skills to deliver high-quality, sustainable care.

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.

The areas where the provider should make improvements are:

- Improve the service statement of purpose to capture all areas of service activity are undertaken.

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

Overall summary

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

Our inspection team

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

Background to Illuminate Skin Clinic

Illuminate Skin Clinic is an independent healthcare provider based in West Malling, Kent. The main activities of this service are ones that do not require regulation such as aesthetic cosmetic services a very small part of the service provides activities that do require registration which include the administration of botox for excessive sweating, blood pressure and blood tests, consultations, examination and treatments for skin diseases and conditions including acne, rosacea, pigmented and vascular lesions and recently minor gynaecological procedures such as cervical screening. Services were provided for people over the age of 18. The provider was in the process of diversifying services to include some wellbeing functions, this included the provision of cervical screening. However, following the inspection we were told by the provider that they had temporarily ceased undertaking cervical screening following our feedback while they reviewed how to proceed.

The address of the service is:

50 Churchill Square
Kings Hill
West Malling
ME19 4YU

The provider rents rooms in a privately owned and maintained building. The clinic has a consulting room and treatment rooms on the ground floor. There is a reception and waiting area within the clinic.

The clinical team consists of one doctor (female) based at the clinic two days a week and one nurse (female) based at the clinic one day a week.

Illuminate Skin Clinic is open for bookings and enquiries Monday to Friday for all aspects of its service not just those requiring registration.:

Monday 9.30-6

Tuesday 9.30-6

Wednesday 9.30-8

Thursday 9.30-8

Friday 9.30-5.30

Saturday 10-4 (one per month)

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We reviewed a range of information we hold about the clinic in advance of the inspection.

During our visit we:

Spoke with the doctor, the service manager and reception staff.

Reviewed comment cards where patients shared their views and experiences.

Looked at information the clinic used to deliver care and treatment plans.

Reviewed documents relating to 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.

12 patients provided feedback about the service, and all the feedback was positive. This feedback was given via our CQC comment cards and it was not possible to identify which patients had accessed the service as part of CQCs regulated activities.

Good

Are services safe?

We rated safe as Good because:

Safety systems and processes

The service had systems to keep people safe and safeguarded from abuse.

- The service had appropriate safety policies, which were regularly reviewed and communicated to staff. They outlined clearly who to go to for further guidance. Staff received safety information from the service as part of their induction and refresher training. The service had systems to safeguard children and vulnerable adults from abuse.
- Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were undertaken where required. (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).
- All staff received up-to-date safeguarding and safety training. The service sent evidence that showed the doctor had completed safeguarding training at level three. Non-clinical staff did not act as chaperones. All staff had received a DBS check.
- There was an effective system to manage infection prevention and control. However, there was no evidence of ongoing infection control training for staff. Weekly and daily cleaning tasks were recorded, and a cleaning log was maintained for each room within the clinic. Monthly infection control audits were carried out and we saw evidence of action including replenishing hand gel and removing clutter from rooms. A legionella risk assessment had been carried out and action taken, including the monitoring of water temperatures.
- Equipment was routinely safety checked and electrical safety testing was carried out on a regular basis.
- There were systems for safely managing healthcare waste.
- The provider conducted safety risk assessments. However, not all areas of risk had been identified. For example, there were fire and legionella risk assessments and evidence of mitigating action such as fire drills, fire training and water temperature checks.There was no risk assessment recorded for the storage of oxygen and the storage of liquid nitrogen on the premises. However, following the inspection the provider completed these and sent them to the commission.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed.
- Staff had some understanding of their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. For example, clinical staff had completed sepsis training. Reception staff had not received training in basic life support, although were familiar with how to access the emergency medicine kits.
- There were suitable medicines to deal with medical emergencies which were stored appropriately and checked regularly.
- When there were changes to services or staff, the service assessed and monitored the impact on safety.
- There were appropriate indemnity arrangements covering all practitioners working within the service.

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.

Safe and appropriate use of medicines

The service had systems for appropriate and safe handling of medicines. However, there was no process for the calibration of the medicines fridge temperature gauge and there were no audits of prescribing.

Good

Are services safe?

- The systems and arrangements for managing medicines, including emergency medicines and equipment minimised risks. For example, there was a system for monthly checks of all emergency medicines and oxygen.
- The service prescribed minimal amounts of medication but they did not carry out regular medicines audits to ensure prescribing was in line with best practice guidelines for safe prescribing. However, we were told that there were plans to do so.
- The service does not prescribe Schedule 2 and 3 controlled drugs (medicines that have the highest level of control due to their risk of misuse and dependence).
- The doctor prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. There were processes for checking medicines and staff kept accurate records of medicines.

Track record on safety and incidents

The service maintained safety records, however there were some gaps in the systems for managing risk.

- There was a system in place for assessing risks within the service and identifying action to mitigate these risks. However, there were gaps apparent in relation to control of substances hazardous to health (COSHH) risk assessments in relation to oxygen and liquid nitrogen storage. Following the inspection the provider completed these and sent them to the commission.
- 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.
- The service did not have a system for receiving and acting on safety alerts, however, relevant safety alerts were likely to be minimal.

Lessons learned, and improvements made

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events. Staff understood their duty to raise concerns and report incidents and near misses.
- There were adequate systems for reviewing and investigating when things went wrong. The service learned, shared lessons and identified themes and took action to improve safety in the service. For example, a case study had been recorded relating to a patient who had a post procedure infection. The case study demonstrated that the event had been reflected on and additional safety measures had been put in place to reduce the potential for reoccurrence.
- The provider was aware of and complied with the requirements of the Duty of Candour. The significant event protocol included informing patients when things went wrong and offering an apology and thorough investigation.

Good

Are services effective?

We rated effective as Good because:

- The service demonstrated some quality improvement activity. However, clinical audits were not routinely carried out.
- **The provider did not have assurance that staff had the skills, knowledge and experience to carry out their roles.**
- **The service obtained consent to care and treatment in line with legislation and guidance .**

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 and delivered care and treatment in line with current legislation, standards and guidance relevant to the service.

- The provider assessed needs and delivered care in line with relevant and current evidence-based guidance and standards. Treatment staff attended relevant national and international meetings and updated protocols in line with recognised guidance. We saw evidence of attendance at conferences and seminars relevant to the treatments provided by the service.
- 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. For example, they had arrangements with an appropriately accredited laboratory. In addition, where necessary they liaised with a dermatologist regarding the diagnosis and treatment of skin conditions.
- 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 demonstrated some quality improvement activity. However, clinical audits were not routinely carried out.

- The service used information about care and treatment to make improvements as a result of patient experience. For example, they had carried out a review of a patient who had developed an infection following a procedure. The review included a reflective exercise and action to prevent reoccurrence. However, the service did not have a clinical audit plan.

Effective staffing

The provider did not have assurance that staff had the skills, knowledge and experience to carry out their roles.

- The provider had an induction programme for all newly appointed staff.
- Relevant professionals (medical and nursing) were registered with the General Medical Council (GMC)/ Nursing and Midwifery Council and were up to date with revalidation.
- . Examples of staff training included fire safety, moving and handling, health and safety and safeguarding training. Staff were encouraged and given opportunities to develop. However, there was no training log maintained and it was unclear what the provider classed as mandatory or essential training for staff. For example, there was no record of staff having completed infection control training. Clinical staff had undertaken basic life support training, but non-clinical staff had not.
- The service had diversified to include undertaking cervical smears and had a nurse with a practice nursing background to carry these out. However, the provider had not assured themselves of the competency of the person undertaking the cervical smear. prior to this part of the service commencing.. The service had only undertaken one smear and this had been taken and reported on correctly and had taken the decision to temporarily cease cervical screening while they reviewed how to deliver the service.

Coordinating patient care and information sharing

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

- Patients received coordinated and person-centred care. Staff referred to, and communicated effectively with, other services when appropriate. For example, liaising with patient's GPs as appropriate and with consent, and working with specialist services such as dermatology when treating patients with skin conditions.
- Before providing treatment, doctors at the service ensured they had adequate knowledge of the patient's

health, any relevant test results and their medicines history. We saw examples of patients being signposted to more suitable sources of treatment where this information was not available to ensure safe care and treatment.

- All patients were asked for consent to share details of their consultation and any medicines prescribed with their registered GP on each occasion they used the service.
- Care and treatment for patients in vulnerable circumstances was coordinated with other services. For example, the service flagged if patients had a history of poor mental health and monitored patient's psychological wellbeing as part of assessment processes.
- Patient information was shared appropriately (this included when patients moved to other professional services), and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way. There were clear and effective arrangements for following up on people who had been referred to other services.

Supporting patients to live healthier lives

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

- Where appropriate, staff gave people advice, so they could self-care. For example, patient information leaflets were provided with information about after care following treatments.
- Risk factors were identified, highlighted to patients and where appropriate highlighted to their normal care provider for additional support.
- 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 .

- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions. The service did not treat patients who did not have mental capacity to make a decision. Clinical staff had completed training in relation to the Mental Capacity Act.
- The service monitored the process for seeking consent appropriately. Appropriate records of consent were maintained in the patient records we viewed.

Good

Are services caring?

We rated caring as Good because:

- Staff treated people with kindness, respect and compassion.
- Patients felt involved in decisions about care and treatment.
- People's privacy and dignity were respected.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- The service sought feedback on the satisfaction with and quality of clinical care patients received, however, this was largely in relation to cosmetic procedures within the service.
- Feedback from patients was positive about the way staff treat people.
- Staff 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.

- Interpretation services were available for patients who did not have English as a first language.
- Patients told us through comment cards, that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.
- Staff communicated with people in a way that they could understand and allowed time for questions and clarification.

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.
- We observed staff interacting with patients in a way that respected their privacy and dignity. For example, by taking patients to a private area to discuss their treatment.

Good

Are services responsive to people's needs?

We rated responsive as Good because:

- The needs and preferences of individual patients were taken into account.
- Patients were able to access care and treatment in a timely way.
- Complaints and concerns were taken seriously, and the provider responded to these appropriately with a view to improving care.

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. For example, an audit of patient experience of a particular procedure identified that people's expectations of the procedure and recovery may not have been realistic. As a result, the provider introduced new educational tools including photographic illustrations of what to expect. In addition, the provider introduced the process of consent at the initial consultation with consent forms being shared with people at this point, rather than immediately prior to the procedure.
- 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, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised. For example, in the event of abnormal test results, the provider contacted the patient's GP where urgent treatment was required. In the event of non-urgent abnormal results patients were offered a face to face appointment with the doctor. The doctor was available by phone on days when not based at the clinic.
- Referrals and transfers to other services were undertaken in a timely way.

Listening and learning from concerns and complaints

The service took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The service informed patients of any further action that may be available to them should they not be satisfied with the response to their complaint.
- The service had a complaint policy and procedures. The service learned lessons from individual concerns, complaints and from analysis of trends. It acted as a result to improve the quality of care. For example, complaints were reviewed and discussed with all staff at quarterly meetings with a view to improving the patient experience. We reviewed five complaints that had been responded to appropriately and in a timely way.

Requires improvement

Are services well-led?

We rated well-led as Requires improvement because:

- **Responsibilities, roles and systems of accountability to support good governance and management were not clear.**
- Not all risks were identified and effectively managed.
-

Leadership capacity and capability;

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

- Leaders had identified the challenges relating to the quality and future of the services. They had processes in place to monitor the quality of the service and plans to develop the service.
- Leaders at all levels 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 strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values.
- The service developed its vision, values and strategy jointly with staff who 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.

- Staff felt respected, supported and valued.
- The service focused on the needs of patients and had a holistic view of patient treatment and care.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. For example, we saw evidence of complaint investigations and apologies given where appropriate. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary. Clinical staff, including nurses, were considered valued members of the team. They were given protected time for professional time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff. There were quarterly meetings within the service where staff were involved in discussions and reviews and their views were listened to.
- Staff felt they were treated equally. Some staff had received equality and diversity training, although this was not consistent across the whole staff team.
- There were positive relationships between staff and teams.

Governance arrangements

Responsibilities, roles and systems of accountability to support good governance and management were not clear.

- Structures, processes and systems to support good governance and management were not consistently, effective.
- Staff were clear on their roles and accountabilities.
- Leaders had established proper policies, procedures and activities to ensure safety however, they had not assured themselves that they were operating as intended. For example;
  - Training logs were not maintained and the provider had not evidenced that all staff had up to date training or competencies for their role.
  - Clinical audits were not carried out in relation to prescribing, however, the provider told us they had plans to do this.
  - There was no process for the calibration of the medicines fridge temperature gauge.
  - Risk assessments did not identify and mitigate all the risks within the service.

Requires improvement

Are services well-led?

- There was no system in place for receiving and acting on safety alerts.

Managing risks, issues and performance

There were processes for managing risks, issues and performance. However, not all risks were identified.

- There was a process to identify, understand, monitor and address current and future risks including risks to patient safety. Risk assessments were undertaken and regularly reviewed, including action to mitigate risks, although there were some gaps in risk assessments, in particular in relation to the storage of oxygen and liquid nitrogen. Following the inspection the provider completed these and sent them to the commission.
- The service had processes to manage current and future performance. For example, there was evidence of a reflective review of when things went wrong. Leaders had oversight of incidents and complaints.
- There was some evidence of action to change services to improve quality. For example, through patient feedback where changes such as improvements to patient information given prior to a procedure being carried out.
- The provider did not have plans for major incidents and business continuity.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients. For example, the service reviewed feedback from patients, as well as reviews of specific procedures with a view to identifying and improving patient outcomes.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The service used performance information which was reported and monitored, and management and staff were held to account
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- 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.

Engagement with patients, the public, staff and external partners

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

- The service encouraged and heard views and concerns from the public, patients, staff and external partners and acted on them to shape services and culture. For example, they discussed patient feedback in staff meetings and reviewed patient feedback from survey results and online feedback sources. An annual survey was conducted within the service and patients were asked for feedback after each consultation.
- The service sought patient feedback relating to specific treatments and made changes as a result. For example, as a result of feedback the service changed the timing of information shared with patients about procedures so that it was given at the point of booking an appointment rather than at their appointment.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement.
- The service made use of internal reviews of complaints although did not have any recorded incidents. Learning was shared and used to make improvements. For example, they reviewed and updated information given to patients about specific procedures as a result of feedback and reviews.
- 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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met… The registered person had systems or processes in place that operating ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular: There was no system to receive and act on safety alerts. Risk management processes did not include the identification of all risks. There was no process for the calibration of the medicines fridge temperature gauge. There was no record of training, skills updates or monitoring for the nurse undertaking cervical screening. There was no record of staff having received infection control training. This was in breach of Regulation 12 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.