

# Coltishall Cosmetic Clinic

## Inspection report

Bure House, Rectory Road  
Horstead  
Norwich  
Norfolk  
NR12 7EP  
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<https://coltishallclinic.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

Inadequate 

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

# Overall summary

## **This service is rated as Inadequate overall.**

The key questions are rated as:

Are services safe? – Inadequate

Are services effective? – Inadequate

Are services caring? – Good

Are services responsive? – Requires improvement

Are services well-led? – Inadequate

We carried out an announced comprehensive inspection at Coltishall Cosmetic Clinic on 17 July 2019. This inspection was to rate the service.

Coltishall Cosmetic Clinic is an independent provider of cosmetic services. The clinic is located in the village of Horstead, a few minutes' drive from the centre of Norwich. They offer treatments for aesthetic and medical purposes.

This clinic is registered with Care Quality Commission (CQC) under the Health and Social Care Act 2008 in respect of some, but not all, of the practices it provides. There are some exemptions from regulation by CQC which relate to particular types of services and these are set out in Schedule 2 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Coltishall Cosmetic Clinic is registered in respect of the provision of treatment of diseases and surgical procedures. Therefore, we were only able to inspect treatments relating to medical purposes, such as Botox for excessive sweating, ultrasound, surgical procedures including mole removal, liposuction and face lifts and weight loss services. The clinic offered other services such as laser treatment for hair removal and tattoo removal and Botox for aesthetical reasons, these services are exempt from regulation.

The practice is registered with the CQC under the Health and Social Care Act 2008 to provide the following regulated activities:

- Surgical procedures
- Treatment of disease, disorder or injury.

The lead doctor is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the practice. 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 practice is run. The lead doctor

is also the nominated individual. (A nominated individual is a person who is registered with the Care Quality Commission to supervise the management of the regulated activities and for ensuring the quality of the practices provided).

As part of our inspection we asked for CQC comment cards to be completed by clients prior to our inspection visit. We received 40 comment cards, all were wholly positive about the service. The cards reflected the kind and caring nature of staff, how informative staff were, the pleasant environment and the positive effects of the treatment received. Other forms of feedback, including patient surveys and social media feedback were consistently positive.

## **Our key findings were:**

We have rated the service as **inadequate** for providing safe services because:

- The provider told us they did not carry out DBS checks for all staff as most staff had worked at the service for over ten years. (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). Staff who acted as chaperones were not trained for the role and not all have received a DBS checks.
- The systems in place to manage environmental infection prevention and control risks were ineffective.
- The provider did not ensure facilities and equipment were safe and equipment was maintained according to manufacturers' instructions.
- The provider did not carry out appropriate environmental risk assessments such as legionella, fire and health and safety risk assessments. The provider sent us some risk assessments after the inspection.
- Staff could detail what actions they would take in an emergency, however, they had not had appropriate training in basic life support. Staff had not completed training in safeguarding.
- The clinic did not have the all of the emergency medicines in line with recognised guidance and they had not risk assessed this.
- Individual care records were not written and managed in a way that kept patients safe. For example, some care

# Overall summary

records were illegible and were not signed by clinicians. We also noted concerns with some of the observations taken for patients which were not shared with the patients' GP.

- The service did not have a system in place to retain medical records in line with Department of Health and Social Care (DHSC) guidance in the event that they cease trading.
- There was not a clear system for recording and acting on significant events.
- The service told us they were aware of safety alerts, however, there was not a system in place to document receiving, review and action of safety alerts, including medicines safety alerts.

We have rated the service as **inadequate** for providing effective services because:

- The provider did not always assess needs and deliver care in line with relevant and current national evidence-based guidance and standards.
- We did not always see the clinic gained appropriate information on the patients' medicines history.
- The service would refer patients back to their registered GP for some issues, however, this was not consistent or in line with their protocol for referring back to the registered GP.
- Staff were not all appropriately qualified. The provider did not have a comprehensive induction programme for all newly appointed staff.
- The provider did not assess the learning needs of staff as there was no evidence of a formal appraisal system.
- Before providing treatment, the doctor at the service asked for an overview of the patient's health. However, they did not gain reassurance or validate this information.

We rated the provider as **good** for providing caring services because:

- All patients said they were treated with compassion, dignity, and respect and they were involved in their care and decisions about their treatment.
- The service proactively sought feedback from staff and patients, which it acted on. Regular surveys were undertaken.

We rated the provider as **requires improvement** for providing responsive services because:

- The facilities and premises had not been risk assessed to ensure they were appropriate for the services delivered.
- Referrals and transfers to other services were not always undertaken in a timely way.
- We saw examples where the clinic was not aware of the Duty of Candour.

We rated the provider as **inadequate** for providing well-led services because:

- The lead doctor was not knowledgeable about issues and priorities relating to the quality and future of services. They had not put the appropriate systems or processes in place to manage potential risks to the service.
- There were not effective processes in place for providing all staff with the development they needed.
- Structures, processes and systems to support good governance and management were not in place. We found serious concerns relating to the legibility of notes and the observations taken of some consultations.
- The provider had some policies, procedures and activities. However, we found these lacked information to appropriately advise staff.
- The clinic did not have appropriate systems to identify, understand, monitor and address current and future risks including risks to patient safety.
- The service did not fully monitor current and future performance.

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

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure staff are suitably qualified, competent, skilled and experienced persons are deployed to meet the fundamental standards of care and treatment.
- Ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed.

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key

# Overall summary

question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

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

Special measures will give people who use the service the reassurance that the care they get should improve.

**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 advisor and a CQC hospitals inspector.

## Background to Coltishall Cosmetic Clinic

- The provider of this service is Coltishall Cosmetic Clinic.
- Coltishall Cosmetic Clinic is located at Bure House, Rectory Road, Horsted, Norfolk, NR12 7EP.
- The website address is: <https://coltishallclinic.co.uk/>
- Coltishall Cosmetic Clinic is an independent provider of cosmetic services. The clinic is located in the village of Horstead, a few minutes' drive from the centre of Norwich. They offer treatments for aesthetic and medical purposes.
- Coltishall Cosmetic Clinic is registered in respect of the provision of treatment of diseases and surgical procedures. Therefore, we were only able to inspect treatments relating to medical purposes, such as Botox for excessive sweating, ultrasound, surgical procedures including mole removal, liposuction and face lifts and weight loss services. The clinic offered other services such as laser treatment for hair removal and tattoo removal and Botox for aesthetical reasons.
- The clinic had flexible opening times according to patient demand. They were open between Tuesday and Saturday.

Before visiting, we reviewed a range of information we hold about the service and asked them to send us some pre- inspection information which we reviewed.

During our visit we:

- Spoke with a range of staff from the service including the doctor lead, aesthetic assistant and clinic manager.
- Reviewed a sample of treatment records.
- Reviewed comment cards where clients had shared their views and experiences of the service.
- Looked at information the service used to deliver care and treatment plans.

To get to the heart of clients' 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.

# Are services safe?

**We have rated the service as inadequate for providing safe services because:**

## **Safety systems and processes**

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

- The provider did not conduct safety risk assessments. It did not have appropriate safety policies in place. For example, the safeguarding policy was dated 2010 and the standard operating procedure for the service was not detailed enough to advise staff what to do if they had safeguarding concerns. After the inspection, the provider showed us evidence of staff having access to the local county council for safeguarding. The service did not have systems to safeguard children and vulnerable adults from abuse. Staff received some safety information from the service as part of their training, such as health and safety information.
- The doctor told us there had not been any incidents of safeguarding concerns at the clinic.
- We did not see evidence of full recruitment records for staff as these were kept off site. The provider told us they did not carry out DBS checks for all staff as most staff had worked there over ten years. Staff who acted as chaperones were not trained for the role and not all had received a DBS check. After the inspection, the provider told us they had applied for DBS checks for all staff and they would not have unsupervised access to patients until they were complete.
- Staff did not receive up-to-date safeguarding and safety training appropriate to their role. Staff we spoke with did not know how to identify and report concerns. Since the inspection, we have been provided with evidence that some training had been completed.
- The systems in place to manage environmental infection prevention and control risks were ineffective. There were sharps bins and protective equipment available. A review for infection prevention and control had been completed in 2017 and had not been reviewed since. We did not see evidence of a full infection prevention and control audit.
- The provider did not ensure facilities and equipment were safe and equipment was maintained according to manufacturers' instructions. For example, there was no system in place for the calibration of equipment such as

blood pressure machines. After the inspection, the provider told us they were in the process of finding a company to complete calibration. Lasers were tested according to manufacturer's instructions and equipment had portable appliance testing. There were systems for safely managing healthcare waste.

- The provider did not carry out appropriate environmental risk assessments such as legionella, fire and health and safety risk assessments. There was a visual check log for health and safety risks and some improvements had been made such as purchasing a higher sofa in reception to make it easier for patients. The log did not detail the areas assessed. After the inspection, we were provided with a health and safety, fire, legionella and infection prevention and control risk assessments that had been completed after the inspection.

## **Risks to patients**

**There were no systems in place to assess, monitor and manage risks to patient safety.**

- There were arrangements for planning and monitoring the number and mix of staff needed. If the lead doctor was unavailable, the clinic closed.
- Staff could detail what actions they would take in an emergency, however, they had not had appropriate training in basic life support. The provider told us all training for staff, including basic life support, would be completed by September 2019.
- There were some appropriate emergency medicines in place and the medicines we checked were in date. However, the clinic had very few emergency medicines in line with recognised guidance and they had not risk assessed this. After the inspection, the provider produced a risk assessment which had been completed after the inspection for the medicines they did not stock. The clinic had a defibrillator and oxygen in case of an emergency, however the defibrillator had not been calibrated and the pads were out of date. These were replaced immediately.
- There were appropriate indemnity arrangements in place to cover all potential liabilities.

## **Information to deliver safe care and treatment**

# Are services safe?

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

- Individual care records were not 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 not always available to relevant staff in an accessible way. For example, some care records were illegible and were not signed by clinicians. We noted concerns with some of the observations taken for patients which were not shared with the patients' GP. After the inspection, we received an action plan which included improving the legibility of notes and completing regular audits on notes. Following our inspection, the provider conducted a notes audit and found all of the notes audited were legible.
- The service had some systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. The clinic told us they did not share routine histology or blood test results with the patient's own GP. The doctor told us they shared abnormal results with the GP, however we did not see evidence of this.
- The service did not have a system in place to retain medical records in line with Department of Health and Social Care (DHSC) guidance in the event that they cease trading. The provider told us they would contact the relevant agencies to ask for advice if there were unforeseen circumstances that made the provider cease trading.

## **Safe and appropriate use of medicines**

### **The service had some systems for appropriate and safe handling of medicines.**

- The systems and arrangements for managing medicines and equipment did not minimise risks as we found equipment was not calibrated. The medicines cabinet was not locked; however it was in a clinical room which we were told was not accessed by patients without a clinician present. After the inspection, we were informed that the cabinet was unlocked due to the inspection.
- Staff prescribed medicines to patients and gave advice on medicines that were not in line with legal requirements and guidance. For example, the provider

told us they prescribed cephalexin antibiotics to all patients that had undergone a liposuction procedure and was not familiar with the guidance to support this. However, we viewed notes of the procedure where this was not the case. After the inspection, the provider clarified that antibiotics were prescribed on an individualised basis to patients.

## **Track record on safety and incidents**

### **The service did not have a good safety record.**

- There were no comprehensive risk assessments in relation to safety issues. We found assessments had not been completed for infection prevention and control, health and safety or fire risks. Some safety measures had been taken, such as servicing fire extinguishers and emergency exit signs and lights. After the inspection, the provider sent us a health and safety risk assessment.
- The service monitored and reviewed some activity, such as infection rates post operation.

## **Lessons learned and improvements made**

### **The service did not learn or make improvements when things went wrong.**

- There was not a clear system for recording and acting on significant events. Staff did not understand their duty to raise concerns and report incidents and near misses.
- We saw there had not been any events raised since 2015. However, we noted three laboratory forms had to be amended due to incorrect details; whilst the errors were discussed with individual staff members there were no records to demonstrate learning from these incidents or actions taken to prevent it reoccurring.
- The provider was not aware of the requirements of the Duty of Candour. Since our inspection the provider has compiled updated policies relating to safeguarding and whistleblowing. Staff had also completed training on the Duty of Candour after the inspection.
- The service told us they were aware of safety alerts, however there was not a system in place to document the receiving, review and action of safety alerts, including medicines safety alerts. After the inspection, the provider told us they had signed up to receive all alerts and would action them appropriately.



# Are services effective?

**We have rated the service as inadequate for providing effective services because:**

## **Effective needs assessment, care and treatment**

**The provider did not have systems to keep clinicians up to date with current evidence-based practice. We saw evidence that clinicians did not always assess needs or deliver care and treatment in line with current legislation, standards and guidance (relevant to their service)**

- The provider did not always assess needs and deliver care in line with relevant and current national evidence-based guidance and standards. For example, and the doctor told us they had not kept up to date with guidance relating to antibiotics. After the inspection, the provider sent us an action plan which included keeping up to date with guidelines and clarified they did follow guidance relating to antibiotic use. They also told us they kept updated with guidelines relating to varicose vein treatment.
- Patients' immediate and ongoing needs were assessed. Where appropriate this included their clinical needs and their physical wellbeing. However, we did not always see the clinic gained appropriate information on the patients' medicines history.
- The service would refer patients back to their GP for some issues, however this was not consistent or in line with their protocol for referring back to the GP. We saw evidence where high blood pressure readings were not referred back to the GP.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff assessed and managed patients' pain where appropriate.

## **Monitoring care and treatment**

**The service did not actively take part in quality improvement activity.**

- The service had completed some audits at the time of our inspection. For example, audits for appraisal of the doctor had been completed, including whether there had been any infections post operation. We did not see any evidence of change or improvement as a result of quality improvement activity.

- An audit had also been completed in 2016 on patient records. However, actions from this had not been implemented. For example, the audit noted that eight records were illegible. At the time of our inspection, they were still illegible.
- We viewed patient satisfaction feedback forms which were all positive. However, the clinic had not completed a formal review of the feedback and therefore trends had not been identified.

## **Effective staffing**

**Not all staff had the skills or knowledge to carry out their roles.**

- Staff were not all appropriately trained. The provider did not have a comprehensive induction programme for all newly appointed staff. We saw some evidence of a health and safety presentation being given to staff, but other forms of induction were not documented. The provider told us this was because all staff had worked at the clinic for a number of years. The provider sent us an action plan after the inspection, which included all staff being appropriately trained by September 2019. Since the inspection, we have been provided with evidence that some training had been completed.
- The doctor was registered with the General Medical Council and was up to date with revalidation.
- The provider did not assess the learning needs of staff as there was no evidence of a formal appraisal system. We saw some records of skills, qualifications and training for the lead doctor and technician. Some staff did not have training in basic life support. Staff were not trained in safeguarding, fire or infection prevention and control. The provider sent us an action plan after the inspection, which included all staff being appropriately trained by September 2019.

## **Coordinating patient care and information sharing**

**Staff did not always work together with other organisations to deliver effective care and treatment.**

- Before providing treatment, the doctor at the service asked for an overview of the patient's health, any relevant test results and their medicines history. However, they did not gain reassurance or validate this



## Are services effective?

information. We saw examples where this section was incomplete. The doctor told us they signposted to more suitable sources of treatment when this information was not available to ensure safe care and treatment.

- All patients were asked for consent to share details of their consultation when required.
- Care and treatment for patients in vulnerable circumstances was coordinated with other services where required for some patients. The clinic did not see patients with learning disabilities.
- Staff had not been trained in mental health and dementia appropriate to their role. The provider told us staff had some awareness of body dysmorphia.
- Patient information was not always shared appropriately (this included when patients moved to other professional services). We saw examples where the patients' GP had not been informed of abnormal observations.

### **Supporting patients to live healthier lives**

**Staff were consistent 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, including post operation leaflets.
- Risk factors were identified and highlighted to patients. For example, the clinic included consent forms for all treatments which gave details of the procedure and possible side effects. The provider told us they were honest with patients and would advise patients on other suitable avenues if they did not think their preferred treatment choice was appropriate.
- 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 generally 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. However, we noted that a consent form had not been signed for a mole removal.
- There was some evidence of Gillick competency in a standard operating procedure relating to assessing the capacity of patients aged under 16.
- Staff supported patients to make decisions.

# Are services caring?

## **Kindness, respect and compassion**

### **Staff treated patients with kindness, respect and compassion.**

- Feedback from patients was positive about the way staff treat people. The comment cards we received were positive about the kindness and helpfulness of staff. For example, one comment card stated “all staff are so friendly and really make you feel at ease.” Another stated that it was “very friendly and staff were very professional.”
- 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.
- The clinic requested feedback of patient satisfaction.

## **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, if this was required.

- 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. For example, one comment card stated “the doctor took time with me, even though I was anxious”.
- Staff communicated with people in a way they could understand; for example, a comment card told us staff took extra time with them due to their mental health needs.

## **Privacy and Dignity**

### **The service respected patients’ privacy and dignity.**

- Staff recognised the importance of people’s dignity and respect. The reception area was separate from the clinical rooms and the waiting area and the front door was locked, which improved confidentiality and staff safety.
- Staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

# Are services responsive to people's needs?

**We have rated the service as requires improvement for providing responsive services because:**

## **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, the clinic had placed more hand towels in the patient toilet due to patient feedback.
- The facilities and premises had not been risk assessed to ensure they were appropriate for the services delivered.
- Reasonable adjustments had been made so people in vulnerable circumstances could access and use services on an equal basis to others.

## **Timely access to the service**

**Patients were able to access care and treatment from the service within an appropriate timescale for their needs. However, referrals to other services were not always undertaken in a timely way.**

- Patients had timely access to initial assessment, test results and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately. The clinic called patients to cancel appointments if necessary.

- The comment cards we received reported the clinic was easy to access and there was not a long wait for appointments.
- Referrals and transfers to other services were not always undertaken in a timely way. For example, we saw evidence where the clinic had not referred back to the patient's own GP despite high blood pressure readings.

## **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 complaint policy and procedures in place. We saw examples of when the service learned lessons from individual concerns and complaints. It acted as a result to improve the quality of care.
- We saw examples where the clinic was not aware of the Duty of Candour. Since our inspection the provider has compiled updated policies relating to safeguarding and whistleblowing. Staff had also completed training on the Duty of Candour after the inspection.

# Are services well-led?

**We rated the provider as inadequate for providing well-led services because:**

## **Leadership capacity and capability;**

**Leaders did not have the capacity and skills to deliver high-quality, sustainable care.**

- The lead doctor had not taken appropriate action to ensure the quality and safety of services. They had not put the appropriate systems or processes in place to manage potential risks to the service.
- The lead doctor was visible and approachable. They worked closely with staff within the clinic but did not always work effectively with other agencies, such as GPs. Staff commented positively on the leadership within the clinic and felt their concerns would be acted on.
- After the inspection, we sent the provider a letter asking for them to take immediate action to reduce the risk to patients. The provider submitted an action plan which addressed most areas raised, with completion dates and details of actions already taken.

## **Vision and strategy**

**The service had a vision for the clinic.**

- The service told us they had a clear vision and ethos which was:
  - “Driven by passion, committed to quality.”
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.

## **Culture**

**The service had a positive team morale within the clinic but did not have systems to support appropriate training and development.**

- Staff felt respected, supported and valued. They were proud to work for the service and reported they felt the service treated patients holistically.
- The service focused on the needs of patients who wished to access their services. The service told us they did not accept all patients and assessed for body dysmorphism.
- Openness, honesty and transparency were demonstrated when responding to complaints.

However, we found the provider did not always record, respond to and learn from significant events. For example, where external services had reported issues with documentation.

- Staff told us they could raise concerns. They had confidence that these would be addressed. However, staff had not raised any significant events.
- There were not effective processes in place for providing all staff with the development they needed. For example, we did not see competency checks or appropriate training for technicians. Appraisals had not been completed for staff. Since the inspection, we have been provided with evidence that some training had been completed.

## **Governance arrangements**

**The governance systems were inadequate and had led to safety concerns.**

- Structures, processes and systems to support good governance and management were not in place. We found serious concerns relating to the legibility of notes and the observations taken of some consultations. We had concerns relating to patients with high blood pressure that had not been referred back to their GP.
- The provider had some policies, procedures and activities. However, we found these lacked information to appropriately advise staff. For example, the safeguarding policy was a Norfolk wide policy published in 2010 and had not been reviewed or updated.

## **Managing risks, issues and performance**

**The systems for managing risks, issues and performance were ineffective and led to patient safety concerns.**

- The clinic did not have appropriate systems to identify, understand, monitor and address current and future risks including risks to patient safety. There were no risk assessments in place for fire, health and safety or legionella. After the inspection, the provider sent us a health and safety risk assessment and legionella water testing that had been completed after our inspection.
- The system to manage infection prevention and control was ineffective. We did not see a recent audit.
- The service did not fully monitor current and future performance. For example, no audits had been completed on the prescribing of medicines within the clinic.

# Are services well-led?

## Appropriate and accurate information

### The service did not act on appropriate and accurate information.

- The service did not have formal documented meetings. The provider told us this was because they were not needed due to the small team. Staff reported they were able to raise concerns however we did not see evidence of recent significant events.
- The clinic had hand written patient notes, some of which were illegible. Information was not always corresponded to the patients regular GP in a timely and safe manner. Following our inspection, the provider conducted a notes audit and found all of the notes audited were legible.
- The clinic did not document receiving or acting on patient safety alerts. After the inspection, the provider told us they had signed up to receive alerts.

### Engagement with patients, the public, staff and external partners

### The service involved patients in the service but did not always engage with external partners appropriately.

- Patients views and concerns were heard and acted on. For example, the clinic had put more hand towels in the toilet.
- Surveys of patient satisfaction were undertaken.
- Staff reported their views were heard and they felt part of the team, involved in decision making and were happy to work at the clinic.
- The clinic had a very active social media presence and posted information on there.
- We saw some engagement with external stakeholders such as GPs but this was inconsistent.

### Continuous improvement and innovation

- The lead for the clinic attended regular international conferences and the clinic utilised innovative technological treatments.

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

Surgical procedures  
Treatment of disease, disorder or injury

#### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

- Technician staff had not completed appropriate training. The provider told us after the inspection this had been booked and completed.
- Competency checks for technicians had not been completed.
- Staff did not have training in safeguarding, basic life support, fire or infection prevention and control. After the inspection, the provider submitted an action plan detailing that training would be completed by September 2019.
- Appraisals and career development conversations had not been undertaken for staff.

**This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

#### Regulated activity

Surgical procedures  
Treatment of disease, disorder or injury

#### Regulation

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

- Recruitment files were incomplete for some members of staff.
- Not all staff had DBS checks. The provider told us they had applied for the checks and would not allow staff to have unsupervised access with patients until these were received.

**This was in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

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 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. We took enforcement action because the quality of healthcare required significant improvement.

#### Regulated activity

Surgical procedures  
Treatment of disease, disorder or injury

#### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

##### **A warning notice was issued.**

- We looked at 26 service user records. Some service user records were illegible, notes were not signed by the clinician and they did not state who was making the entry. We found issues with five patient notes.
- In the action plan sent by the provider on 21st July 2019, we noted there were plans in place to review patient notes and complete audits on legibility and to create a standard letter to GPs. This process required embedding.
- Equipment including the defibrillator and blood pressure machines had not been calibrated. We received an update in the action plan relating to sourcing a calibration company, however this required completion to ensure equipment was safe to use.

This was in breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

#### Regulated activity

Surgical procedures  
Treatment of disease, disorder or injury

#### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

##### **A warning notice was issued.**

- We found a lack of focus on the clinical leadership and governance systems. This resulted in the following issues that threatened the delivery of safe and effective care which had not been identified or adequately managed as part of an effective system or process to ensure compliance with the regulations.



## Enforcement actions

- The service did not have a system in place to retain medical records in line with Department of Health and Social Care (DHSC) guidance in the event that they cease trading.
- There was no evidence of significant events being recorded by the clinic since 2015. We found evidence of three forms sent back from histology in 2018 with incorrect service user details completed by the clinic but these had not been recorded as events and there was no evidence of learning from these. The process for raising events required embedding into practice.
- There was no embedded system or process to assess the risks in the clinic, including those relating to health and safety, fire, legionella and infection prevention and control. After the inspection, we received these risk assessments, however the system to continually review risks required embedding.

This was in breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.