# Natasha Lucy Clinics

## Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

## Ratings

| | |
|---|---|
| Overall rating for this location | 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 Natasha Lucy Clinics on 22 November 2022. This was the first CQC inspection of this location under the current CQC inspection methodology.

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. Natasha Lucy Clinics provides a range of non-surgical cosmetic interventions, for example skin care, which are not within CQC scope of registration. Therefore, we did not inspect or report on these services.

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:**

- There were systems, processes and operating procedures to manage incidents and to safeguard patients from abuse and the clinical environment. However, we found improvements were required to safety processes, specifically medicines management, patient identification checks and information needed to deliver safe care and treatment.
- The service monitored the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence based guidelines and that staff had the skills, knowledge and training to provide an effective service. However, the service did not always obtain consent to care and treatment in line with legislation and guidance.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- The service organised and delivered services to meet patient's needs. Patients were well informed about aspects of the service provided.
- The registered manager had the capacity and skills to deliver high-quality, sustainable care. However, we found some systems and processes, specifically around medicines management and information needed to deliver safe care and treatment, were not consistently applied and managed.

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

# Overall summary

- 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.

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

In addition, the areas where the provider **should** make improvements are:

- Continue to seek assurances that emergency medical equipment is properly maintained, in line with medical devices regulations.
- Develop a programme of clinical audit to monitor patient outcomes, including second cycle audits.

**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

The inspection was led by a CQC inspector who had access to advice from a specialist advisor.

## Background to Natasha Lucy Clinics

Natasha Lucy Clinics is an independent provider of medical services. The service provides a broad range of aesthetic services that are not regulated by the Care Quality Commission (CQC),but some services that are, including hyperhidrosis for excessive sweating, Botox for migraines and IV vitamin therapy. This report references only those services that are regulated by CQC. The service is provided to adults only.

Natasha Lucy Clinics is based at Suite B2A, Sterling House, Langston Road, Loughton, IG10 3TS. The service is for private fee-paying patients only, the service does not see NHS patients. The provider is registered with the CQC to deliver the regulated activity of treatment of disease, disorder or injury.

The service is self-contained within a business unit, with patients checking in at reception. The service has two clinic rooms.

The service operates Monday from 12pm until 8pm and Tuesday to Friday 10am until 5pm and one Saturday a month. The service does not formally provide a service outside of these hours. Prescriptions at the service are conducted by the nurse practitioner. The service employs one clinic manager, one receptionist and a therapist.

**How we inspected this 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:**

We identified safety concerns that were rectified on the day of inspection. The likelihood of this happening again in the future is low and therefore our concerns for patients using the service, in terms of the quality and safety of clinical care are minor. (see full details of the action we asked the provider to take in the Requirement Notices at the end of this report).

**Safety systems and processes**

**The service had systems 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. 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.
- The service worked with other agencies to support patients and protect them from neglect and 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 appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- During the inspection we saw that there was not an effective protocol in place for verifying the identity of patients accessing the service, including patients who may be under the age of 18. Following the inspection, the provider introduced a system to check patients details when accessing the service and had contacted all patients who had undergone any regulated treatment to verify their identity.

**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.
- There was an effective induction system for agency staff tailored to their role.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example sepsis.
- When there were changes to services or staff the service assessed and monitored the impact on safety.
- There were appropriate indemnity arrangements in place.
- Appropriate standards of cleanliness, hygiene and infection prevention and control were in place. Staff had made adaptions to infection prevention and control during the COVID-19 pandemic in line with national guidance.
- There were arrangements for managing waste and clinical specimens. Sharps bins were available in all clinical rooms and were appropriately labelled, secured and were not overfilled.
- There was an effective system to manage infection prevention and control. A Legionella risk assessment undertaken on 21 November 2022 did not identify any areas of concern or action.
- 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. The provider had identified a lead within the organisation to monitor and review compliance.

Requires Improvement

# Are services safe?

- The provider carried out appropriate environmental risk assessments, which took into account the profile of people using the service and those who may be accompanying them.
- There were suitable medicines and equipment to deal with medical emergencies which were stored appropriately and checked regularly. If items recommended in national guidance were not kept, there was an appropriate risk assessment to inform this decision. The provider had access to an automated external defibrillator (AED) within the local vicinity, this was managed by the Landlord of the building. However, the service could not demonstrate how they were assured of the maintenance of this medical device. Following the inspection, the provider had included the risks associated with access to AED on the provider risk register and identified a skills orientation session for all staff.

**Information to deliver safe care and treatment**

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

- Individual care records were not always written and managed in a way that kept patients safe. The care records we viewed showed that information needed to deliver safe care and treatment was not always available to relevant staff in an accessible way. We reviewed a random sample of records and saw that one record did not contain a documented signed consent form for treatment, and another record did not contain GP or emergency contact details. Staff told us that this information would have always been discussed with the patient. Following the inspection, the provider had undertaken an incident review and reviewed and amended the medical record system. All patients identified had been contacted and going forward monthly audits planned to demonstrate quality improvement.
- The service rarely needed to share information with staff and other agencies to enable them to deliver safe care and treatment. However, there were processes in place to share information in accordance with data laws.
- The service had 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.

**Safe and appropriate use of medicines**

**There were gaps in systems for appropriate and safe handling of medicines.**

- The systems and arrangements for managing medicines, emergency medicines and equipment required strengthening. There were gaps in systems in place to check expiry dates for medicines and equipment, for example we identified three medicines which had expired in the medicine cabinet and one expired medicine in the medical fridge. Staff confirmed that the medicines identified had not been administered to patients. Following the inspection to provider submitted evidence to confirm the medicines identified had been disposed of safely, and actions for ongoing weekly monitoring had been put in place. An incident review and learning had been disseminated to all staff.
- A medical emergencies and emergency oxygen risk assessment had been conducted in March 2022. The provider told us plans were in place to provide oxygen on site, however the service had considered the risk of this being required as extremely low.
- The service carried out regular medicines audit to ensure prescribing was in line with best practice guidelines for safe prescribing. For example, the provider had undertaken an Intravenous (IV) infusion therapy audit in November 2022, actions had been identified and future re-audits planned.
- Staff prescribed and administered limited medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. We identified gaps in processes for checking medicines, we saw that staff had kept records of medicines, but these were not always accurate. Where there was a different approach taken from national guidance there was a clear rationale for this that protected patient safety.

**Track record on safety and incidents**

Requires Improvement

# Are services safe?

**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**

**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. Staff confirmed an open-door policy was used to support staff to raise issues.
- There were adequate systems for reviewing and investigating when things went wrong. The service learned and shared lessons, identified themes and took action to improve safety in the service. For example, the provider had taken steps to increase the level of premises security following a security incident and learning had been shared with all staff.
- The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty.
- The service gave affected people reasonable support, truthful information and a verbal and written apology.
- They kept written records of verbal interactions as well as written correspondence.
- The service acted on and learned from external safety events as well as patient and medicine safety alerts. The service had an effective mechanism in place to disseminate alerts to all members of the team.

Requires Improvement

# Are services effective?

**We rated effective as Requires improvement because:**

- The service did not have an established quality improvement programme in place, including second cycle audits.
- The service did not always obtain 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 their service).**

- The provider assessed needs and delivered care in line with relevant and current evidence based guidance and standards such as the National Institute for Health and Care Excellence (NICE) best practice guidelines.
- 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. The provider told us that patients would often return to the service due to high patient satisfaction.
- Staff assessed and managed patients' pain where appropriate.

**Monitoring care and treatment**

**We saw limited evidence of the service being involved in quality improvement activity**.

- The service used information about care and treatment to make improvements. We saw limited evidence that the service made improvements through the use of completed audits. Following the inspection, the provider identified additional audits and had implemented a future audit programme.
- The provider did monitor patient outcomes. They received individual patient feedback and a feedback form was in place to monitor themes and trends.

**Effective staffing**

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

- The Registered Manager was the only clinician who carried out regulated activities which were in scope of registration with the Commission and was appropriately qualified.
- The relevant professional was registered with the Nursing and Midwifery Council and up to date with revalidation.
- The provider understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.

**Coordinating patient care and information sharing**

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

Requires Improvement

# Are services effective?

- Patients received coordinated and person-centred care. Staff referred to, and communicated effectively with, other services when appropriate. For example, the provider would request consent for their GP to be notified and kept informed of their treatment plan to ensure patient safety.
- Before providing treatment, the registered manager ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines history. Staff gave examples of patients being signposted to more suitable sources of treatment.
- Overall 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, however we did identify gaps in this process during our onsite review of medical records.
- The provider had risk assessed the treatments they offered.
- The provider did not always monitor the process for seeking consent appropriately. During the inspection we identified that consent was not always documented within the patient record in a consistent way. It was not always clear from the patient record that consent from the patient had been received.

**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.**

- Due to the nature of the service provided, patients were not routinely given advice on living healthier lives. Where appropriate, staff gave people advice so they could self-care.
- 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 did not always obtain 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. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

Good

# Are services caring?

**We rated caring as Good because:**

- Staff treated patients with kindness, treated them respectfully and involved them in decisions about their treatment.

**Kindness, respect and compassion**

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

- The service sought feedback on the quality of clinical care patients received
- Feedback from patients was positive about the way staff treat 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.**

- Information leaflets were available in easy read formats, to help patients be involved in decisions about their care. Staff told us interpretation services would be available for patients who did not have English as a first language but there had not been an identified need for the service.
- Staff communicated with people in a way that they could understand. Before providing any treatments, people attended for a face to face consultation where the clinician discussed the risk and benefits of any treatment and answered any questions. The clinician also discussed realistic outcomes and the costs involved.

**Privacy and Dignity**

**The service respected patients' privacy and dignity.**

- Staff recognised the importance of people's dignity and respect. Consultations were conducted behind closed doors and conversations could not be overheard.
- 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 patient's needs.

**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 made it clear to patients what services it offered, and the limitations of the service were clear.
- The website for the service was clear and easy to understand. In addition, it contained information of the procedures offered, the risks of the procedure and aftercare advice.
- 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 were fee paying patients who had timely access to initial assessment and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients received after-care treatment advice which included access to the provider should they required assistance following treatment when the clinic was closed.

**Listening and learning from concerns and complaints**

**Although the service had not received any complaints within the last twelve months, they took complaints seriously.**

- Information about how to make a complaint or raise concerns was available.
- 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.
- The service had enrolled with an independent complaints mediator.

Requires Improvement

# Are services well-led?

**We rated well-led as Requires improvement because:**

We found some systems and processes, specifically around medicines management and information needed to deliver safe care and treatment, were not consistently applied and managed.

**Leadership capacity and capability;**

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

- Natasha Lucy Clinics is a limited company of one nurse prescriber, who was also the registered manager and nominated individual.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- They had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service.
- The provider had resourced additional external human resources to support capacity and deliver a high-quality service.

**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. The service had a realistic strategy and supporting business plans to achieve priorities.
- The provider had only been registered with the Commission to carry out regulated activities for a short period of time and was continually reviewing ways to improve services to meet regulations. For example, implementing a clinical audit programme to demonstrate ongoing quality improvement.
- 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.**

- Staff felt respected, supported and valued. They were proud to work for the service.
- Openness, honesty and transparency were demonstrated when responding to incidents. The provider 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. They were given protected time for professional time for professional development.
- There was a strong emphasis on the safety and well-being of all staff.

Requires Improvement

# Are services well-led?

- The service actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

**Governance arrangements**

**There were clear responsibilities, roles and systems of accountability to support good governance and management.**

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective.
- 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.
- The service submitted data or notification to external organisations as required.
- 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.
- The service submitted data or notifications to external organisations as required.
- There were 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 were processes for managing risks, issues and performance, however some of these required strengthening.**

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety. A risk register was being developed to incorporate the ongoing monitoring of risk.
- The service had processes to manage current and future performance. Clinical performance of staff could be demonstrated through internal audit of their consultations. The registered manager had access to external peer review processes. They had oversight of safety alerts, incidents, and complaints.
- Quality improvement undertaken had a positive impact on quality of care and outcomes for patients. The provider had plans in place to review and increase clinical audit activity in the future.
- The provider had plans in place and had trained staff for major incidents.

**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.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.

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

Requires Improvement

# Are services well-led?

**The service involved patients, the public, staff and external partners to support high-quality sustainable services.**

- Patients and staff concerns were encouraged, heard and acted on to shape service and culture.
- There were systems to support improvement and innovation work. The provider had identified opportunities in the future to work with other providers to share expertise and knowledge.
- Staff could describe to us the systems in place to give feedback, which included patient survey and a survey after each consultation.
- Patients were given a two-week cooling off period following initial contact with the provider.

**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 provider had taken a proactive approach to learning from concerns raised during the inspection and had shared the learning with staff.
- The service made use of internal and external reviews of incidents. Learning was shared and used to make improvements.
- 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 | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>How the regulation was not being met:<br><br>The registered person did not do all that was reasonably practicable to ensure the proper and safe management of medicines by failing to:<br><br>Follow policies and procedures about managing medicines, in line with current legislation and guidance to address the storing, dispensing and preparation of medicines. |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>How the regulation was not being met:<br><br>The registered person did not do all that was reasonably practicable to maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of care and treatment, provided to the service user and of decisions taken in relation to the care and treatment provided by failing to:<br><br>Ensure an accurate record of all decisions taken in relation to care and treatment were recorded, this includes consent records and patient verification. |