City Skin Doctor Clinic

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?	Requires Improvement
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? – Requires improvement

Are services responsive? – Good

Are services well-led? – Requires improvement

We carried out an announced comprehensive inspection of City Skin Doctor Clinic on 2 February 2023 as part of our inspection programme. This was the first inspection of this service.

City Skin Doctor Clinic is a medical aesthetic clinic providing surgical, non-surgical and laser treatments.

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. City Skin Doctors Clinic provides a range of non-surgical cosmetic interventions which are not within CQC scope of registration. Therefore, we did not inspect or report on these services.

Our key findings were:

- We found gaps in the mandatory training for staff members, including the appropriate level of safeguarding training. The system for oversight of staff training was not sufficient.
- We found that the practice had a governance framework, however, it was not always effectively managing risks. This included the risks associated with keeping comprehensive clinical records, recording patient safety alerts, ensuring appropriate emergency medicines and equipment were kept on site, keeping comprehensive and up to date staff recruitment files, ensuring the staff immunisation programme was in line with UK Health Security Agency guidance and providing independent interpreter services for patients.
- We did not see evidence of any clinical audits that had been undertaken which identified areas for improvement or evidence of other quality improvement activity.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- The service actively sought and acted on feedback from patients to improve services.

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

In addition to the above, the practice **should**:

Overall summary

- Improve the process for patient identification and audit this process on a regular basis.
- Review and improve infection control processes, in particular in relation to the assembly of sharps bins.
- Review and improve the process and put in place a policy for the handling of pathology results.
- Improve the recording of staff meetings so that notes from meetings were available to staff members.

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

Our inspection team

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

Background to City Skin Doctor Clinic

City Skin Doctor Clinic is an independent health clinic which operates out of 396 Harrow Road, London, W9 2HU and occupies two stories of a building, with consulting rooms and reception on the ground floor, and training academy in the basement floor. The services offered medical services and treatments which included: minor surgery; Endolift; Polydioxanone thread lifts; treatment of hyperhidrosis with Botox; dermal fillers; blepharoplasty; skin rejuvenation; mesotherapy; platelet-rich plasma; medical microdermabrasion; mole removal; vascular lesions; skin spots treatment; acne treatment; rosacea treatment; hyperpigmentation treatment; hair problem treatments; and slimming treatments. The medical services provided were inspected as they are within CQC scope of registration. The clinic offered a range of non-surgical cosmetic treatments which included: laser treatments and facials, which are not within CQC scope of registration and we did not inspect or report on these services.

The service consists of a lead doctor, a laser and beauty therapist, a clinic manager and a receptionist. The reception area is on the ground floor of the building and is accessible to patients with mobility issues. The service is open from 10am to 5pm, Monday to Saturday. The service treats adults over the age of 18 only. The service treats between 100 and 200 patients a month.

The service is registered with CQC to provide the following regulated activities: treatment of disease, disorder or injury; surgical procedures; and services in slimming clinics.

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 found gaps in the mandatory training for staff members. Staff had not received safeguarding children training to the appropriate level. Staff members had not completed external mandatory training.
- We found that the staff immunisation programme was not implemented as per UK Health Security Agency guidance.
- We found gaps in staff recruitment files.
- We found that the service did not keep emergency equipment on site and had not completed a risk assessment for emergency medicines not kept on site.
- We found that the practice had a patient identification policy, however, this was not always being followed.
- We found that clinical records were not always completed comprehensively. In particular, we saw that they did not record the history, consultation and safety netting and signposting advice given to patients in detail.
- We found that the service had a system for managing patient safety alerts but did not keep a log of alerts received.

Safety systems and processes

The service had systems to keep people safe and safeguarded from abuse, however some improvements were required.

- We found gaps in the mandatory training for staff members. We saw when we inspected that staff had not received safeguarding children training to the appropriate level. Staff members had completed some mandatory training, including safeguarding training, with the lead doctor during induction and annually, however we did not have details of the course content. The service told us that it planned to ensure that staff had completed online mandatory training within the next 3 months.
- The service treated adults only (patients over the age of 18). The service had not made any safeguarding referrals. The service told us how it would work with other agencies to support patients and protect them from neglect and abuse if it had any concerns. The service had a safeguarding policy and had completed safeguarding audit risk assessments in January and November 2022.
- The service had undertaken Disclosure and Barring Service (DBS) checks for staff. 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.
- We identified gaps in relation to staff member immunisations. We did not see evidence that the service had checked staff member immunisations. We found that the staff immunisation programme was not implemented as per UK Health Security Agency guidance.
- The service had a chaperone policy and the service manager and therapist acted as chaperones where required. Staff members had received chaperone training from the lead doctor. The new patient welcome pack provided patients with information about arrangements for chaperones at the service.
- During our site visit, we saw some gaps in the recruitment files for staff members. These included the lead doctor's recruitment file, which was not available, curriculum vitae or application forms for staff members, proof of identity, record of immunisations and references for staff members. The service told us that their employment at the clinic was their first job and therefore it was not possible to request references for previous employment. The service showed us copies of staff member identification documents when we requested these, and we provided feedback that these should be saved in staff files.
- There was an effective system to manage infection prevention and control (IPC) at the premises. The lead doctor was the lead for IPC at the service and the service told us that staff employed by the clinic completed the cleaning of the premises. We saw evidence of cleaning rotas, cleaning schedule checklists, and an infection risk assessment that had been completed on 10 January 2022 and 15 December 2022. The service had completed clinical room risk

assessments on 10 February 2022 and 18 December 2022. The service had a Covid-19 policy, which detailed the service's arrangements for IPC and we saw adequate personal protective equipment (PPE) on site. The service told us that IPC training had been provided by the lead doctor at induction and annually. We noted during our site visit that sharps bins had not been signed and dated on assembly.

- An external fire risk assessment was completed by an external company in January 2022 and the service completed an internal health and safety risk assessment on 12 February 2022. We saw evidence of regular fire extinguisher checks and fire alarm and emergency lights checks and fire drill log. The service had completed a ventilation risk assessment (undated) and environmental risk assessment on 12 February 2022, which was due to be reaudited in January 2023. The service completed a legionella risk assessment on 25 January 2022.
- The service ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. The service had a clinical waste disposal policy and there were systems in place for safely managing healthcare waste.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety, however improvements were required.

- The service had a management of deteriorating patients policy and staff members understood their responsibilities to manage emergencies and to recognise those in need or urgent medical attention. We found that whilst there were some emergency medicines kept on site, which were checked routinely by the lead doctor, there was no risk assessment for items not kept on site. The practice did not keep emergency equipment on site, including a defibrillator and oxygen. The service told us that it planned to acquire this emergency equipment in the future.
- We found that the practice had a patient identification policy, however, this was not always being followed. The policy stated that patients must provide patient specific identifiers, including name, and then address or date of birth. We saw evidence when we reviewed a sample of clinical records that this policy was not always complied with. The service told us that would be carrying out an audit of the clinical records to check that the minimum standard was being met.
- There were appropriate indemnity arrangements in place.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients, however improvements were required.

- Individual care records were not written and managed in a way that kept patients safe. The clinical records we reviewed were not always completed comprehensively. In particular, we saw that they did not record the history, consultation and safety netting and signposting advice given to patients in detail. The service told us that a history would be taken from each patient and a consultation would take place, however, this was not always recorded in detail. We noted that the service provided patients with leaflets relevant to their treatments but this was not documented in the clinical records.
- There was a process in place for the sharing of information with staff and other agencies where permission had been provided by patients, to enable them to deliver safe care and treatment. The service told us that would be putting in place a policy for the handling of pathology results.

Safe and appropriate use of medicines

Requires Improvement

Are services safe?

The service had reliable systems for appropriate and safe handling of medicines, however some improvements were required.

- The service had a medicines management and prescribing policy which specified that the service issued prescriptions in hard copy, which were collected by the patient and electronic prescriptions. Prescription pads were kept securely in a locked safe in the lead doctor's office and access to this safe was restricted. The service had a slimming medicines policy and protocol. The service told us that prior to prescribing, blood test monitoring would be completed.
- We did not see any evidence that the service carried out any formal clinical audits in relation to the appropriate and safe handling of medicines to ensure that prescribing was in line with best practice guidelines for safe prescribing.

Track record on safety and incidents

The service had a good safety record.

- Clinical and electrical equipment had been checked to ensure it was working safely.
- 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, however improvements were required.

- The service had not reported or investigated any significant events in the last 12 months.
- Staff we spoke with told us that they understood their duty to raise concerns and report incidents and near misses. The service was aware of the requirements of the duty of candour.
- The service had a system for managing patient safety alerts but did not record alerts centrally when received. We provided feedback to the service that a record of all patient safety alerts should be kept for staff to refer to. The service told us after our inspection that it had a patient alert system in place and would flag on a patient's file if appropriate, however, we did not see evidence to support that patient safety alerts were logged centrally.

Requires Improvement

Are services effective?

We rated effective as Requires improvement because:

- We found that the clinical records did not always include full assessments and patient aftercare information was not always detailed in records and clear about aftercare emergency contacts, and the service did not undertake clinical audits or formal quality assurance activity to review and improve patient care outcomes.

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence-based practice. We saw some evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance (relevant to their service), however improvements were required.

- The service told us that patients' immediate and ongoing needs were fully assessed, however we did not always see evidence of this in the clinical records.
- We did not see consistent evidence in the clinical records that clinicians had enough information to make or confirm a diagnosis.
- We saw no evidence of discrimination when making care and treatment decisions.
- We saw evidence of leaflets provided to patients following their treatment which provided information about aftercare and instructions, however, this was not always recorded in the clinical records. We provided feedback that the leaflets could provide clearer information about who to contact if their condition worsened, and who to contact in an emergency situation, which was consistent across all aftercare information provided to patients.

Monitoring care and treatment

The service was not actively involved in quality improvement activity.

- The service ensured that care and treatment was delivered using current evidence-based guidelines. The service had a quality assurance policy.
- We did not see any evidence that the service carried out any formal clinical audits. We did not see that the service had carried out any prescribing audits to ensure prescribing was in line with best practice. The service provided us with evidence of some audits that had been completed, for example, patient feedback audit, information governance audit, human resources audit, safeguarding audit, control of infection risk audit, clinical room audit, environmental risk audit and ventilation risk audit. The service told us that it had also completed an audit reviewing 'did not attend' appointments and had put in place some strategies to reduce the number of appointments where patients did not attend. The lead doctor told us that they completed a clinical review annually with the British College of Aesthetic Medicine, which reviewed the side effects and complications from treatments. The lead doctor had not had any independent audit or peer review of their practice in the preceding 12 months.

Effective staffing

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

- Staff were appropriately qualified. The relevant professional was registered with the General Medical Council and was up to date with revalidation.
- We identified some gaps in mandatory training of staff, in particular in relation to safeguarding training to an appropriate level.

Requires Improvement

Are services effective?

- The laser and beauty therapist and receptionist had not been employed by the service for 12 months and therefore had not had an appraisal. The clinic manager told us that the lead doctor completed their appraisal. The service told us that appraisals for staff would be completed in the future when appropriate. Staff members had regular supervision sessions where learning and development needs were considered. The lead doctor had their last appraisal in December 2022.

Coordinating patient care and information sharing

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

- Patients received person-centred care. Staff referred to other services where appropriate.
- The service told us that before providing treatment, it ensures they had adequate knowledge of the patient's health and history before treatment, however, this was not always evident in the clinical records.
- The service told us that patients were sometimes asked for their consent to share information with their registered GP. The service told us that generally information was not shared with a patient's registered GP due to the treatment being cosmetic, however, patients would be asked for their consent if required.
- Clinicians made referrals to other specialists and services where appropriate.

Supporting patients to live healthier lives

Staff were 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, the service signposted patients to a dietician if appropriate or to their registered GP.
- 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.

- The service had a client consent policy and 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.
- We saw one clinical record where the consent form had not been completed fully as the clinician had not signed the form.
- The service monitored the process for seeking consent appropriately.

Requires Improvement

Are services caring?

We rated caring as Requires improvement because:

- We found that the service did not have appropriate arrangements for confidential interpretation services for patients who did not have English as a first language.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- The service sought feedback on the quality of clinical care patients received. The service told us that the clinic manager spoke with patients immediately following treatment and at their review appointment, usually 2 weeks post treatment. The service had feedback cards in the reception area where patients could record and provide feedback on the care they had received. The service told us that this feedback was periodically reviewed and discussed during staff meetings, which were usually held every 2 weeks.
- 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, however improvements were required.

- The service told us that patients sometimes required interpreter services and were assisted by family members, friends, and that at times the service asked other patients to assist with translation. The service told us that patient confidentiality was maintained however they had not considered the risks of this for their patients. We provided feedback to the service that requesting family and friends to provide interpretation services was not best practice and that asking other patients to assist with interpretation may breach patient confidentiality. Following our inspection, the service provided us with assurances that it was putting in place plans to provide independent interpretation services for patients and would not be using friends, family or other patients for translation.

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 support and would discuss their needs.

Good

Are services responsive to people's needs?

We rated responsive as Good because:

- Reasonable adjustments were made so that people in vulnerable circumstances could access and use services on an equal basis to others.
- People had timely access to appointments, initial assessment, test results, diagnosis and treatment.
- The service took complaints and concerns seriously and responded to them appropriately to improve the quality of 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 patients and improved services in response to those needs.
- The facilities and premises were appropriate for the services delivered.
- Reasonable adjustments had been made so that people in vulnerable circumstances could access and use services on an equal basis to others. The service had a ramp for access for patients who had mobility issues and the consulting rooms were on the ground floor. The service did not have toilet facilities for patients with mobility issues as the bathroom on the ground floor was only accessible via steps. The service did not have a hearing loop. Staff told us about how they would communicate with patients in a way they could understand, for example, by using communication aids such as writing things down for patients with impaired hearing and providing written information and patient information leaflets.

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.
- Patients were able to book appointments by telephone, email, online and by walking into the clinic. The service provided information sheets to patients with aftercare advice, although this was not documented in the clinical records, some of which included information about what patients should expect, when to seek urgent review and when immediate help could be required. We provided feedback that the information sheets could provide clearer information about who to contact if a patient's condition worsened and who to contact in an emergency situation, which was consistent across all aftercare information provided to patients. The service opening hours were 10am to 5pm, Monday to Saturday, and telephones were diverted to the lead doctor's mobile telephone out of hours.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- The service did not provide home treatments.
- 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.

Good

Are services responsive to people's needs?

- The new patient information pack provided to patients included information on how to make a complaint to the service and the process for management of complaints and the service had a complaints policy. Staff we spoke with were aware of the complaints process and how to escalate concerns raised.
- The service told us that it had received 2 complaints in the previous 12 months. We reviewed 1 of these complaints, which was regarding a patient being unhappy with the outcome of a cosmetic procedure. The service told us that it had made improvements following the receipt of complaints, which included increasing the length of consultations and reviewing consent forms.
- The service provided evidence of a patient feedback report dated 4 August 2022, which included analysis of patient feedback received based on 45 responses. The report did not provide information about the time period where this feedback had been gathered. The report indicated that all feedback analysed was positive about the service.
- The service told us that it discussed incidents, significant events, complaints and patient feedback at staff meetings, however it did not take notes of these meetings. We provided feedback that minutes should be produced for these meetings for staff to refer to.

Requires Improvement

Are services well-led?

We rated well-led as Requires improvement because:

- The practice had a governance framework, however, it was not always effectively managing risks. This included the risks associated with keeping comprehensive clinical records, recording patient safety alerts, ensuring appropriate emergency medicines and equipment were kept on site, keeping comprehensive and up to date staff recruitment files, ensuring the staff immunisation programme was in line with UK Health Security Agency guidance, ensuring staff had up to date mandatory training and providing independent interpreter services for patients.
- We did not see evidence of clinical audits that had been undertaken or other evidence of quality improvement.

Leadership capacity and capability

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

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and told us that they would be addressed.
- Leaders were visible and approachable. They worked closely with staff to make sure they prioritised compassionate and inclusive leadership.

Vision and strategy

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

- The new patient information pack set out the service's vision and values. The service had a realistic strategy and supporting business plans to achieve priorities.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.

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.
- The service focused on the needs of patients.
- The service actively promoted equality and diversity.
- Staff were clear on their roles and accountabilities.

Governance arrangements

There was a lack of good governance in some areas and improvements were required.

- The service had a governance framework, however, it was not always effectively managing risks. This included the risks associated with keeping comprehensive clinical records, recording patient safety alerts, ensuring appropriate emergency medicines and equipment were kept on site (or ensuring risk assessments had been completed), keeping comprehensive and up to date staff recruitment files, ensuring the staff immunisation programme was in line with UK Health Security Agency guidance, ensuring staff had up to date mandatory training and providing independent interpreter services for patients.

Requires Improvement

Are services well-led?

- The service had a clinical system to store patients' medical records securely and maintain privacy of confidential information.

Managing risks, issues and performance

There were processes for managing risks, issues and performance, however some improvements were required.

- There were processes in place to identify, understand, monitor and address current and future risks including risks to patient safety.
- The service had processes to manage current and future performance.
- We did not see evidence of any clinical audits that had been undertaken which identified any areas for improvement.

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.

Engagement with patients, the public, staff and external partners

The service involved patients, the public, staff and external partners 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. The service sought feedback from patients and analysed responses provided.
- Staff told us about the systems in place to give feedback.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation, however some improvements were required.

- The system for oversight of staff training was not sufficient. We found that some staff had not received safeguarding to the appropriate level and had not completed external mandatory training. The service told us that this would be addressed within the next 3 months following the inspection.

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
Services in slimming clinics Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Processes and procedures to keep patients safe were not always effective. **How the regulation was not being met:** In particular we found: • The service did not have emergency equipment, including a defibrillator and oxygen, available on site. The service had not completed a risk assessment for emergency medicines not held on site. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Services in slimming clinics Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Not all systems and processes were established and operated effectively to ensure compliance with requirements to demonstrate good governance. **How the regulation was not being met:** In particular we found: • The service did not always complete clinical records comprehensively, including recording the history, consultation, and safety netting and signposting advice given to patients.

This section is primarily information for the provider

Requirement notices

- The service had a system for managing patient safety alerts but did not keep a log of patient safety alerts received.
- Staff files were not complete and had missing application details, photographic identification and references. Staff had not completed external mandatory training and had not completed safeguarding training to the appropriate level.
- There were gaps in relation to staff member immunisations and the staff immunisation programme was not in line with UK Health Security Agency guidance.
- The service did not undertake clinical audits or formal quality assurance activity to review and improve patient care outcomes.
- The service did not have appropriate arrangements for confidential interpretation services for patients who did not have English as a first language.

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