Dermaspa London LTD

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 Dermaspa London LTD as part of our inspection programme.

The service offers skin-related treatments and treatment for hyperhidrosis (a common condition in which a person sweats excessively).

This service is registered with CQC under the Health and Social Care Act 2008 in respect of some, but not all, of the services it provides. There are some exemptions from regulation by CQC which relate to particular types of regulated activities and services and these are set out in Schedule 1 and Schedule 2 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Dermaspa London LTD provides a range of non-surgical cosmetic interventions, for example, botox injections and dermal fillers which are not within the CQC scope of registration. Therefore, we did not inspect or report on these services.

The 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 was a lack of good governance in some areas.
- Recruitment checks were not always carried out in accordance with regulations including Disclosure and Barring Service (DBS) checks.
- On the day of the inspection, the oxygen cylinder gauge was not connected, and it was not ready for use. This was addressed a few days after the inspection.
- The service was unable to provide documentary evidence to demonstrate that doctors had received formal safeguarding children training and basic life support training relevant to their role.
- There was a lack of information recorded in the consultation notes.
- Staff meeting minutes were not formally documented.
- Annual appraisals were carried out regularly.
- There was an infection prevention and control policy and procedures were in place to reduce the risk and spread of infection.
- Patients were able to access care and treatment in a timely manner.

Overall summary

- Patients were asked for feedback following each appointment. This feedback was logged, analysed and shared with staff.
- We received positive feedback from the 2 patients we spoke with during the inspection.
- The service had systems to manage and learn from complaints.

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.

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

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

- Review and improve the method for checking patients' identity.
- Carry out a documented risk assessment to assess if it is required to keep other emergency medicines in stock.

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

Chief Inspector of Health Care

Our inspection team

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

Background to Dermaspa London LTD

Dermaspa London LTD is an independent clinic in central London.

Services are provided from: 11 Elystan Street, London, SW3 3NT. We visited this location as part of the inspection on 30 August 2023.

The service provides skin-care related treatments.

The service was open to adults only.

Online services can be accessed from the practice website: www.skinplusiq.co.uk

The clinic is open from 10am to 6.30pm Monday to Friday, and 10am to 4pm on Saturday.

The team consists of two doctors. The director is supported by a clinic manager and 3 skin consultants.

The service is registered with the CQC to provide the regulated activity of surgical procedures.

How we inspected this service

Pre-inspection information was gathered and reviewed before the inspection. We spoke with the clinic manager and two skin consultants (therapists) as both doctors were not available during this inspection. We spoke with the director over the telephone a few days after the inspection. We looked at records related to patient assessments and the provision of care and treatment. We also reviewed documentation related to the management of the service. We spoke to 2 patients and reviewed patient feedback collected by the service.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Requires Improvement

Are services safe?

We rated safe as Requires improvement because:

- Recruitment checks were not always carried out in accordance with regulations including Disclosure and Barring Service (DBS) checks.
- The service was unable to demonstrate that the doctors had received child safeguarding training and basic life support training which was appropriate to their role.
- On the day of the inspection, the oxygen cylinder gauge was not connected, and it was not ready for use. This was addressed a few days after the inspection.

Safety systems and processes

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

- The service conducted some 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.
- The service offered healthcare services to adults only. The service had systems to safeguard 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.
- All staff had completed safeguarding adult training appropriate to their role. The doctors had completed safeguarding children training. However, the level of training was not included on the certificate for one doctor and a training certificate was not available for the 2nd doctor. The service was unable to demonstrate that the doctors had received child safeguarding training which was appropriate to their role in line with intercollegiate guidance for all staff working in healthcare settings.
- Evidence of basic life support training was not available for 1 doctor and the 2nd doctor had completed it in 2018.
- We noted that appropriate recruitment checks had not always been undertaken prior to employment. For example, the 2 staff files we reviewed showed that references (satisfactory evidence of conduct in previous employment) had not been undertaken prior to employment for 1 member of staff. Appropriate health checks (satisfactory information about any physical or mental health conditions) had not been undertaken prior to employment and interview notes were not always kept in staff files for either staff. Contracts were available, however, they were not signed by the employer. The confidentiality agreement was not signed by either staff.
- Disclosure and Barring Service (DBS) checks were not always undertaken where required or not always kept in staff files. For example, on the day of the inspection, evidence of DBS checks was not available for either doctor. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). The skin consultant and the clinical manager had received a 'basic' DBS which was not appropriate to their role. The service had not carried out any risk assessment to mitigate the risks this may pose to patients.
- The clinic manager who acted as a chaperone was trained for the role. However, we noted that they had received a 'basic' DBS check, which was not appropriate to their role and an appropriate risk assessment was not completed.
- There was a system to manage infection prevention and control. An infection control audit was carried out on 13 March 2023.
- The service carried out legionella risk assessments on 25 August 2021 and on 2 September 2022. We noted regular water temperature checks had been carried out (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- 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 carried out appropriate environmental risk assessments, which took into account the profile of people using the service and those who may be accompanying them.

Requires Improvement

Are services safe?

- On registering with the service, a patient's identity was not verified. Patients were able to register with the service by verbally providing a date of birth and address. At each consultation, patients confirmed their identity face to face. They were able to pay by debit or credit card and cash.

Risks to patients

There were ineffective 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 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.
- There was equipment available to deal with medical emergencies. However, the non-clinical staff on duty were unable to demonstrate whether the oxygen cylinder was in working order. On the day of the inspection, the oxygen cylinder gauge was not connected, and it was not ready for use. A few days after the inspection, the service informed us that the gauge was connected and the oxygen cylinder was in working order.
- Staff on duty were unable to demonstrate how to carry out a defibrillator self-test. This was carried out on the day of the inspection, and it was in working order. The monthly checklist log displayed a dash instead of a tick every month, so it was unclear whether the defibrillator had been checked.
- The service had adrenaline as emergency medicine in the stock. The service had not carried out a documented risk assessment to assess if they were required to keep other emergency medicines.
- 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.

- Individual care record was written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The service had 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

The service had reliable systems for appropriate and safe handling of medicines.

- The service offered a range of aesthetic services (including botox injections and dermal fillers), which were out of the scope of this inspection. In addition, the service offered one appointment in the last 12 months for the treatment for hyperhidrosis (a common condition in which a person sweats excessively).
- The service had not carried out a medicines audit as they did not prescribe any medicines. They did not treat acute or long term conditions.
- The service did not prescribe Schedule 2 and 3 controlled drugs (medicines that have the highest level of control due to their risk of misuse and dependence). Neither did they prescribe schedule 4 or 5 controlled drugs.
- The fridge temperature was monitored regularly and records were maintained.

Track record on safety and incidents

The service had a good safety record.

Requires Improvement

Are services safe?

- The premises was well maintained and the facilities were satisfactory. There were comprehensive risk assessments in relation to safety issues.
- The service had an up-to-date fire risk assessment (2 July 2021) in place and they were carrying out regular fire safety checks.
- The fire extinguishers were serviced annually.
- The fire drills were carried out.
- The electrical installation condition checks of the premises had been carried out in May 2020.
- 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. There had been no significant events.
- There were adequate systems for reviewing and investigating when things went wrong.
- 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:

- There was a lack of information recorded in the consultation notes.

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence based practice.

- The service had developed a documented policy to ensure that patients' needs were fully assessed and they received care and treatment supported by clear clinical pathways and protocols.
- The service offered a range of aesthetic services (including botox injections and dermal fillers), which were out of the scope of this inspection.
- We found a lack of information within the set of consultation notes we reviewed. The outcome of the assessment was not clearly recorded and presented with explanations to make their meaning clear.

Monitoring care and treatment

The service was actively involved in quality improvement activity.

- The service carried out a record keeping audit to ensure effective monitoring and assessment of the quality of the service.
- The service carried out a regular housekeeping audit.
- They carried out a healthcare waste audit.
- They carried out treatment room monitoring and decontamination audits.
- The service was regularly collecting the patient's feedback to monitor the effectiveness of the treatment provided.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. However, some improvements were required.

- All staff were appropriately qualified. The provider had an induction programme for all newly appointed staff.
- Relevant professionals were registered with the General Medical Council (GMC) and the General Dental Council (GDC) and were up to date with revalidation.
- The service understood the learning needs of staff and provided protected time and training to meet them. However, we found some gaps in safeguarding children and basic life support training.
- All staff had received an appraisal within the last 12 months.

Coordinating patient care and information sharing

Staff worked well together to deliver effective care and treatment.

- Patients received coordinated and person-centred care. However, most of the services offered were out of the scope of this inspection.
- Before providing treatment, doctors at the service ensured they had adequate knowledge of the patient's health and clinical history.
- Patient information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.

Supporting patients to live healthier lives

Requires Improvement

Are services effective?

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.
- The service informed us that if risk factors were identified, then patients were advised to contact their normal care provider for additional support.
- Where patients needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Consent to care and treatment

The service obtained consent to care and treatment in line with legislation and guidance.

- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The service monitored the process for seeking consent appropriately.

Good

Are services caring?

We rated caring as Good because:

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- The service sought feedback on the quality of clinical care patients received.
- We spoke with two patients over the telephone during this inspection. Feedback from patients was positive about the way staff treated people.
- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

- Interpretation services were available for patients who did not have English as a first language.
- The service gave patients clear information to help them make informed choices. The information included details of the scope of services offered and information on fees.
- Patients told us through telephone discussion, that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.
- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect.
- Staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

Good

Are services responsive to people's needs?

We rated responsive as Good because:

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.

- Patients' individual needs and preferences were central to the planning and delivery of tailored services.
- 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 offered consultations to anyone who requested and paid the appropriate fee and did not discriminate against anyone.
- They provided services to patients with an ethos of providing individualised care and treatment, considering and respecting the wishes of its patients.

Timely access to the service

Patients were able to access care and treatment from the service within an appropriate timescale for their needs.

- Patients had timely access to initial assessment and treatments.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that the appointment system was easy to use.
- Appointments were available between 10am and 6.30pm Monday to Friday and 10am to 4pm on Saturdays.
- The service was not an emergency service. Patients who had a medical emergency were advised to seek immediate medical help via 999 or if more appropriate to contact their own GP or NHS 111.

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The service informed patients of any further action that may be available to them should they not be satisfied with the response to their complaint.
- The service had a complaint policy and procedures in place. The service learned lessons from individual concerns, complaints and from analysis of trends. It acted as a result to improve the quality of service. For example, the service offered customer service training to the staff members.

Requires Improvement

Are services well-led?

We rated well-led as Requires improvement because:

- There was a lack of good governance in most areas, which included emergency medicines and equipment, recruitment checks and staff training.
- Staff meetings were not formally documented.

Leadership capacity and capability;

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

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. However, they were required to make improvements.
- Staff we spoke with informed us that leaders were approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.

Vision and strategy

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

- The service had the vision to provide a high-quality person-centred service.
- The service had a strategy and supporting to achieve priorities. However, the service did not always monitor the progress against the 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.
- The service focused on the needs of patients.
- Openness, honesty and transparency were demonstrated when responding to complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they needed. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year.
- There was a strong emphasis on the safety and well-being of all staff.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

There was a lack of good governance and improvements were required. For example:

- The service had established proper policies and procedures. However, they were not working as intended. For example, we found gaps in recruitment checks including DBS and staff training. Some documents were not kept in staff files.
- Staff meeting minutes were not formally documented.
- Staff were clear on their roles and accountabilities.

Requires Improvement

Are services well-led?

Managing risks, issues and performance

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

- There were some arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. However, monitoring of specific areas required improvement, such as emergency equipment and there was a lack of information in the consultation notes.
- The audits were carried out to monitor the quality of service and outcomes for patients.
- The service had plans in place and had trained staff for major incidents.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Patient assessments and consultation notes were recorded on a secure electronic system.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.
- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- The service used performance information which was reported and monitored and management and staff were held to account.
- The service was registered with the Information Commissioner's Office (ICO).

Engagement with patients, the public, staff and external partners

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

- The service encouraged and valued feedback from patients. These were reviewed and considered by the provider.
- There were examples of compliments received by the service. We saw a number of positive comments documented on the online review websites at the time of our inspection. This was highly positive about the quality of service patients received.

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement. However, some staff had not received formal training relevant to their role.
- The service made use of complaints. Learning was shared and used to make improvements.

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
Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The provider had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular, we found: • On the day of the inspection, the oxygen cylinder gauge was not connected, and it was not ready for use. This was addressed a few days after the inspection. • There was a lack of information in the consultation notes. The outcome of the assessment was not clearly recorded and presented with explanations to make their meaning clear. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Surgical procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The provider had not done all that was reasonably practicable to assure systems and processes were established and operated effectively to ensure compliance with requirements to demonstrate good governance. • There was a lack of good governance in some areas. • Recruitment checks were not always carried out in accordance with regulations including Disclosure and Barring Service (DBS) checks. • Staff meeting minutes were not formally documented.

This section is primarily information for the provider

Requirement notices

- The service was unable to provide documentary evidence to demonstrate that doctors had received formal safeguarding children training and basic life support training relevant to their role.

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