Announced Care Inspection Report
18 October 2016

Medi-Cosmetic

Type of Service: Cosmetic Independent Hospital (IH) – Cosmetic Laser/IPL Service
Address: 683A Shore Road, Newtownabbey, BT37 0ST
Tel No: 028 9086 1186
Inspectors: Emily Campbell and Liz Colgan

1.0 Summary

An announced inspection of Medi-Cosmetic took place on 18 October 2016 from 09.50 to 12.40.

The inspection sought to assess progress with any issues raised during and since the last care inspection and to determine if the cosmetic laser/IPL service was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

Observations made, review of documentation and discussion with Mrs Denise Beck, registered person, demonstrated that further development is needed to ensure that care provided to clients is safe and avoids and prevents harm. Areas reviewed included laser safety, staffing, recruitment and selection, safeguarding, management of medical emergencies, infection prevention control and decontamination and the general environment. A requirement has been made that a fire risk assessment is developed and reviewed on an annual basis. Four recommendations have been made in relation to the development of a formal induction programme, further development of recruitment processes, fire safety training and evacuation drills and safeguarding adults at risk of harm policy review and training.

Is care effective?

Observations made, review of documentation and discussion with Mrs Denise Beck, registered person, and staff demonstrated that systems and processes were in place to ensure that care provided in the establishment was effective. Areas reviewed included care pathway, audits and communication. No requirements or recommendations have been made.

Is care compassionate?

Observations made, review of documentation and discussion with Mrs Denise Beck demonstrated that arrangements are in place to promote clients' dignity, respect and involvement in decision making. No requirements or recommendations have been made.

Is the service well led?

Information gathered during the inspection evidenced that in general there was effective leadership and governance arrangements in place which creates a culture focused on the needs clients in order to deliver safe, effective and compassionate care. Areas reviewed included organisational and staff working arrangements, the arrangements for policy and risk assessment reviews, the arrangements for dealing with complaints, incidents and alerts, insurance arrangements and the registered person's understanding of their role and responsibility in accordance with legislation. No requirements or recommendations have been made. However, as discussed previously issues were identified in relation to fire safety, induction, recruitment and selection and safeguarding under the 'is care safe' domain which all relate to quality assurance and good governance. Addressing the requirement and recommendations made will further enhance the quality and governance arrangements already in place.

This inspection was underpinned by The Independent Health Care Regulations (Northern Ireland) 2005, The Regulation and Improvement Authority (Independent Health Care) (Fees and Frequency of Inspections) (Amendment) Regulations (Northern Ireland) 2011 and The

Department of Health, Social Services and Public Safety (DHSPPS) Minimum Care Standards for Independent Healthcare Establishments (July 2014).

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	1	4

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Denise Beck, registered person, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action did not result from the findings of this inspection.

1.2 Actions/enforcement taken following the most recent care inspection

There were no further actions required to be taken following the most recent inspection on 18 October 2015.

2.0 Service details

Registered organisation/registered person: Denise Beck	**Registered manager:** Denise Beck
Person in charge of the home at the time of inspection: Denise Beck	**Date manager registered:** 03 December 2012
Categories of care: Independent Hospital (IH) - PT(IL) Prescribed techniques or prescribed technology: establishments using intense light sources	

IPL equipment

Manufacturer: Ellipse
Model: Light
Serial Number: 080411117

Laser protection advisor (LPA) - Dr Anna Bass (Lasermet)

Laser protection supervisor (LPS) – Mrs Denise Beck

Medical support services - Dr Paul Myers (Lasermet)

Authorised users - Denise Beck, Rebecca Hutton, Shannon Donnelly and Aimee Simms

Types of treatment provided - Hair removal, skin rejuvenation, thread vein removal, acne treatments.

3.0 Methods/processes

Questionnaires were provided to clients and staff prior to the inspection by the establishment on behalf of the RQIA. Prior to inspection we analysed the following records: complaints declaration and returned completed staff and client questionnaires.

During the inspection the inspector met with Mrs Denise Beck; no other authorised users were present.

Records were examined during the inspection in relation to the following areas:

- staffing
- recruitment and selection
- safeguarding
- laser safety
- management of medical emergencies
- infection prevention and control
- information provision
- care pathway
- management and governance arrangements
- maintenance arrangements

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 30 June 2015

The most recent inspection of the Medi-Cosmetic was an announced care inspection. No requirements or recommendations were made during this inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 30 June 2015

As above.

4.3 Is care safe?

Staffing

Discussion with Mrs Beck, confirmed that there is sufficient staff in the various roles to fulfil the needs of the establishment and clients.

Mrs Beck confirmed that IPL treatments are only carried out by authorised users. A register of authorised users for the IPL is maintained and kept up to date.

A review of the personal file of one new staff member indicated that there is no formal written induction programme. Mrs Beck confirmed that new staff are given an informal verbal induction. A recommendation was made that a formal written induction programme is developed and copies of completed inductions are retained in the personnel files of any new staff recruited.

A review of training records evidenced that authorised users have up to date training in core of knowledge training, application training for the equipment in use, basic life support, infection prevention and control. Mrs Beck stated that fire safety training had been provided, however, no records were available at the time of the inspection. Fire drills had not been carried out; these should be undertaken as least annually. A recommendation was made that fire safety awareness training is provided and fire drills undertaken on at least an annual basis. Records should be retained for inspection.

All other staff employed at the establishment, but not directly involved in the use of the IPL equipment, had received laser safety awareness training.

Discussion with Mrs Beck and review of documentation confirmed that authorised users take part in appraisal on an annual basis.

Recruitment and selection

Review of one personnel file of an authorised user recruited since the previous inspection and discussion with Mrs Beck confirmed that the staff member was not fully recruited as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005. The reviewed file did not contain evidence of written references, health assessment and declaration of a criminal conviction. A recommendation was made in this regard. Mrs Beck stated that she attempted to obtain references from previous employer but was unable to do.

Safeguarding

Mrs Beck was generally aware of the types and indicators of abuse and the actions to be taken in the event of a safeguarding issue being identified.

Review of records demonstrated that all staff in the establishment had not received training in safeguarding adults as outlined in the Minimum Care Standards for Independent Healthcare Establishments July 2014

Policies and procedures were in place for the safeguarding and protection of adults and children. A recommendation was made to revise the policy and procedure for adult protection in accordance to the new regional guidance Adult Safeguarding Prevention and Protection in

Partnership (July2015) and to provide training for staff on the revised policy. A copy of the relevant contact details for onward referral to the local Health and Social Care Trust should a safeguarding adults at risk of harm issue arise, was shared with Mrs Beck during inspection.

IPL safety

A laser safety file was in place which contained all of the relevant information in relation to IPL equipment.

There was written confirmation of the appointment and duties of a certified laser protection advisor (LPA) which is reviewed on an annual basis. The service level agreement between the establishment and the LPA was reviewed and this expires on 1 November 2016.

Laser procedures are carried out by trained operators in accordance with medical treatment protocols produced by Dr Paul Myers (Lasermet). Systems are in place to review the medical treatment protocols on an annual basis. The medical treatment protocols contained the relevant information pertaining to the treatments being provided.

Local rules were in place developed by the LPA. The local rules contained the relevant information pertaining to the IPL equipment being used. The rules needed to be updated to reflect the change of laser protection supervisor (LPS). Mrs Beck emailed updated local rules following the inspection, on the 24 October 2016 which confirmed that Mrs Beck is now the LPS.

The establishment's LPA completed a risk assessment of the premises on 2 November 2015; no recommendations were made. The next review is due on 1 November 2016.

The laser protection supervisor (LPS) has overall responsibility for safety during laser treatments and a list of authorised users is maintained. Authorised users have signed to state that they have read and understood the local rules and medical treatment protocols.

When the IPL equipment is in use, the safety of all persons in the controlled area is the responsibility of the LPS. Arrangements are in place for another authorised user, who is suitably skilled to fulfil the role, to deputise for the LPS in their absence. Discussion with Mrs Beck confirmed that systems are in place to ensure other authorised users are aware of who the LPS on duty is. The environment in which the IPL equipment is used was found to be safe and controlled to protect other persons while treatment is in progress. The door to the treatment room is locked when the IPL equipment is in use but can be opened from the outside in the event of an emergency.

The IPL equipment is operated using a key. Arrangements are in place for the safe custody of the IPL key when not in use. Protective eyewear is available for the client and operator as outlined in the local rules.

The controlled area is clearly defined and not used for other purposes, or as access to areas, when treatment is being carried out. Laser safety warning signs are displayed when the laser equipment is in use and removed when not in use.

The establishment has an IPL register which is completed every time the equipment is operated and includes:

- the name of the person treated
- the date
- the operator
- the treatment given
- the precise exposure
- any accident or adverse incident (added at the time of inspection)

There are arrangements in place to service and maintain the IPL equipment in line with the manufacturer's guidance. The most recent service report of 17 June 2016 was reviewed as part of the inspection process.

Management of emergencies

As discussed, authorised users have up to date training in basic life support. Discussion with staff confirmed they were aware what action to take in the event of a medical emergency.

There was a resuscitation policy in place.

Infection prevention and control and decontamination procedures

The treatment room was clean and clutter free. Discussion with Mrs Beck evidenced that appropriate procedures were in place for the decontamination of equipment between use. Hand washing facilities were available and adequate supplies of personal protective equipment (PPE) were provided. As discussed previously, authorised users have up to date training in infection prevention and control.

Environment

The premises were maintained to a good standard of maintenance and décor. Cleaning schedules for the establishment were in place.

Observations made evidenced that a carbon dioxide (CO2) fire extinguisher is available which has been serviced within the last year.

The fire risk assessment could not be located and Mrs Beck agreed to email this to RQIA. A document was emailed to RQIA on 28 October 2016; however, on review, it was identified that the submitted document was a fire safety policy and evacuation protocol, not a fire risk assessment. A requirement was made that a fire risk assessment should be completed and reviewed on an annual basis. The fire risk assessment should be retained in the establishment and available for inspection. Advice and guidance can be obtained from the Health and Safety Executive, Northern Ireland (HSENI) and the Northern Ireland Fire and Rescue Service in this regard. As discussed previously a recommendation was made to provide fire safety awareness training and implement fire drills.

Staff views

Two client questionnaires submitted had been filled in by staff in error; therefore no questionnaires from clients were received by RQIA.

Three staff submitted questionnaire responses. All indicated that they felt that clients are safe and protected from harm. No comments were included in submitted questionnaire responses.

Areas for improvement

- Develop a formal induction programme and retain copies of completed induction records in the personnel files of any new staff recruited.
- Fire safety awareness training should be provided and fire drills undertaken at least on an annual basis. Records should be retained for inspection.
- The recruitment and selection process should be further developed to include two written references, one of which should be the current/most recent employer, a health assessment and a criminal conviction declaration in respect of any new staff recruited.
- The policy and procedure for adult protection should be further developed in accordance to the new regional guidance and training provided to staff.
- A fire risk assessment should be developed and reviewed on an annual basis. The fire risk assessment should be retained in the establishment and available for inspection.

Number of requirements	1	Number of recommendations	4

4.4 Is care effective?

Care pathway

Clients are provided with an initial consultation to discuss their treatment and any concerns they may have. Written information is provided to the client pre and post treatment which outlines the treatment provided, any risks, complications and expected outcomes. The establishment has a list of fees available for each IPL procedure. Fees for treatments are agreed during the initial consultation and may vary depending on the type of treatment provided and the individual requirements of the client.

During the initial consultation, clients are asked to complete a health questionnaire. There are systems in place to contact the client's general practitioner, with their consent, for further information if necessary.

Five client care records were reviewed. There is an accurate and up to date treatment record for every client which includes:

- client details
- medical history
- signed consent form
- skin assessment (where appropriate)
- patch test (where appropriate)
- record of treatment delivered including number of shots and fluence settings (where appropriate)

Observations made evidenced that client records are securely stored. A policy and procedure is available which includes the creation, storage, recording, retention and disposal of records and data protection.

Mrs Beck confirmed the establishment is registered with the Information Commissioners Office (ICO) and a copy of the ICO registration certificate was emailed to RQIA on 28 October 2016 confirming this.

Communication

As discussed, there is written information for clients that provides a clear explanation of any treatment and includes effects, side-effects, risks, complications and expected outcomes. Information is jargon free, accurate, accessible, up-to-date and includes the cost of the treatment.

The establishment has a policy for advertising and marketing which is in line with legislation.

Mrs Beck confirmed that staff meetings are held on a three monthly basis.

Staff views

All questionnaire responses submitted by staff indicated that they felt that clients get the right care, at the right time and with the best outcome for them. No comments were included in submitted questionnaire responses.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	**Number of recommendations**	0

4.5 Is care compassionate?

Dignity respect and involvement with decision making

Discussion with Mrs Beck regarding the consultation and treatment process, confirmed that clients are treated with dignity and respect. The consultation and treatment is provided in a private room with the client and authorised user present. Information is provided to the client in verbal and written form at the initial consultation and subsequent treatment sessions to allow the client to make choices about their care and treatment and provide informed consent.

Appropriate measures are in place to maintain client confidentiality and observations made evidenced that client care records were stored securely in a locked cabinet in a locked room.

Mrs Beck confirmed that client satisfaction surveys are carried out by the establishment on an annual basis and the results of these are collated to provide a summary report which is made available to clients and other interested parties. This survey was not available at the time of the inspection but was forwarded to RQIA on 24 October 2016. Mrs Beck was requested to include details of the period that the consultation pertained to, the number of questionnaire responses collated and to add client comments if any. Mrs Beck confirmed by email that these had been included and that the results would be made available to clients and include any actions taken as a result of the survey.

Staff views

All questionnaire responses submitted by staff indicated that they felt that clients are treated with dignity and respect and are involved in decision making affecting their care. No comments were included in submitted questionnaire responses.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	**Number of recommendations**	0

4.6 Is the service well led?

Management and governance

There was a clear organisational structure within the establishment and Mrs Beck, who is an authorised user, was able to describe roles and responsibilities. No other authorised users were available to speak with at the time of the inspection. Arrangements were in place to facilitate annual staff appraisal. Mrs Beck has overall responsibility for the day to day management of the service.

Policies and procedures were available for staff reference. Observations made confirmed that policies and procedures were indexed, dated and systematically reviewed on a three yearly basis.

A copy of the complaints procedure was available in the establishment. Discussion with Mrs Beck demonstrated good awareness of complaints management. A complaints questionnaire was forwarded by RQIA to the establishment for completion. The returned questionnaire indicated that no complaints have been received for the period 1 April 2015 to 31 March 2016.

Discussion with Mrs Beck confirmed that a system was in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies as appropriate. A system was in place to ensure that urgent communications, safety alerts and notices are reviewed and where appropriate, made available to key staff in a timely manner.

Discussion with Mrs Beck confirmed that arrangements were in place to monitor, audit and review the effectiveness and quality of care delivered to clients at appropriate intervals. Mrs Beck confirmed that if required an action plan would be developed and embedded into practice to address any shortfalls identified during the audit process. As discussed previously issues were identified in relation to fire safety, induction, recruitment and selection and safeguarding under the ‘is care safe’ domain which all relate to quality assurance and good governance. Addressing the requirement and recommendations made will further enhance the quality and governance arrangements in place.

A whistleblowing/raising concerns policy was available.

Mrs Beck demonstrated a clear understanding of her role and responsibility in accordance with legislation. However, information requested by RQIA, for example, completed QIPs, has not always been submitted within the specified timeframes. Mrs Beck should ensure attention is paid in relation to this matter regarding future requests. Mrs Beck confirmed that the statement of purpose and client's guide are kept under review, revised and updated when necessary and available on request.

The RQIA certificate of registration was up to date and displayed appropriately.

Observation of insurance documentation confirmed that current insurance policies were in place.

Staff views

All questionnaire responses submitted by staff indicated that they felt that the service is well led. No comments were included in submitted questionnaire responses.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	**Number of recommendations**	0

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mrs Denise Beck, registered person, as part of the inspection process. The timescales commence from the date of inspection.

The registered person/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered person/manager to ensure that all requirements and recommendations contained within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the IH-Cosmetic Laser\Intense Pulsed Light. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The Independent Health Care Regulations (Northern Ireland) 2005, The Regulation and Improvement Authority (Independent Health Care) (Fees and Frequency of Inspections) (Amendment) Regulations (Northern Ireland) 2011.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The DHSSPS Minimum Care Standards for Independent Healthcare Establishments(July 2014). They promote current good practice and if adopted by the registered person(s) may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to Independent.Healthcare@rqia.org.uk for assessment by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan	
Statutory requirements	
Requirement 1 **Ref**: Regulation 4 (f) **Stated:** First time	The registered provider must ensure a fire risk assessment is developed and reviewed on an annual basis. The fire risk assessment should be retained in the establishment and available for inspection.
To be completed by: 18 December 2016	**Response by registered provider detailing the actions taken:** Fire risk assessment completed.
Recommendations	
Recommendation 1 **Ref**: Standard 13.3 **Stated:** First time	A formal written induction programme should be developed. Copies of completed induction records should be retained in the personnel files of any new staff recruited.
To be completed by: 18 December 2016	**Response by registered provider detailing the actions taken:** Completed.

Recommendation 2 **Ref**: Standard 24 **Stated:** First time **To be completed by:** 18 December 2016	Fire safety awareness training should be provided and fire drills undertaken on at least an annual basis. Records should be retained for inspection.
	Response by registered provider detailing the actions taken: Achieved.
Recommendation 3 **Ref**: Standard 14.2 **Stated:** First time **To be completed by:** 18 October 2016	Recruitment and selection procedures should be further developed to ensure the following are obtained and details retained in personnel files on recruitment of new staff: • two written references, one of which should be from the current/most recent employer • a health assessment • criminal conviction declarations on application
	Response by registered provider detailing the actions taken: New application forms for all new Staff
Recommendation 4 **Ref**: Standard 3 **Stated:** First time **To be completed by:** 18 December 2016	The policy and procedure for adult protection should be further developed in accordance to the new regional guidance Adult Safeguarding Prevention and Protection in Partnership (July2015) and training provided to staff. Training records should be retained.
	Response by registered provider detailing the actions taken: Iasecnet contacted re new Policy. Awaiting Reply.

Please ensure this document is completed in full and returned to Independent.Healthcare@rqia.org.uk from the authorised email address

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