Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

# Quality Check Summary
# Emerald Tattoo Company
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Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or via

Phone: 0300 062 8163

Email: hiw@gov.wales

Website: www.hiw.org.uk

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# Quality Check Summary

## Our approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Emerald Tattoo Company as part of its programme of assurance work. The service is located in Talbot Green and provides laser tattoo removal for adults over the age of 18.

HIW's quality checks form part of a new tailored approach to assurance and are one of a number of ways in which it examines how healthcare services are meeting the Independent Health Care (Wales) Regulations 2011. Feedback is made available to service representatives at the end of the quality check, in a way which supports learning, development and improvement at both operational and strategic levels.

Quality checks are a snapshot of the standards of care within healthcare services. They are conducted entirely offsite and focus on three key areas; infection prevention and control, governance (specifically around staffing) and the environment of care. The work explores arrangements put in place to protect staff and patients from COVID 19, enabling us provide fast and supportive improvement advice on the safe operation of services during the pandemic. More information on our approach to assurance and inspections can be found here.

We spoke to the registered manager on 29 November 2021 who provided us with information and evidence about their service. We used the following key lines of enquiry:

- How are you ensuring that the infection prevention and control (IPC) and cleaning regimes are effective in order to keep staff, patients and visitors safe?
- How are you ensuring that the environment is safe for staff, patients and visitors, and how patient dignity is maintained? What changes, if any, have been made as a result of COVID-19?
- How do you meet the needs of Welsh speaking patients when accessing healthcare services in the medium of Welsh?
- How are you ensuring that staff are appropriately trained in order to provide safe and effective care?
- How are you ensuring that treatment is provided in a safe and effective manner, including how laser equipment is appropriately maintained?

## Environment

During the quality check, we considered how the service has responded to the challenges presented by COVID-19 and how the service has designed and managed the environment of care to keep it as safe as possible for patients, staff and visitors.

The key documents we reviewed included:

- Environmental risk assessment
- Fire safety policy
- Fire risk assessment
- Fire extinguisher servicing certificate
- Insurance liability certificate

We also questioned the service representatives on the changes they have made to make sure patients continue to receive care and treatment according to their needs.

**The following positive evidence was received:**

The registered manager described a range of steps the service had taken in response to the pandemic to help promote a safe environment. These included hand sanitising stations throughout the studio; floor markers, posters and spacing seating within the waiting area to maintain social distancing. In addition, the service has an air filtration unit and implemented a staggered start time for staff. A screen has been installed in the reception area to protect staff. We were told that appropriate Personal Protective Equipment (PPE) is being used by staff and patients are asked to wear a mask, unless they are exempt.

We were told that the service received and implemented guidance and advice from government announcements as well as from their Laser Protection Adviser (LPA). The advice has enabled them to implement the changes listed above which help provide a safer environment for their staff and patients.

We saw evidence to confirm an environmental risk assessment had been completed in July 2021. The assessment does not highlight any outstanding actions for the setting to complete. The fire extinguishers had been serviced within the last 12 months and a fire risk assessment completed in March 2021.

We confirmed that there was a valid public liability insurance certificate in place. The manager provided us with a series of documents outlining their approach to risk assessments in the workplace, routine checks of the environment, equipment and items used within the clinic and fire safety.

Dignity and confidentiality are preserved as only one client is present in the laser room at any one time. We were told that staff leave the room to allow a client to change and

disposable dignity towels are provided where applicable. The patients' journey is discussed with them prior to any treatment starting.

**The following areas for improvement were identified:**

We were told that the clinic does not routinely offer bilingual information and services to their patients and that this has not been requested to date. However, the registered manager told us she is able to converse in Welsh should this be requested.

We therefore recommend that a review of Standard 18 of the National Minimum Standards (Communicating Effectively) which states that information is provided in a format that takes into account the needs of service user. In addition Regulation 9 (1) (g) of the Independent Health Care (Wales) Regulations 2011 requires the registered provider to have a policy in place that outlines how they provide information to patients. This policy should set out how the service is going to approach the need to communicate and provide information in Welsh should a patient request it.

## Infection prevention and control

During the quality check, we considered how the service has responded to the challenges presented by COVID-19, and how well it manages and controls the risk of infection to help keep patients, visitors and staff safe.

The key documents we reviewed included:

- Infection prevention control policy
- Cleaning schedules
- Post treatment cleaning list
- Studio risk assessment

**The following positive evidence was received:**

The registered manager described a range of steps the service had taken in response to the pandemic to help promote good IPC practices. These included use of appropriate PPE by staff and patients at all times, cleaning schedule for daily tasks and after every client, including door handles, treatment bench and eye protector glasses. Hand sanitising stations and hand washing sinks for staff and patients.

We were told that patients are asked to complete a COVID-19 screening tool electronically in advance of their appointment and that they are checked again for symptoms when they

arrive on the day of their appointment. The registered manager added that patients are asked to wear appropriate PPE to their appointment and that appropriate hand hygiene facilities are provided.

The studio risk assessment dated July 2021 identified a list of environmental hazards and also included how COVID-19 was being managed. The risk assessment documented the action taken to control the risk, the person/s responsible and timescales. The IPC policy and cleaning schedules had been updated in light of COVID-19.

The registered manager informed us that all paper copies of the patient guide had been removed from the clinic (now available via their website or printed specifically for a patient) in order to reduce the risk of cross contamination and appropriate PPE was being used by staff and patients.

**No areas for improvements were identified.**

## Governance / Staffing

As part of this standard, HIW questioned the service representatives about how, in the light of the impact of COVID-19, they have adapted their service. We explored whether management arrangements ensure that staff are suitable in their roles and are appropriately trained in order to provide safe and effective care.

The key documents we reviewed included:

- Safeguarding training certificates
- Safeguarding policy
- Core of knowledge certificates
- Patients guide
- Online consultation forms, including medical history and COVID-19 questionnaire
- Treatment and medical protocols
- Local rules
- LPA risk assessment

**The following positive evidence was received:**

We were provided with evidence to confirm the laser operators had attended the Core of Knowledge course for continuing professional development. Certificates were also provided that confirmed staff had successfully completed training in the use of the laser.

The registered manager confirmed that the service complies with their condition of registration to only treat patients over the age of 18 years old. The procedures the service will follow in the event of any safeguarding concerns were detailed in their safeguarding policy. We saw certification that the laser operators had completed level 4 safeguarding training.

We were told of the checks that would be completed if new staff were to start at the studio to ensure their suitability. We received confirmation that DBS checks had been undertaken for the laser operators.

We were provided with the latest copy of the services' statement of purpose which contained all the relevant information required by the Regulations.

**The following areas for improvement were identified:**

We recommended that the registered manager review their safeguarding policy to include the contact details of the local authority safeguarding team. In addition, consideration should also be given towards the advice, guidance and legislation referenced in the All-Wales safeguarding procedures.

## Safe and effective care

During the quality check, we considered how the service has delivered treatment safely and effectively to patients. We considered the arrangements in place to explain treatments to patients, how treatment needs are assessed and how the service manages the risks associated with the laser equipment.

**The following positive evidence was received:**

The registered manager confirmed that all patients complete an online consultation as well as having a face-to-face discussion prior to the start of any treatment. This includes providing patients with information and allowing potential patients time to consider their treatment options.

Medical histories are collected as part of the consultation to ensure suitability of the chosen treatment. These are checked and signed by the patient for any changes before any additional treatment. The registered manager confirmed that treatment protocols and suitable medical advice would be sought if there was any doubt as to the suitability of a chosen treatment.

We found that consent is obtained from patients prior to the treatment taking place and at

any subsequent appointments. This process included a discussion around the risks, benefits and likely outcome of the desired treatment.

The registered manager confirmed that a skin patch test is completed for all patients prior to the treatment and that suitable aftercare information was provided for patients following treatment.

We considered how the laser equipment and associated documentation had been maintained throughout the pandemic to ensure that safe and effective care is provided. We found:

- Treatment protocols were in place and had been written by a GMC registered professional
- Local rules were in place and written by a Laser Protection Adviser (LPA). The local rules included the instructions for the safe use of lasers in line with legislation, standards and guidance.
- Laser equipment had been recently serviced and re-calibrated
- Core of Knowledge[1] training had completed.

**The following areas for improvement were identified:**

We were told that during the pandemic, Emerald Tattoo Company was closed and re-opened in 2021. As a result of this no LPA visit took place in 2020. The registered manager provided confirmation that a LPA visit is scheduled for January 2022. Throughout this time, the LPA has provided British Medical Laser Association (BMLA) guidance to the registered manager which we were told has been followed. In line with the conditions of registration, local rules are required to be reviewed annually. Therefore we recommend that these are reviewed as soon as possible.

The medical protocols (burns, drugs associated with photosensitivity and tattoo removal protocol) submitted were dated 2016 or not dated. However, the certificate confirming the studio's support is dated November 2021. We recommend that the registered manager review the information and ensure that issue and review dates are included on all protocols.

# What next?

Where we have identified areas for improvements during our quality check and require the service to tell us about the actions taken to address these, an improvement plan providing

[1] Core of Knowledge training provides a foundation in the safe and effective use of laser and IPL machines

details will be provided at the end of this quality check summary.

Where an improvement plan is required, it should:

- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the areas for improvements identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the quality check.

As a result of the findings from this quality check, the service should:

- Ensure that the areas for improvements are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

If no areas for improvement were identified during this quality check, an improvement plan will not be required, and only the quality check summary report will be published on HIW's website.

# Improvement plan

Setting: Emerald Tattoo Company

Date of activity: 29 November 2021

The table below includes improvements identified during the Quality Check, where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Please note, all actions are expected to be complete within three months of the Quality Check and the final version of the Improvement Plan is to be submitted via Objective Connect once complete.

| Reference Number | Improvement needed | Standard/ Regulation | Service Action | Responsible Officer | Timescale |
|---|---|---|---|---|---|
| 1 | The registered manager should ensure the clinic adopts a policy that outlines how the service is going to approach the need to communicate and provide information in welsh should a patient request it. | National Minimum Standards - Standard 18 – Communicating Effectively<br><br>The Independent Health Care Regulations 2011 - Regulation 9 (1) (g) | Created Communicating Effectively Policy highlighting the approach to communicating and providing information in Welsh along with any other language required where English isn't the client's first language. | Megan Stacey | Completed 16/12/2021 |

| | | | | | |
|---|---|---|---|---|---|
| 2 | The registered manager must review their safeguarding policy and include the contact details of the local safeguarding team. In addition, the policy should reflect any advice, guidance and legislation referenced in the All-Wales safeguarding procedures. | National Minimum Standards - Standard 11 Safeguarding children & vulnerable adults<br><br>The Independent Health Care Regulations 2011 – Regulation 16 (3) (a) | Reviewed safeguarding policy and amended it to add the additional information required. | Megan Stacey | Completed 16/12/2021 |
| 3 | The registered manager must ensure that in line with their conditions of registration, the local rules are reviewed annually. | National Minimum Standards - Standard 1 – Governance & accountability framework<br><br>The Independent Health Care Regulations 2011 – Regulation 15(10) | Have been in communication with our LPA Mike Regan and we are expecting to have a questionnaire mid to late January and a new risk assessment and new local rules by the start of February 2022 | Megan Stacey | Early February 2022 |
| 4 | The registered manager must ensure that the medical protocols have issue and review dates recorded. Also the protocols dated 2016 or not dated need to be reviewed to ensure the information is up to date and relevant for the service. | National Minimum Standards - Standard 20 – Records management<br><br>The Independent Health Care Regulations 2011 – Regulation 45 (1) | All documentation has been reviewed and dated correctly by Dr Paul Myers | Megan Stacey | Completed 16/12/2021 |

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Name: Megan Stacey - Registered Manager

Date: 16/12/2021