Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

# Independent Healthcare Inspection Report (Announced)

## La Belle Skin & Beauty, Cwmbran

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# Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

## Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

## Our values

We place people at the heart of what we do. We are:

- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

## Our goal

To be a trusted voice which influences and drives improvement in healthcare

## Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

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# 1. What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an announced inspection of La Belle Skin & Beauty on 07 November 2025.

The inspection was conducted by two HIW healthcare inspectors.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. A total of eight questionnaires were completed by patients. Feedback and some of the comments we received appear throughout the report.

Where present, quotes in this publication may have been translated from their original language.

Note the inspection findings relate to the point in time that the inspection was undertaken.

# 2. Summary of inspection

## Quality of Patient Experience

Overall summary:
Patients who completed the HIW questionnaire rated the service at 'very good', with patients confirming they received clear information about treatments and the risk and benefits.

The setting provided information on healthy lifestyles in consultations with leaflets available.

The setting was clean and promoted privacy and dignity with doors being kept closed ensuring confidentiality. Consultations included consent checks and patients medical histories were updated at each visit.

We found a policy in place for capacity of consent. We were assured by staff that the option of a chaperone was discussed with patients; however, there was no chaperone policy present and no information displayed.

An equality and diversity policy was made available on the day of the inspection and all respondents to the HIW questionnaire stated they did not experience discrimination at the setting.

We found appropriate feedback options available to patients which was reviewed on a regular basis.

This is what we recommend the service can improve:

- Implement chaperone policy
- Implement provision of information to patients' policy.

This is what the service did well:

- Information available to patient on healthy lifestyle
- A range of ways for patients to provide feedback.

## Delivery of Safe and Effective Care

Overall summary:
We found the setting to be clean, well lit and decorated to a good standard. Security cameras were in place at the setting with signage available to inform patients.

We found an appropriate fire risk assessment in place with fire extinguishers and alarms systems routinely checked. However, we noted fire drills were not being routinely completed. We noted the health and safety risk assessment was basic and required improvement. We found portable appliance testing and five-year fixed wire testing in place.

Infection prevention and control measures were in place with personal protective equipment readily available and cleaning schedules maintained.

We saw a safeguarding policy was in place; however, it was initially missing local contact details which were added on the day.

We found laser equipment to be well maintained with certificates of servicing available and a laser protection advisor contract in place.

We found patient records we kept securely and in line with requirements.

This is what we recommend the service can improve:

- Fabric chair within treatment room needs to be of a wipeable material
- Fire drills to be implemented routinely
- IPC audits to be implemented.

This is what the service did well:

- Effective record keeping
- Clean and well-maintained environment
- Appropriate arrangements for the storage and disposal of clinical waste.

## Quality of Management and Leadership

Overall summary:
La Belle Skin & Beauty is solely operated by the registered manager, who is also the laser operator. We found public liability insurance was available and HIW registration certificates were displayed at the setting entrance.

Policies and procedures were available in a dedicated folder and reviewed routinely. A suitable complaints policy was in place outlining responsibilities, timeframes and escalation routes.

We found training records showed compliance with mandatory requirements; however, we found some certificates were initially not available. This was resolved during the inspection. We found there was no system in place to monitor training and advised the registered manager to implement a training matrix.

This is what we recommend the service can improve:

- Implement a training matrix.

This is what the service did well:

- Policies reviewed routinely
- Third party information available in complaints policy.

# 3. What we found

# Quality of Patient Experience

**Patient feedback**
Before our inspection we invited the setting to hand out HIW questionnaires to patients to obtain their views on the services provided at the clinic. In total, we received eight completed questionnaires. Some patients did not answer all of the questions, and all indicated they had visited within the last two months. All respondents to the HIW questionnaire rated the service as 'very good'.

Patient comments included:

> *"Very knowledgeable, clean, friendly."*

**Health protection and improvement**
We were told the setting promoted healthy lifestyles during the consultation process with patients. We were told information was tailors to the patients needs. Health promotion leaflets were available within the treatment room, with information available on 'stop smoking', the heart foundation, menopause and acne.

**Dignity and respect**
On the day of the inspection, we found the staff member to be friendly and welcoming.

We saw one laser treatment room located on the first floor. We found the patient areas to be clean and organised. We were told all consultations were completed in the treatment room and doors were always kept closed when carrying out treatment to ensure privacy for patients. We found conversations could not be overheard by others ensuring privacy for patients.

We were told staff verbally discuss the option of a chaperone with patients. However, there were no signs available in the treatment room to inform patient of this option. We advised the registered manager to implement posters to inform patients of the option of a chaperone. We saw an additional set of eye wear was available for a chaperone if required. We asked to see a copy of a chaperone policy; however, we were informed the setting did not have one in place.

**The registered manager must implement a suitable chaperone policy.**

**Patient information and consent**
We were told treatments were fully explained to patients at the consultation stage and consent is gained at each appointment prior to treatment. All respondents who completed the HIW questionnaire said they were given enough information to understand all the treatment options, and their risks and benefits. We found the setting had an appropriate capacity of consent policy in place.

During the inspection, we reviewed a selection of five patient records. We saw a consent form was available for all five patient which was kept within the patient file.

We saw evidence of medical histories being checked and updated at each visit. We were told the risks and benefits of treatment were discussed with patients during their consultation with further information available on the consent form.

The registered manager told us patient information was available in large print if requested. We were told the setting does not have a website and any information was shared on social media.

We saw basic information within the settings policies and procedures stating information is given to patients; however, there was not a specific policy for the provision of information to patients.

**The registered manager must implement a provision of information to patients' policy.**

**Communicating effectively**
One the day of the inspection, we requested to see a copy of the Statement of Purpose (SoP). This was provided and we were told it was available on paper or via email if requested. On review of the document, we found all information required was present.

We saw evidence of a patient guide which has all information required present. We were told it is given to patients when they attend for a consultation, with leaflets seen on the wall outside the treatment room.

We were informed the staff member at the clinic could not speak Welsh. We were assured if patients wanted to speak Welsh or needed any other language this would be accommodated through an interpreter.

We were told patients who did not have digital access were able to phone the setting or attend in person to book an appointment and any information would be made available in paper form.

**Care planning and provision**
We were told patients undergo a full consultation face to face. This included cost of treatment, the number of sessions required, expected results and risks and benefits which were all communicated verbally and on paper. We saw evidence of patch tests undertaken and patient medical history form information. All respondents to the questionnaire said they were given a patch test prior to new treatment. We saw evidence that consent was gained from patients before each treatment and all patient who responded to the questionnaire said they signed a consent form before treatment.

We were told information is communicated to patients verbally and provided written on paper. Patients were informed about treatment costs verbally and were provided a price list at consultations.

We saw evidence of an aftercare information leaflet which we were told was provided to patients following treatment. We were also told aftercare information was provided verbally. All responded to the questionnaire said they were given enough information to understand their treatment options and the risks and benefits.

**Equality, diversity and human rights**
We requested to see a copy of the settings equality and diversity policy. The registered manager informed us there was not one available; however, this was resolved on the day. All information included in the policy provided was appropriate to the setting. Further information regarding this can be found in Appendix A.

We were told by the registered manager that all patients who attend the setting are treated equally, and discrimination would not be tolerated. We were told transgender patient rights were upheld, and preferred pronouns were used and changed within the patients record when requested.

All respondents to the HIW questionnaire said they had not faced discrimination when accessing or using the service.

**Citizen engagement and feedback**
We were told feedback was gained through the settings booking application, patients were able to leave Google reviews, and a feedback box was available within the treatment room. We were told the registered manager reviewed feedback regularly and was acted upon where necessary. A summary of patients' feedback was made available within the patient guide.

# Delivery of Safe and Effective Care

**Environment**
We found the setting was visibly clean and decorated to a good standard. We found all areas to be well lit with a modern appearance. The setting had security cameras in place with a notice information patients this was present.

**Managing risk and health and safety**
We saw evidence the setting had an electrical installation certificate which has been completed within the last 5 years and portable appliance testing (PAT) which had been completed in 2022 with a recommendation from the electrician for it to be completed next in 2026. Although not a legal requirement, we advised the registered manager to consider carrying out Portable Appliance Testing at more frequent intervals, in line with Health and Safety Executive (HSE) guidance.

We inspected fire safety arrangements at the setting and found there was a suitable fire risk assessment in place. We viewed evidence of fire extinguishers being serviced within the last 12 months. We saw evidence of monthly checks being carried out for fire alarms and emergency lighting, we advised the setting to complete fire alarm test at more regular intervals. We saw fire exit signs place in appropriate positions throughout the setting. We noted there were no 'no smoking' signs available and no instructions to follow in the event of a fire on display. This was resolved on the day. Further information regarding this can be found in Appendix A. We also noted there were no records of fire drills taking place. Evidence of a fire drill was sent shortly following the inspection; however, this was not completed routinely.

**The registered manager must ensure fire drills are completed twice in a year.**

We reviewed a health and safety risk assessment for the setting; however, we found it to be basic and lacking information.

**The registered manager must implement a robust health and safety risk assessment.**

We saw evidence of first aid certification for the staff member and found a first aid kit readily available with all items within the expiry dates.

**Infection prevention and control (IPC) and decontamination**
We found the laser treatment room to be visibly clean; however, there were lots of items on display for alternative treatments the setting provides giving a cluttered appearance. Equipment and most furniture were of materials which were

easy to wipe down and appropriate levels of personal protective equipment (PPE) were available. However, we noted one separate chair within the treatment room was not a wipeable material.

**The registered manager must ensure all furniture in the treatment room are of a wipeable material to ensure effective infection prevention and control.**

We were provided with daily cleaning schedules of which were fully completed with dates and signatures present. We also noted hand washing facilities were available within the treatment room.

We saw an appropriate infection control policy in place which was reviewed within the last year. We saw a policy and contract in place for the collection and safe disposal of waste and any waste waiting to be collected were stored in a lockable cupboard.

We requested to see a copy of the setting IPC audit; however, we were told there were no IPC audits taking place.

**The registered manager must implement infection prevention and control audits to be completed at regular intervals.**

**Safeguarding children and safeguarding vulnerable adults**
The setting is registered to treat patients 18 years and over, and the registered manager confirmed this was complied with. We were told children were allowed on the ground floor of the premises but were not allowed within the laser treatment room.

We saw evidence of a whistle blowing and safeguarding policy in place; however. it did not have contact details for local safeguarding teams. This was resolved on the day of inspection. Further information regarding this can be found in Appendix A.

We saw the registered manager had the Wales Safeguarding Procedures application available on their phone to ensure policies and procedures were kept up to date.

**Medical devices, equipment and diagnostic systems**
We found the laser machine at the setting was the same as registered with HIW and there was evidence of calibration and servicing. We saw evidence of a current contract in place with a laser protection advisor (LPA). The LPA last attended the setting on 22 October 2025 and provided a report which included local rules and risk assessments. We were also provided with appropriate medical protocols.

The local rules were readily available within the treatment room and were signed by all operators.

**Safe and clinically effective care**
The key for the laser machine was removed when not in use and stored securely elsewhere away from the machine. A sign was on the door of the treatment room informing others a laser machine is used within the room and an additional sliding sign to note when it was actively in use.

We requested to see the eye wear used by the operators and patients when carry out laser treatments. We were provided with three pairs of eye wear to be used by the operator and chaperone, and black out eye covers that were used with cotton eye patches for the patient. We found all eye wear to be in good condition and maintained appropriately. We were told eye wear was checked and cleaned before use; this information was included in the daily cleaning log sheets.

We were told quality assurance checks of the laser machine were undertaken such as checking the lens before use. This was also logged within the daily cleaning schedule.

All staff who operated the laser machine had training in place for the specific machine. We saw evidence in patient records of pre-treatment checks being performed such as patch testing 48 hours before treatment and assessment of skin using the Fitzpatrick scale.

**Participating in quality improvement activities**
We requested to see evidence of quality improvement activities conducted by the setting. We were told by the registered manager that reviews were regularly monitored to ensure the quality of service provided as well as monitoring of complaints. Examples were provided where adjustments were made to improve the quality of service.

**Records management**
We saw patient records were documented on paper with appointments being held digitally. All paper records were kept securely in a lockable cabinet, and digital appointments were held in a secure system. The registered manager told us they have not needed to dispose of patients records yet; however, they were able to describe the process for the disposal of records including data retention periods.

We reviewed a sample of five patient records and found all information was present and legible. We were provided with a treatment registered where all information was present; however, the name and type of equipment that was used

was not present. This was resolved on the day. Further information regarding this can be found in Appendix A.

# Quality of Management and Leadership

**Governance and accountability framework**
La Belle Skin & Beauty was run and owned by the registered manager with no other staff members. The registered manager was the sole operator of the laser machine.

On inspection, we saw evidence of the setting's public liability insurance. We noted the settings HIW registration certificates were available in English and Welsh at the entrance.

We saw a suitable policies and procedures management folder and all policies were reviewed yearly.

**Dealing with concerns and managing incidents**
We saw a suitable complaints policy in place. This included details of the responsible person and time frames for acknowledgment. Contact details for HIW and citizens advice were available if a patient felt a resolution could not be found. We were told by the registered manager no formal complaints have been received. We were told verbal and written complaints were documented within a dedicated complaints booklet.

**Workforce recruitment and employment practices**
Due to the registered manager being the owner and only staff member for the laser setting, there was no recruitment policy in place. We were told the registered manager had no plans to hire any staff in the future. We saw evidence of a disclosure and barring service (DBS) at an appropriate level.

**Workforce planning, training and organisational development**
On the day of the inspection, we requested to see the training records for staff. We were provided with in date training for core of knowledge, specific laser equipment training and first aid. Evidence was not available for safeguarding, fire safety and infection prevention and control. This was resolved on the day. Further information regarding this can be found in Appendix A.

We also noted there was no training completed in equality and diversity, health and safety at work and information governance. However, this training is not mandatory, but we advised staff at the setting to complete this training to strengthen knowledge.

We did not find a system in place to monitor training effectively. We advised the registered manager to implement a training matrix to ensure compliance with mandatory training going forward.

# 4. Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

The improvement plans should:

- Clearly state how the findings identified will be addressed
- 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 findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

As a result of the findings from this inspection the service should:

- Ensure that findings 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.

# Appendix A - Summary of concerns resolved during the inspection

The table below summarises the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

| Immediate concerns Identified | Impact/potential impact on patient care and treatment | How HIW escalated the concern | How the concern was resolved |
|---|---|---|---|
| There was no equality and diversity policy available. | This could lead to a poor patients experience and possible discrimination. | Raised to the registered manager. | The registered manager implemented an equality and diversity policy. |
| We noted there were no 'no smoking' signs available and no instruction to follow in the event of a fire. | Patients may smoke on the premises causing a fire risk and harm to others. Patients may not know the process to follow in the event of a fire. | Raised to the registered manager. | The registered manager placed an order for signs on the day of the inspection and photos were provided shortly following the inspection of the signs in place. |
| The safeguarding policy did not have contact details for local safeguarding teams | Staff would not know who to contact in the event of a safeguarding concern delaying the reporting | Raised to the registered manager. | The registered manager added the required information to the safeguarding policy. |

| | | | |
|---|---|---|---|
| | process potentially putting a person at risk. | | |
| The patient register did not include the name and type of equipment that was used. | There could be a risk in continuity of care if an alternative machine was used with different settings putting patient at risk. | Raised to the registered manager. | The registered manager implemented a new patients register on the day where the name and type of equipment used was present. |
| Evidence was not available for safeguarding, fire safety and infection prevention and control. | Out of date knowledge puts a risk to patients of incorrect procedures being followed. | Raised to registered manager. | The registered manager provided evidence of training completion shortly following the inspection. |

# Appendix B - Immediate improvement plan

**Service:** La Belle Skin & Beauty

**Date of inspection:** 07/11/2025

The table below includes any immediate non-compliance concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

| Risk/finding/issue | | Improvement needed | Standard / Regulation | Service action | Responsible officer | Timescale |
|---|---|---|---|---|---|---|
| 1. | No immediate non-compliance issue identified. | | | | | |

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.

**Service representative:**

**Name (print):**

**Job role:**

**Date:**

# Appendix C - Improvement plan

**Service:** La Belle Skin & Beauty

**Date of inspection:** 07/11/2025

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

| Risk/finding/issue | | Improvement needed | Standard / Regulation | Service action | Responsible officer | Timescale |
|---|---|---|---|---|---|---|
| 1. | We asked to see a copy of a chaperone policy; however, we were informed the setting did not have one in place. | The registered manager must implement a suitable chaperone policy. | The Independent Health Care (Wales) Regulations 2011 Regulation 9 (1) | Provided | Rebekah | Completed |
| 2. | There was not a specific policy for the provision of information to patients. | The registered manager must implement a provision of information to patients' policy. | The Independent Health Care (Wales) Regulations 2011 Regulation 9 (1) | Provided | Rebekah | Completed |
| 3. | We also noted there were no records of fire drills taking place. Evidence of a fire drill was sent shortly | The registered manager must ensure fire drills are completed twice in a year. | The Independent Health Care (Wales) Regulations 2011 Regulation 26 (4)(d) | Provided evidence & regular drills will be carried out monthly | Rebekah | Completed |

| | | | | | | |
|---|---|---|---|---|---|---|
| | following the inspection; however, this was not completed routinely. | | | | | |
| 4. | We reviewed a health and safety risk assessment for the setting; however, we found it to be basic and lacking information. | The registered manager must implement a robust health and safety risk assessment. | The Independent Health Care (Wales) Regulations 2011 Regulation 19 (1)(b) | Provided evidence | Rebekah | Completed |
| 5. | We noted one separate chair within the treatment room was not a wipeable material. | The registered manager must ensure all furniture in the treatment room are of a wipeable material to ensure effective infection prevention and control. | The Independent Health Care (Wales) Regulations Regulation 26 (2)(a) | Chair changed to plastic | Rebekah | Completed |
| 6. | We requested to see a copy of the setting IPC audit; however, we were told there were no IPC audits taking place. | The registered manager must implement infection prevention and control audits to be completed at regular intervals. | The Independent Health Care (Wales) Regulations Regulation 19 (1)(a) | Provided | Rebekah | Completed |

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.

**Service representative**

**Name (print):** **Rebekah Hennah**

**Job role:** **Registered Manager**

**Date:** **17 December 2025**