Window To The Womb

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Not sufficient evidence to rate
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Letter from the Chief Inspector of Hospitals

Window to the Womb is operated by London Scans Limited. The service provides diagnostic imaging services to pregnant women.

We inspected the diagnostic imaging facilities.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 10 December 2018.

To get to the heart of women' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005 (MCA).

The main service provided by this unit was ultrasound scanning.

Services we rate

This was the first inspection of this service. We rated it as **Good** overall.

We found good practice in relation to diagnostic imaging:

- There were sufficient numbers of staff with the necessary skills, experience and qualifications to meet women' needs.
- There was a programme of mandatory training which all staff completed, and systems for
- checking staff competencies.
- Equipment was maintained and serviced appropriately and the environment was visibly clean.
- Records were up to date and complete and protected from unauthorised access.
- The service had implemented a programme of audits, that included audits relating to patient outcomes.
- Staff demonstrated a kind and caring approach to their women and supported their emotional needs.
- Appointments were available during the evening, at weekends and at short notice if required.
- The service had supportive and competent managers. Staff understood the vision and values of the organisation.

However:

- The service did not operate safe recruitment practices, references for staff had not been obtained, the service had not obtained a full employment history.

  Satisfactory written explanation of any gaps in employment had not been obtained, or proof of identity including a recent photograph for a member of staff it employed.
- Staff had not received Safeguarding training for children level two although this had been scheduled.

Dr Nigel Acheson

Deputy Chief inspector of Hospitals (London and the South East)

Summary of findings

Overall summary

Window to the Womb was located on the second floor of the Hanwell Medical Centre at 20 Church Road, Hanwell, London. The service had a large reception area, a scan room and multi-use room. The service had the use of a shared toilet on the first floor of the medical centre. The service used its backroom for storage and record keeping.

Window to the Womb was registered to provide the following regulated activities:

- Diagnostic and screening procedures

During our inspection we spoke with five staff; the manager, clinical lead, director and two receptionists. We gathered views from speaking to women. During our inspection we reviewed 10 patient records.

There were no special reviews or investigations of the unit ongoing by the CQC at any time during the 12 months before this inspection.

The service conducted about 300 scans per month. Staff in the service consisted of one whole time equivalent (WTE) registered manager, five sonographers and six scan assistants. On each shift the service operated with a team leader/manager a sonographer and three scan assistants. Sonographers were also employed by local NHS trusts.

Track record on safety

- No Never events.
- No serious injuries.
- No incidences of healthcare acquired Meticillin-resistant Staphylococcus aureus (MRSA).
- No incidences of healthcare acquired Meticillin-sensitive staphylococcus aureus (MSSA).
- No incidences of healthcare acquired Clostridium difficile (c. diff).
- No incidences of healthcare acquired Escherichia coli (E-Coli).
- No deaths.

Services provided under service level agreement:

- Clinical and or non-clinical waste removal
- Building Maintenance and services
- Ultrasound machine maintenance

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good 	Diagnostics was the only activity the service provided. We rated this service as good because it was safe, effective, caring and responsive. However, we rated well led as requiring improvement

Summary of findings

Contents

Good

Window to the Womb

Services we looked at
Diagnostic imaging.

Summary of this inspection

Background to Window To The Womb

This report relates to diagnostic imaging services provided by Window to the womb.

London Scans Limited operating as Window to the Womb(Ealing) began in December 2015 with an aim to provide diagnostic imaging services to pregnant women between the ages of 18 - 65. Initially working 3 days a week 5.30pm to 9.30 pm, Tuesdays and Thursdays evenings and all day Sunday. Gradually the hours and days of services have been increased to suit the needs of service users. The service has recently introduced early pregnancy scans to provide services to pregnant women from six weeks gestation onwards. London Scans Limited is a private company operating under the Windows to the womb franchise.

The service provides ultrasound examinations to private women from the local area.

The service has had a registered manager in post since October 2017. We inspected this service on 11 December 2018. This was the first inspection since registration.

Our inspection team

The team that inspected the service comprised a CQC lead inspector. The inspection was overseen by Terri Salt Head of Hospital Inspection.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as **Good** because:

- The service had systems in place to ensure staff had received mandatory training in key skills and made sure that everyone had completed it.
- The service controlled infection risk well. Staff kept equipment and the premises visibly clean. They used control measures to prevent the spread of infection.
- All staff demonstrated an understanding of the duty of candour and the principles behind this.
- Equipment was serviced and there were processes to ensure all items were well maintained.

However

- The service had not ensured that it had conducted appropriate checks on those people it employed.
- Staff had not received Safeguarding training for children level two although this had been scheduled.

Are services effective?

Not sufficient evidence to rate

We do not currently rate effective for diagnostic imaging.

- Policies, procedures and guidelines were up to date and based on National Institute for Health and Care Excellence (NICE) guidelines, relevant regulations and legislation.
- Staff worked collaboratively as part of a multi-professional team to meet women' needs.
- There were systems to show whether staff were competent to undertake their jobs and to develop their skills or to manage under-performance.
- There was effective multidisciplinary team working throughout the unit and with other providers.
- Information provided by the unit demonstrated 100% of staff had been appraised.

Are services caring?

Good

We rated caring as **Good** because:

- Women were treated with kindness, dignity and respect. This was reflected in feedback we received from women.

Summary of this inspection

- Women received information in a way which they understood and felt involved in their care. Women were always given the opportunity to ask staff questions, and women felt comfortable doing so.
- Staff provided women and those close to them with emotional support; staff were supportive of anxious or distressed women

Are services responsive?

Good

We rated responsive as **Good** because:

- The service offered a number of scans for pregnant women such as, well-being, viability, growth and presentation and gender, together with the ability for digital images.
- Patient complaints and concerns were managed according to the services policy.
- Complaints were investigated and learning was identified and shared to improve service quality.

Are services well-led?

Requires improvement

We rated well-led as **Requires improvement** because:

- Systems did not ensure that recruitment practices were safe.
- References for staff had not been obtained, the service had not obtained a full employment history.
- Satisfactory written explanation of any gaps in employment had not been obtained or proof of identity including a recent photograph for a member of staff it employed.

However

- Staff said managers were visible and approachable. Staff informed us they felt supported by the management team.
- There was a clear governance structure, which all members of staff were aware of.
- The unit had its own risk register and the manager had clear visibility of the risks and were knowledgeable about actions to mitigate risks.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Good	Not rated	Good	Good	Requires improvement	Good
Overall	Good	Not rated	Good	Good	Requires improvement	Good

Good

Diagnostic imaging

Safe	Good
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Requires improvement

Are diagnostic imaging services safe?

Good

We rated Safe as Good

Mandatory training

The service had systems in place to ensure staff had received mandatory training in key skills and made sure that everyone had completed it.

Annual mandatory training courses were undertaken and regularly updated, training was provided either face to face, online or by means of webinars. The service provided us with its training matrix which showed staff received mandatory training in; fire safety and evacuation, health and safety in healthcare, equality and diversity, infection prevention and control, safeguarding adults, customer care and complaints, basic life support (BLS) and data security awareness.

Mandatory training rates were reviewed yearly. At the time of this inspection records we viewed demonstrated 100% of staff had completed mandatory training. The service had a rolling monthly programme of mandatory training which meant that every month staff would receive training in a different aspect of their mandatory training.

Safeguarding

Staff understood how to protect women from abuse. Staff had some training on how to recognise and report abuse and knew how to apply it.

The lead for adults and children's safeguarding was the clinic manager. Staff were trained to recognise adults and young people at risk and were supported by the Window to the Womb safeguarding adults' and children's policy, staff received training in adults and children's safeguarding during induction to the service.

The provider had developed safety and safeguarding policies which were in place that staff were familiar with and had access to it on the intranet. Both policies were up to date and reviewed regularly. They also clearly outlined staff responsibilities and how they should raise a safeguarding concern as well as immediate action to be taken where concerns related to a child.

Staff we spoke with demonstrated they understood their responsibilities and adhered to the company's safeguarding policies and procedures. The policies were clear, thorough and covered all types of abuse including female genital mutilation (FGM).

At the time of this inspection the manager of the service was trained to level three for both safeguarding adults and safeguarding children to whom the staff had access, whilst staff had received level one training. Intercollegiate guidance: 'Safeguarding Children and Young People: Roles and competencies for Health Care Staff', March 2014. Guidance states all non-clinical and clinical staff that have any contact with children, young people, parents or carers should be trained to level two safeguarding we discussed this with the provider who confirmed that all staff had been booked to receive level two training within the forthcoming week.

Staff knew how to report a safeguarding concern but there were no safeguarding concerns raised from September 2017 to September 2018 we saw contact phone numbers for local authority adult and children's safeguarding teams were in the unit's office.

Good

Diagnostic imaging

Window to the Womb did not provide services for women under the age of 18 years.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept equipment and the premises visibly clean. They used control measures to prevent the spread of infection.

The service had infection prevention and control policy which provided staff with guidance on such things as cleaning and waste control.

During this inspection we saw all areas of the service were visibly clean. An external cleaning company cleaned the scanning room each day according to the services cleaning manual and room specifications document. This was recorded on a daily check spreadsheet and was reviewed by the clinic manager each week.

Staff followed manufacturers' instructions and the Window to the Womb guidelines for routine disinfection. This included the cleaning of the medical devices between each patient and at the end of each day. Equipment and machines were cleaned following each use with alcohol wipes, this included such things as transvaginal probe covers for the transvaginal probe used for internal examinations. Couches were covered with a disposable paper towel which was changed following each scan. We reviewed the machine in use during this inspection, and saw where appropriate, disinfection had taken place and evidence of a weekly check of the machine was available.

We found that the service ensured the safe storage of substances hazardous to health (COSHH) and other chemicals were stored in a locked cabinet

Between September 2017 and September 2018 there had been no incidences of health care acquired infection in the service.

The clinic manager observed staff compliance towards hand hygiene, and infection prevention and control, as evidenced by daily and weekly audits, although the service did not conduct specific hand hygiene audit to measure staff compliance with the World Health Organisation's (WHO) 'Five Moments for Hand Hygiene.' These guidelines are for all staff working in healthcare environments and define the key moments when staff should be performing hand hygiene to reduce risk of cross contamination between women. Staff had access to hand washing facilities.

Staff were bare below the elbow and had access to a supply of personal protective equipment (PPE), including gloves and aprons.

Waste was handled and disposed of in a way that kept people safe. Waste was labelled appropriately and staff followed correct procedures to handle and sort different types of waste. Bins were emptied under the tenancy agreement in place with the medical centre.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

The layout of the unit was compatible with health and building notification (HBN06) guidance. Access to the service was available through Church Road. There was a large reception area with a reception desk that was staffed during opening hours. Within the reception area was a range of magazines, refreshments and toilet facilities for women and relatives. The service was located on the second floor and access could be gained by either a lift or stairs.

The provider's maintenance and use of their facilities kept people safe. Waiting areas were visibly clean and tidy throughout. The scanning room was spacious and well-lit and had a sign on the door to notify people when it was in use. Within the scanning room the service had two television screens linked to the scanning equipment to enable family members to see images being viewed by the sonographer. The condition, maintenance and appearance of the environment was good and information was clearly displayed.

The service's ultrasound machine was maintained and regularly serviced by the manufacturers. We reviewed service records for the equipment, which detailed the maintenance history and service due dates of equipment. The service had systems in place to ensure machines or equipment were repaired in a timely manner, when required. This ensured women would not experience prolonged delays to their care and treatment due to equipment being broken and out of use.

Good

Diagnostic imaging

Staff had sufficient space to move around the ultrasound machines for scans to be carried out safely and there were comfortable couches for women and stools for the operator.

All equipment conformed to relevant safety standards non-medical portable appliance electrical equipment was tested.

The service had a first aid kit available, upon checking we found all the contents to be in date.

We reviewed the local audits conducted by the manager along with the clinical governance audit conducted by the franchisor during 2018 concerning such things as the cleanliness of the environment and health and safety which found the service to be compliant in all areas.

Assessing and responding to patient risk

Staff reviewed and updated risk assessments for each patient through individual referral forms.

Access to the service was through self-referral. Women completed a referral form, which included their personal details, pregnancy history, including the number of previous ectopic pregnancies and consent. The referral form included space for other notes to be added for the sonographer. Staff were trained to ask women reasons for their attendance at the service. The service provided two options for women, the first was a 'first scan'. This was a scan available for women who were pregnant between seven and 15 weeks. Its primary purpose was to determine the viability of the pregnancy using ultrasound. The scan could also be used to date the pregnancy and determine whether it was a single or multiple pregnancy. The second option was for well-being scans with the option of 4D pictures.

There were posters within the unit reminding staff to carry out identification checks. A pause and check process had been recommended to help combat errors. This consisted of the three-point check to correctly identify the patient, this check includes first name, last name and date of birth.

Sonographers discussed the relative risks and benefits with women. We were told and saw a list of women they had signposted to the early pregnancy unit and informed franchisor, this was in line with the services fetal abnormalities policy.

If the sonographers observed areas of a scan that could indicate concerns the service would refer the patient to their local hospital for further investigations and management. There was no service level agreement in place for this with local hospitals but the service documented all referrals it had made to early pregnancy units.

Following each scan, the sonographer provided the patient with a 'fetal well-being report.' The report contained information about the pre-scan checks conducted by the sonographer, such as 'Are you (the sonographer) satisfied that the service is appropriate for the service user and can therefore be offered to the service user?' It also documented both fetal and placenta position checks. Finally, it documented the fetal anatomy sweep (The sweep examines the fetal head and face, spine, and chest, abdomen, and pelvis), including such things as fetus gender, limbs, restrictions of view and growth measurements. The report instructed that the report should be shared with the patient's midwife to ensure appropriate antenatal care.

Medical emergency procedures were regularly audited. We viewed the unit's medical emergency audit dated October 2018. There were procedures for removal of a collapsed patient. All clinical staff were basic life support (BLS) trained, the service only accepted women who were physically well and did not offer the services provided by early pregnancy units and they told us if a patient required urgent treatment they would call 999. Should women arrive at the service in pain or bleeding then they would be signposted to the early pregnancy unit.

Staffing

When the service was open the manager would ensure there was a sonographer, manager and three scan assistants present. On average the service had 15 appointments booked each day and sufficient staffing to manage appointments. The service did not use agency staff.

The manager was responsible for monitoring the hours worked by staff and ensuring they did not exceed working time limits. This included ensuring staff working longer than 6 hours at a time received a 20-minute rest break. Workers were entitled to a daily rest period with at least

11 hours uninterrupted rest in every 24-hour period, as well as a weekly rest period of 24 hours uninterrupted in every seven-day period. The clinic manager could adjust staffing numbers to meet demand.

The service had business continuity plans to enable it to respond to changing circumstances. For example, staff sickness, absence and workforce changes.

The service had a recruitment policy and procedure in place but this was not always followed. The policy stated the service must obtain at least one reference to ensure an appropriate reference check had been conducted.

We reviewed three recruitment records for the service we found that references for two staff had not been obtained, which included one of the sonographers employed by the service.

We saw that during the recruitment process application forms had not been completed fully, the section relating to employment history had been left blank. As a result, the service had not obtained a full employment history and had not been aware of any gaps in employment.

We also saw in the third personnel file that the service had not obtained proof of identity including a recent photograph for a member of staff it employed.

Records

Staff kept and updated individual patient care records in a way that protected patient's confidentiality. Patient care records were accessible to staff.

The service sought confirmation from women that they had considered the information provided in the information sheet, been provided with the opportunity to ask questions, discuss the test and had had any questions satisfactorily answered.

Women' personal data and information were kept secure. Only authorised staff had access to women' personal information. Staff training on information governance and records management was part of the mandatory training programme and we saw that all staff had completed it.

We reviewed five patient care records during this inspection and saw records were accurate, completed, legible and up to date. Reports of the scans were given to the patient directly.

Medicines

Medicines were not used at Window to the womb. Allergies were documented and checked on arrival to the service and were documented on the notes for the sonographer.

Incidents

The service had systems to manage patient safety incidents.

The service had an incident reporting policy and procedure to guide staff in the process of reporting incidents. Staff understood their responsibilities to raise concerns, to record safety incidents and investigate and record near misses. An accident and incident book was kept in the clinic manager's office to which all staff had access. We reviewed the accident and incident book and found that staff had been completing it appropriately.

We saw that should an incident occur then staff would inform the manager of the service who would record the incident on the services spreadsheet, and conduct an investigation if necessary. We were told and saw evidence that the manager submitted a monthly return to the franchisor.

We reviewed the services incident log, this documented two incidents one related to the lift used by the service being out of order resulting in a cancelled appointment and the other relating to aggressive behaviour of a women's partner toward staff. We found these incidents had received appropriate review by the manager. However, during our review of complaints received by the service, we noted a complaint made by a patient regarding a sonographer which should have also been reported as an incident. This had not been communicated to the manager by staff and therefore this had not been investigated. We were told that this incident would be documented and investigated following our inspection.

During the period October 2017 to October 2018 there had been no serious incidents requiring investigation. Serious incidents are events in health care where the potential for learning is so great, or the consequences to women, families and carers, staff or organisations are so significant, they warrant using additional resources to mount a comprehensive investigation.

Good

Diagnostic imaging

There had been no 'never events' in the previous 12 months prior to this inspection. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.

There had been no notifiable safety incidents that met the requirements of the duty of candour regulation in the 12 months preceding this inspection. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify women (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.

An organisational policy and procedure was available to staff providing guidance on the process to follow if an incident was to occur that met the requirements of the duty of candour regulation.

Staff we spoke with demonstrated they understood the requirements of the duty of candour regulation. Incidents involving patient or service user harm were assessed with the 'notifiable safety incident' criteria as defined within regulation 20 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. Incidents meeting this threshold were managed under the organisations 'adverse events (incident) reporting and management policy' and 'Duty of Candour, procedure for the notification of a notifiable safety incident' standard operating procedure.

Are diagnostic imaging services effective?

Not sufficient evidence to rate

We do not currently rate effective for diagnostic imaging.

Evidence-based care and treatment

Women's care and treatment was delivered and clinical outcomes monitored in accordance with guidance from the National Institute for Health and Care Excellence (NICE). NICE guidance was followed for diagnostic imaging pathways as part of specific clinical conditions.

Staff assessed women's needs and planned and delivered patient care in line with evidence-based, guidance, standards and best practice.

Nutrition and hydration

Women had access to water and hot drinks whilst awaiting their scan, there was also a small selection of snacks available for purchase.

Pain relief

Pain assessments were not undertaken at window to the womb although staff told us they would make women comfortable during the scanning procedure.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them.

The service had implemented a programme of audits, these included peer to peer audits that would review findings documented against the imagery that had been recorded during the scan for things such as gender or anomalies, sonographers would categorise audits using the Red Amber Green system, when we reviewed these peer to peer audits we found that most were rated green and non were red rated.

The service reviewed and recorded how many women it had referred to the early pregnancy unit, the number of rescans it had conducted and the number of occasions the gender had been sought but was incorrect.

Further audits were conducted by the Window to the Womb lead sonographer these were completed off-site and a report of findings following the review was sent to both the sonographer and the manager of the service to be discussed during their supervision to improve their practice. The lead sonographer would also visit the service to conduct on-site competency assessments.

Sonographers at the service would conduct There was also a process to conduct random monthly quality audits the results would be fed back to the individual sonographers

Other audits such as a 'clinical compliance audit' and local audits were conducted including, patient experience, health and safety, safeguarding, equipment and privacy and dignity. We found that audits were discussed at team meetings.

Good

Diagnostic imaging

Competent staff

The service made sure staff were competent for their roles. Managers appraised staffs work.

performance and provided support. All staff had completed a structured induction programme for the service, which included the use of equipment and office systems. Sonographers had also completed a further induction programme at under the direction of the provider's clinical lead. Records we checked confirmed staff received an annual appraisal and monthly supervision, which was up to date.

We found that although sonographers could be employed and received professional development from the NHS, the service ensured that specific sonographer training was given at national meetings and by video learning, which had been developed by the franchisor.

Staff had the right skills and training to undertake ultrasound scans, this was closely reviewed at the service with the clinical lead having the ability to review periodically sonographer's scans and provide feedback, this was possible as all scans completed at the service were videoed and uploaded to central servers to which the clinical lead could access.

Multidisciplinary working

Staff at the service told us that their aim was to work closely with women to support a seamless treatment pathway. If concerns were identified from a scan these were escalated to the patient's local NHS trust.

Seven-day services

The service was operational from 5.30pm to 8pm Tuesday, Wednesday and Thursday and 9.30am to 5.30pm on Saturdays and Sundays.

Appointments were flexible to meet the needs of women, and appointments were available at short notice.

Health promotion

Information leaflets were provided in the service for women on what the scan would entail, keeping healthy, which included giving up smoking and alcohol, movements of the baby, foods to be avoided and questions they could ask of their midwife.

Consent and Mental Capacity Act

Staff understood how and when to assess whether a patient had the capacity to make decisions about their scan.

Women completed a consent form. Staff understood their responsibility to gain consent from women before they performed an ultrasound scan. They recognised and respected a patient's choice if they decided not to have a scan after arriving for an appointment.

Staff informed us they explained the imagining procedure to women and as well as requiring women to complete an informed consent form, a verbal request was also made. We found that staff we spoke with had knowledge of the requirements of the Mental Capacity Act 2005 (MCA). Although they told us that they did not have experience of supporting women who had been assessed as lacking capacity to make decisions about the scanning procedure.

Are diagnostic imaging services caring?

Good

We rated caring as **good.**

Compassionate care

During this inspection women told us that staff treated them with dignity, kindness, compassion, courtesy and respect. Staff introduced themselves prior to the start of a scan, interacted well with women and included women in general conversation.

Feedback provided by women we spoke with staff demonstrated a kind and caring attitude to women. Women said, 'I had a lovely experience, the team are wonderful' 'Amazing experience' and 'What a wonderful experience, staff were helpful, thoroughly enjoyable'.

The service could ensure that women' privacy and dignity was maintained during their time in the unit and during scanning and had both sign on the scan room door and access to a privacy screen.

Patient satisfaction was formally measured through completion of the patient survey following their scan. The service had a response rate of 5% from the 724 questionnaires issued rated their satisfaction as 'Good'.

Emotional support

Good

Diagnostic imaging

Staff provided emotional support to women to minimise any distress.

Staff provided reassurance throughout the scanning process, they updated the patient on the progress of the scan and how long they had before their scan was complete.

Staff felt recognising and providing emotional support to women was an important aspect of the work they did, staff had received training in discussing potentially bad news. The service did not have a quiet room where bad news could be discussed but we were told that the service would use the scanning room which was equipped with comfortable seating.

Understanding and involvement of women and those close to them

Staff involved women and those close to them in decisions about their care.

Staff communicated with women in a way that ensured they understood the reasons for attending the unit. All women were welcomed into the reception area and reassured about their procedure.

Staff recognised when women or relatives needed additional support to help them understand and be involved in their care and treatment. Staff enabled them to access this, including access to interpreting and translation services.

Women and relatives were given the opportunity to ask questions about their scan. A range of ultrasound related leaflets were available to women in the service. Women could also access information on different types of scans, and pricing information from the Window to the Womb website.

The service encouraged partners to be present with the patient for the scan.

Are diagnostic imaging services responsive?

Good

We rated it as **good.**

Service delivery to meet the needs of local people

The diagnostic service was located on the second floor of the building, and women and visitors could access the service by a lift or staircase, in cases of emergency the service could access emergency exits and for people with reduced mobility the health centre provided emergency chairs.

The service provided payment details in a confirmation email prior to each patient's attendance.

These included a clear price list and different options for payment. The service was registered with UK insurers for the provision of care and public liability.

The service offered a number of scans for pregnant women such as, well-being, viability, growth and presentation and gender, together with the ability for digital images. There was a single scan room, toilet facilities a reception area and a room used to store records and equipment.

The service provided evening and weekend appointments to meet the requirements of women.

The service was located within a medical centre. It was accessible by public transport being located close to bus routes and the service could be accessed by car, with public carparks within walking distance. The service provided information on travelling to the centre on its website.

The environment was patient centred. The unit had sufficient seating in the reception area. Toilets and drinks machines were available to women and visitors in the main reception waiting area.

Meeting people's individual needs

Staff had an understanding of the cultural, social and religious needs of women. There was a diverse staff group with multilingual and diverse faith backgrounds.

During scanning, staff made women comfortable. Women were advised that if they wanted to stop their scan, staff would assist them and discuss choices for further imaging or different techniques or coping mechanisms to complete their imaging. Relatives could be present in the scanning room if required.

Women with reduced mobility needs accessed the service by a lift. Couches were suitable for bariatric (relating to the treatment of obesity) women.

Good

Diagnostic imaging

Staff told us the patient would inform them if translation services were required and they would organise this in advance. Easy to read leaflets and large print patient information was available and braille could be provided on request.

Access and flow

Women self-referred they could book appointments through several media platforms including, telephone and email through the Window to the Womb website. Women' appointments were usually made by telephone at a time and date agreed by them. In the case of a requirement to conduct a scan at short notice the service told us that it would attempt to make an appointment as soon as possible.

There were very few delays and appointment times were closely adhered to. Fetal well-being reports were produced and shared in a timely manner, on the same day.

From September 2017 to September 2018 no planned examinations were cancelled for non-clinical reasons and no planned examinations had been delayed in the same period.

The service did not routinely record the data for women who did not attend, we were told that if a person did not attend or if they cancelled, they would be contacted to ascertain the reasons for their non-attendance and an appointment would be re-booked if necessary.

Learning from complaints and concerns

Staff were encouraged to resolve complaints and concerns locally. The service had a complaints handling policy and all had staff had completed a mandatory training course on customer care and complaints.

The unit had a complaints log. The unit had received 11 complaints in the period September 2017 to September 2018. All were managed through the informal complaints procedure. The complaints log recorded actions the unit had taken in response to the complaint. The log recorded when women had received a verbal apology from the service. Most complaints related to the quality of the picture image and in these cases, we saw that a re-scan was offered.

The complaints procedure was displayed for women and relatives to read in the main reception area.

Are diagnostic imaging services well-led?

Requires improvement

We rated it as **requires improvement.**

Leadership

Window to the Womb Ealing was managed by the registered manager, supported by the Nominated Individual (The nominated individual is responsible for supervising the management of the regulated activity provided) and was also supported by the wider Window to the Womb group. The registered manager had taken up the role in October 2017.

The management structure within the service consisted of a registered manager supported by a senior scan assistant. Staff also had specialist lead roles within the unit. For example. The registered manager was the lead for health and safety, safeguarding, and infection prevention and control (IPC).

Staff told us managers were visible and approachable and that they felt supported by the management team. All the staff we spoke with were positive about the management of the service.

Vision and strategy

The services vision and aims were to provide expectant parents with first class, independent ultrasound services within their local community.

All staff were introduced into these values during induction when first employed during the corporate induction. The appraisal process for staff was also aligned to these values of the service and each individual's learning objectives.

Culture

Managers and staff promoted a positive culture, creating a sense of common purpose based on shared values.

All of the staff we spoke with were very positive and happy in their roles and stated the service was a good place to work. Staff told us that the manager was flexible in their approach to running the service, stating that the manager was considered a friend.

Most staff we spoke with told us they felt supported, respected and valued. They were actively encouraged to make suggestions about changes and improvements to the services provided.

Staff demonstrated pride in their work and the service they delivered to women and their partners. Staff told us they had sufficient time to support women.

Staff told us there was a positive approach regarding incidents and they always received feedback from incidents.

Equality and diversity was promoted within the service and was part of mandatory training.

A whistle blowing policy and a duty of candour policy was in place and the service also provided staff with a leaflet developed by Window to the Womb outlining how to raise a concern and what response they could expect. Staff told us they had attended duty of candour training and described to us the principles of duty of candour.

Governance

Governance systems did not ensure that recruitment practices were safe, we found that the service had a recruitment policy and procedure in place but this was not always followed. The policy stated the service must obtain at least one reference to ensure an appropriate reference check had been conducted.

We reviewed three recruitment records for the service we found that references for two staff had not been obtained, which included one of the sonographers employed by the service.

We saw that during the recruitment process application forms had not been completed fully, the section relating to employment history had been left blank. As a result, the service had not obtained a full employment history and had not been aware of any gaps in employment.

We also saw in the third personnel file that the service had not obtained proof of identity including a recent photograph for a member of staff it employed.

We also found that audits undertaken had not identified that people had not been recruited in line with the provider's policy.

The provider improved service quality and safeguarded high standards of care a framework was managed by the service manager and the provider, which oversaw service delivery and quality of care, this included weekly audits and random audits by lead sonographers, directors or clinical leads.

Window to the Womb operated a clinical governance framework which aimed to assure the quality of services provided. Policies were available online or in hard copy for staff to read.

Formal minuted team meetings were held monthly. We were provided with minutes from these meetings which included; how the unit was progressing in regard to the company strategy, performance, policies, and reviews of incidents and complaints and any lessons learnt.

The manager also ensured that regular health and safety audits were conducted monthly. This ensured actions to improve services were recorded and monitored to completion.

Managing risks, issues and performance

The service monitored monthly its performance regarding delayed appointments dashboards and reports were produced enabled comparisons and benchmarking.

There was a local risk assessment system (risk register) which included a process of escalation to escalate risks it was reviewed and updated monthly and new risks added regularly, these covered hazards and precautions in relation to a range of factors, including infection control, electrical safety, fire safety and substances hazardous to health.

There was a business continuity policy which highlighted key hazards and mitigations, contact details for relevant staff and an emergency response checklist.

Managing information

The provider collected, analysed, managed and used information to support all its activities, using secure electronic systems with security safeguards.

Staff told us there were sufficient numbers of computers in the unit. This enabled staff to access the computer system when they needed to.

Good

Diagnostic imaging

All staff we spoke with demonstrated they could locate and access relevant information and records easily, this enabled them to carry out their day to day roles. Patient records could be accessed easily but were kept secure to prevent unauthorised access to data.

Engagement

The service did not routinely undertake staff satisfaction surveys. We were told this was because the service had a relatively small number of permanent employees and the numbers would not produce meaningful data. It was explained that staff had access to the clinic and registered manager together with the nominated individual all of whom operated an open-door policy. They told us that regular supervision and appraisal ensured the service provided staff with the opportunity to comment on the service.

The service enabled women to provide feedback by email or comment cards. We reviewed the feedback received by the service from women which was wholly positive.

Learning, continuous improvement and innovation

The service offered women such things as 'Instant Midwife', this was a service available through social media messaging systems, that would provide answers to the most common questions asked by pregnant women.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that staff are recruited in line with policy and governance processes effectively manage this.

Action the provider SHOULD take to improve

- The provider should ensure that all staff are trained to level two in safeguarding children.
- The provider should ensure that it has a programme in place to conduct hand hygiene audits.

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
Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA (RA) Regulations 2014 Good Governance The service had not ensured processes were in place to assure itself that people had been recruited safely. This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.