Princess Royal MRI Unit

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?	
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Princess Royal MRI Unit is operated by Alliance Medical Limited. The service provides magnetic resonance imaging (MRI) and dual-energy X-ray absorptiometry (DXA) (an X-ray scanner that uses two different X-ray energies to measure bone mineral density) scanning for Princess Royal Hospital as part of a contract with Brighton and Sussex University Hospitals NHS Trust. Princess Royal MRI Unit registered with CQC in April 2016 and has not been inspected before.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced visit to the service on 13 February 2019.

We rated it as **Good** overall.

Our key findings were as follows

- There was evidence of investigation, learning and dissemination of learning from incidents within the Alliance Medical Limited organisation.
- Equipment was well maintained and tested annually or in accordance with manufacturer's guidelines.
- Staff demonstrated a kind and caring approach to patients, supported their emotional needs and provided reassurance. We observed staff providing care in a compassionate and respectful manner. Staff ensured patients understood the procedures, answered questions and obtained consent before providing care.
- The service provided care and treatment based on national guidance and evidence of its effectiveness.
- The service offered people appointment times to reflect their needs and preferences, for example if they had limited mobility.
- The unit manager ran an audit programme to monitor the effectiveness of care, procedures and policies. Staff used the findings to improve the service. They carried out a monthly image quality audit to evaluate images and techniques to improve image quality.
- The service made sure staff were competent for their roles. There were systems to check staff professional registration, appraise their work and provide support.
- The service leaders had a sound understanding of their risks and challenges. These were reflected on the local risk register and reported to reported to the regional director and liaised with the central quality and risk team.
- Staff described a visible and approachable local leadership team and told us they were able to raise concerns and report incidents.

However:

- Access to the MRI units were not always well restricted. In the static unit there was no lockable door separating the waiting room from the controlled area of the three tesla (3T) scanner. This created a risk to patients and/or visitors with implanted devices such as a pacemaker if they crossed the threshold without being screened.
- The DXA room had a carpeted floor, which did not meet the requirements of Health Building Notice (HBN) 00-09: Infection control in the built environment.
- Contrast media was not always recorded in ward patient records of care, in line with best practice.

Dr Nigel Acheson
Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good 	We rated this service good because it was safe, caring, responsive and well led. We do not rate effective for this type of service.

Summary of findings

Contents

Good

Princess Royal MRI Unit

Services we looked at
Diagnostic imaging

Summary of this inspection

Background to Princess Royal MRI Unit

Princess Royal MRI Unit opened in April 216. The service is located in Haywards Heath and primarily serves the communities of West Sussex. It also accepts private patient referrals from outside this area.

The service has a registered manager who has been in post since the service opened.

The service has two MRI scanners and one DXA scanner. The service is open Monday to Sunday from 8.00am to 8.00pm. The service cares for adults and children from 13 years old.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, an assistant inspector, and a specialist advisor with expertise in radiography. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.

Information about Princess Royal MRI Unit

The service is registered to provide the following regulated activities:

- Diagnostic and screening procedures.

During the inspection, we visited both MRI scanning areas. We spoke with eight staff including the unit manager, radiographers, clinical and administrative assistants. We spoke with four patients and one relative. We reviewed four sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The service has never been inspected since registering with CQC.

Activity (October 2017 to November 2018)

- There were 10,728 patients scanned on the MRI scanners and 562 on the DXA scanner.
- The service scanned 38 children and young people aged 13 to 17 years old.
- The majority of patients were NHS-funded patients referred from the host trust.

Track record on safety

- No Never events, serious injuries, Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) reportable incidents or deaths.
- 18 Clinical incidents nine no harm, three unknown harm, three low harm, two near misses, and one moderate harm.
- No incidences of healthcare acquired Methicillin-resistant Staphylococcus aureus (MRSA), Methicillin-sensitive staphylococcus aureus (MSSA), Clostridium difficile (c.diff), and E-Coli
- Three complaints

Services accredited by a national body:

- Imaging Services Accreditation Scheme (July 2021) - Whole organisation
- ISO27001 (June 2021)- Whole organisation
- Investors in People (March 2020) - Whole organisation

Services provided at the service under service level agreement:

- Medical Physics Expert provision

Summary of this inspection

- Radiation Protection Advisor provision
- Clinical and or non-clinical waste removal
- Interpreting services
- Laundry
- Maintenance of medical equipment

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 it as **Good** because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Patients' individual care records were generally written and managed in a way that kept people safe. Records seen were accurate, complete, legible, and up-to-date.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

Are services effective?

We did not rate effective for this service, however we found that:

- Managers monitored the effectiveness of care and treatment and used the findings to improve them.
- The service monitored the effectiveness of care, polices and procedures and used the findings to improve the service.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.
- Policies and procedures were in date. Staff had access to dual policies used by both the host trust's imaging department and the service. The unit manager encouraged and monitored the uptake of new policies ensuring all staff were up to date with the latest guidance.

Are services caring?

Good

We rated it as **Good** because:

- Patients spoke positively about the service and we observed staff treating in accordance with the service's dignity and respect policy.
- We observed staff providing patients with constant reassurance throughout their scan and ensured that patients were comfortable throughout the procedure.
- Staff involved patients and those close to them in decisions about their care and treatments. Patients where provided with information in a format that suited their needs.

Summary of this inspection

Are services responsive?

Good

We rated it as **Good** because:

- The service ensured there were appointments available to meet the needs of the patients.
- Interpretation services were available for patients whose first language was not English.
- The service was accessible to patients with limited mobility. There was sufficient space to manoeuvre a wheel chair and equipment to transfer patients safely.
- The service generally ran on time and when delays occurred, patients were kept informed.
- The unit manager was aware of risks to the service. There were systems to manage new and existing risks.

Are services well-led?

Good

We rated it as **Good** because:

- The service leaders had the right skills and abilities to run a service providing sustainable care.
- Staff understood the service's vision and how their work contributed to achieving this.
- All staff we spoke with told us they felt respected and valued.
- The service collected, analysed, managed, and used information well to support its activities.
- The unit manager was aware of risks to the service. There were systems to manage new and existing risks.
- Princess Royal MRI Unit was committed to improving services by learning, promoting training and innovation.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Good	N/A	Good	Good	Good	Good

Good

Diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are diagnostic imaging services safe?

Good

We rated it as **good.**

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

- Mandatory training was provided through online training, with courses such as intermediate life support training completed through face to face training. Staff had access to mandatory training provided by Alliance Medical Limited and by the host site such as intermediate life support training. We saw compliance was recorded electronically and in paper form.
- Staff told us they received an email 60 days and 30 days before training expired, reminding them to book a course. Additionally, the unit manager kept a local mandatory training tracker and ensured staff were up to date with training or booked onto a course.
- Staff told us they were given time to complete training during their working hours. The unit manager supported staff to complete training by allocating time for staff to undertake training on the staff rotas and providing cover for them.
- Mandatory training covered 16 topics including but not limited to, fire safety, infection control, moving and positioning people, and information governance. At the time of our inspection the service achieved a compliance rate of 91% meeting the organisation's target of 90%.
- The service had up to date local rules, describing safe operating procedures in line with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) guidance. Records showed that all staff had read and understood the local rules.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

- We spoke to both administrative and clinical staff who understood how to protect patients from abuse. Radiographers and administrative staff had attended training on how to recognise and report abuse and they knew how to apply it. Staff we spoke with demonstrated they understood their responsibilities to safeguard both adults and children.
- The statement of purpose said that that the service scanned children and young people aged 13 and above. Records showed all staff had completed level one adult and child safeguarding. All radiographers were safeguarding children level three trained, meaning there was always an appropriately trained member of staff present when a child was scanned. This met intercollegiate guidance: Safeguarding Children and Young People: Roles and competencies for Health Care Staff (March 2014).
- The service had individual adult and child safeguarding policies for staff to follow which were in

date. The policies detailed the different types of abuse for staff to be aware of when providing care and treatment to adults and children such as female genital mutilation (FGM). FGM is a ritual of cutting or removing some or all the external female genitalia.

- Policies contained contact details for adult and child safeguarding leads from Alliance Medical Limited and the host site. Staff could locate contact details for the local child protection team and other professional organisations who were involved in safeguarding both vulnerable adults and children and young people.
- There were no safeguarding concerns reported to CQC within the last 12 months.

Cleanliness, infection control and hygiene

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

- Prevention and control of infection for the service was supported by policy, procedure, and an annual audit. These reflected best practice guidelines. The service had an infection control lead who was responsible for ensuring standards were maintained and offer infection prevention and control support.
- An annual infection prevention and control audit was undertaken in June 2018. The service achieved a score of 85%, which was an improvement of five percent from the previous year. However, the unit did not meet the organisation's target of 90%. Every room in the service was cleaned daily under a third-party agreement with the host trust.
- Disinfectant wipes were available in each room. We saw staff cleaning equipment between patients to prevent the risk of cross infection. Most areas we visited and equipment we saw was visibly clean although we found light layers of dust in high areas.
- We saw staff were bare below the elbow and demonstrated an effective hand washing technique in line with 'five moments for hand hygiene' from the World Health Organisation (WHO) guidelines on hand hygiene in health care. The service completed monthly hand hygiene audits and performed well in these. Result showed an average compliance rate of 98% over the last 12 months.
- There were sufficient numbers of hand washing sinks available, in line with Health Building Note (HBN) 00-09: Infection control in the built environment. Soap and disposable hand towels were available next to sinks and instructions on how to effectively decontaminate hands were displayed above the sinks.
- Hand gel dispensers were available at key points throughout the service for staff, patients, and visitors to use. For example, there was a hand gel dispenser at the reception desk and as you moved from one area of the unit to another. We saw staff using these throughout our inspection.
- Personal protective equipment (PPE) such as disposable aprons and gloves were easily accessible for staff. We observed staff wearing them when delivering personal care for example, when performing cannulation on a patient to give contrast medium.
- The service had completed a monthly insertion of peripheral vascular device (such as cannulating) audit and achieved an average score of 100% over the last 12 months. There were no areas of concern noted.
- The sharps bin in the patient preparation area we visited was not overfilled. The bin was labelled and dated correctly ensuring safe use and traceability.
- The DXA room had a carpeted floor. This did not meet the requirements of Health Building Notice (HBN) 00-09: Infection control in the built environment. The room was only used once a week and housekeeping staff cleaned the room after use. Staff told us the carpet was deep cleaned every six months. We did not see any records of the deep cleans taking place. However, there were no concerns or reported incidents relating to infection prevention and control during the last 12 months.
- Staff adhered to the standards of the DH Health Technical Memorandum 07-01 in relation to safe standards of waste disposal. Clinical waste was separated in colour-coded bags and stored securely.

Environment and equipment

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

Good

Diagnostic imaging

- The service had two MRI scanners and one DXA scanner. The first MRI scanner was located in the static unit which also housed the DXA scanner, a waiting room, a reception area, and a patient preparation area.
- We found that there were limited controls to restrict unauthorised persons from entering both MRI units. In the modular unit, the service had placed a link chain across the entrance of the ramp that lead to the unit. This was as a result of patients and visitors wondering into the unit after mistaking it for the service's main reception. The main door to the unit was not locked when in use, so there was a risk of patients or visitors entering the unit whilst another patient was having their scan.
- In the static unit, the controlled area and preparation area were separated from the waiting room by a curtain and a tensor barrier. The tensor barrier was only used when the machine was not in use. We identified and staff raised concerns about the strength of the MRI scanner. The scanner operated at a strength of 3 tesla (3T). This was twice the strength of a normal MRI scanner, which generated a higher quality image. However, this also created a risk to patients with implants particularly those with older pacemakers that were not compatible with MRI.
- The service tried to reduce risks by screening all patients and visitors planning to enter the scanning room using the MRI patient safety questionnaire. Furthermore, administrative staff told us there was always a member of staff in the reception area, ensuring no unauthorised persons entered the controlled area. However, on two occasions during our inspection we saw no staff manning the reception area. We also noted the short distance between the entrance to the service and the controlled area, so it was easy for a visitor to cross the threshold before being stopped. We could not be sure this risk was well mitigated.
- The service had completed its own risk assessment which scored this risk as a medium risk of 6. The risk assessment had recommended actions to reduce the risk. Actions included installing a no entry sign on the floor and another at the door or unit. Actions were due to be completed by March 2019.
- We saw that access to the DXA scanner was well controlled. The DXA scanner was located behind the reception area and access was gained through a corridor leading to non-clinical and, staff only areas. We saw the door was kept locked when the scanner was not in use and the key was kept locked in a key locker in the reception area.
- The second MRI scanner was housed in a modular unit next to the main building for the service. The modular unit had small waiting area, changing area, scanning room and equipment room. The unit had its own water supply and electricity. There was a supply of oxygen, suction equipment, and a bag valve mask, so in the event of a medical emergency, staff could begin basic life support.
- There was one resuscitation trolley for the service kept in the main building's patient preparation area. The trolley was temper evident and staff recorded the replacement tag each time the seal was broken for access. We broke the seal and carried out a check of the equipment and consumables kept in the trolley and saw they were in date. Equipment such as oxygen masks, came in a range of sizes suitable for children, young people and adults. The resuscitation trolley checklist had been checked in accordance with service's policy, with three omissions between December 2018 and February 2019.
- All equipment was subject to a comprehensive preventative maintenance programme. The unit manager told us servicing was completed every six months and we reviewed records showing all scanning equipment had been last serviced in the last 12 months. For example, the DXA scanner was last serviced in September 2018.
- The service used equipment supplied by the manufacturer which was classed as magnetic resonance (MR) safe (a piece of equipment that has no known hazards in all MRI environments) Additional equipment that was not supplied by the manufacturer and used within the MRI environment was risk assessed and labelled as MR safe, MR conditional or MR unsafe in line with medicines and healthcare products regulatory agency (MHRA) safety guidelines for magnetic resonance imaging equipment in clinical use (2015). For example, we observed staff using a trolley to transfer patients with limited mobility from a

wheel chair to the scanning bed. The trolley was labelled MR conditional. Staff explained that the trolley could be used within the MRI scanning room, as long as it was kept a certain distance away from the bore of the machine.

- Records showed fire extinguishers in the unit were serviced in the last 12 months and these were placed in prominent positions. The service displayed a map of the unit and the points where to find specific extinguishers in the event of a fire. For example, a water fire extinguisher suitable for fighting fires involving solid combustibles such as paper and wood. The display also highlighted the extinguishers safe to take into the MRI scanning room.
- Fire alarm testing was conducted every Wednesday between 8.00am and 9.00am. We saw fire exits were accessible and clear from obstructions. Information on actions to take in the event of a fire were displayed throughout the service, including where the muster point was located.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient.

- All radiographers and clinical assistants had been trained and assessed as competent against the Immediate Life Support (ILS) standard as recognised by the Resuscitation Council UK (RCUK). In addition, 50% of clinical staff had undertaken training in Paediatric Immediate Life Support (PILS) to provide the required standard of care for paediatric patients that used the service.
- The service used the host trust's escalation procedure when patients became unwell in the unit. Staff said they raised the alarm by dialling the NHS standard cardiac arrest number '2222'. Patients were cared for by ILS trained staff. All patient care was documented on the Alliance Medical Limited electronic radiology information system (RIS) and the host trust's system.
- The service ensured the requesting of diagnostic imaging was only made by individuals entitled to act as a referrer accordance with IR(ME)R guidelines. All referrals were made using dedicated referral forms which were vetted against a set criterion by the radiographers. The vetting process ensure patients were on the correct patient pathway and that all necessary information was present on the form.
- All patients referred for a contrast MRI scan had kidney function blood tests prior to scanning to reduce the risk of contrast-induced nephropathy. This was in keeping with the National Institute of Care and Excellence (NICE) acute kidney injury guidelines and the Royal College of Radiologists standards for intravascular contrast agent administration.
- All patients undergoing an MRI scan completed an MRI safety questionnaire before scanning took place. We observed staff reviewing the form after completion and verbally checking questions again with the patient as an additional safety check. Questions included asking whether the patient had a pacemaker, if they were pregnant or if they had shrapnel injuries.
- The service followed the host trust's policy in identifying pregnant women. Staff told us that the service only scanned pregnant patients after they received approval from a radiologist. This was in line with medicines and healthcare products regulatory agency (MHRA) guidelines, which recommended that where possible, the decision to scan should be made by the referring clinician, an MRI radiologist, and the patient, based on information about risks weighed against the clinical benefit to the patient.
- The service did not employ medical staff however, the Alliance Medical Limited staff had access to the host site's on call radiologist 24 hours a day and medical staff from the host trust A&E in the event of an emergency.

Staffing

The service had enough staff with the right qualifications, skills, training, and experience to keep people safe from avoidable harm and to provide the right care and treatment.

- The service ensured staffing levels were safe by using a staffing calculator, bringing the unit into compliance with Alliance Medical Limited's safe staffing policy. The service had 16 members of staff in post on full time

and part time contracts. The staff consisted of a unit manager, seven radiographers, two clinical assistants, five administrators and a one clinical and administrative assistant.

- The service reported a low sickness rate for all staff groups. The average rate of sickness absence in the three months before our inspection was zero for radiography staff, 5% for clinical assistant staff and 3% for administration staff.
- In the last three months before our inspection 12 radiography shifts were filled by bank staff and 12 by agency staff.
- All staff including bank and agency staff had completed a local induction. Bank and agency staff complete a shorter version of the induction which was specific to the service on their first day and read the site guidance.
- At the time of our inspection the service had one vacancy for a radiographer.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, and easily available to all staff providing care.

- We reviewed four sets of records and found they had all necessary information. This included but was not limited to, completed consent forms, patient details and MRI reports once reviewed by the radiologists.
- Staff at the unit had access to both the Alliance Medical Limited systems and the host trust radiology systems to record patient details and care records. Administrative staff explained that all patients referred to the service from the trust, had their images uploaded onto the host trust's picture archiving and communication system (PACS). All private patients had their images and reports transferred and stored on to the Alliance Medical Limited system.
- Images that had been reviewed and reported on by the radiologists, were issued from the host trust's clinical radiology information system (CRIS). Results were sent either via post or internal mail to the originating referrer. CRIS was integrated with another electronic system which local GP's and referrers had access to.
- Staff were able to maintain accurate records in the event of an IT failure. On the day of our inspection, the host trust's IT system was not in working order. Staff told us that as they duplicated records on both systems, this had not caused much disruption. They could document records of care on the Alliance Medical Limited system and duplicate these to the host trust's system when the system was operational.

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines.

- Medicines management was in accordance with policy and Alliance Medical Limited had an appointed pharmacy advisor who supported the service to meet national requirements. The service was supported by a specialist pharmacist from the host site in accordance with the corporate service level agreement they shared.
- Medicines, including intravenous fluids, were stored securely. The service did not store and/or administer controlled drugs as part of the services provided in this unit. Medicines requiring storage within a designated room were stored at the correct temperatures, in line with the manufacturers' recommendations, to ensure they would be fit for use.
- Clinical staff were trained on the safe administration of contrast medium including intravenous contrast. We reviewed staff competency files and saw all staff had received this training.
- Emergency medicines were available in the event of an anaphylactic reaction.
- The service worked under the host trust's patient group directions for all patients requiring intravenous contrast enhanced MRI imaging and other medicines. A patient group direction (PGD) is a written instruction for the supply or administration of a licensed medicine (or medicines) in an identified clinical situation, where the patient may, or may not, be individually identified before presenting for treatment. The service used PGD's for various medicines for example, contrast media and sodium chloride 0.9% solution and we saw that staff had read and signed to say they understood how and when you use these.

- Radiographers assumed the responsibility for preparing a range contrast solution which had been identified for use for a range of MRI scans.
- Allergies were identified on patient records and there was access to emergency medicines stored on the resuscitation trolley.
- Contrast media administered was prescribed according to patient weight and recorded on the electronic system including the dose and batch number in line with national guidance. However, staff told us that on occasions, ward patients did not travel with their patient records when they attended for their scan. Any contrast administered for the scan, would not be recorded in the patient notes. This meant in the event of a patient reacting to the contrast post scan, ward staff would be unaware of the cause which could result in a delay in recognising and managing contrast reactions.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately.

- The service had an incident reporting procedure and staff reported incidents via an electronic system. Staff knew how to report an incident and could give examples of lesson or changes to practice as a result of an incident. The unit manager was responsible for investigating all incidents and told us learning from incidents was shared via a monthly risk bulletin.
- The service had an incident policy for staff to follow which was in date and due for a review in February 2021. This guided staff on the reporting procedure for incidents and the organisations that needed to be informed when certain types of incidents had occurred. Staff we spoke with were aware of this policy and the incident reporting procedure.
- There were no never events reported by the service from October 2017 to November 2018. 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.
- The service reported 18 clinical incidents in the reporting period. Of these, 15 were classified as low risk while three were classified as moderate risk. Nine incidents which had resulted in no harm caused, three unknown harm, three low harm, two near misses, and one moderate harm which was reported to MHRA.
- 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 patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. Staff members could explain the process they would undertake if they needed to implement the duty of candour following an incident which met the requirements.

Are diagnostic imaging services effective?

We did not rate effective for this service.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness.

- Policies and procedures were developed in conjunction with statutory guidelines and best practice such as the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R 2017) as well as the National Institute for Health and Care Excellent (NICE), the Society and College of Radiographers.
- The service had a dual policy agreement which the unit manager and the host trust's imaging manager had agreed on. Both managers reviewed dual policies yearly to ensure policies were up to date and reflected best practice. Staff told us and we saw they had access to the dual policies and Alliance Medical Limited policies via the shared drive on the service's computers.
- New policies and procedure were reviewed and signed by staff to confirm understanding. The unit manager monitored the uptake of new policies.

Nutrition and hydration

- The waiting room had a water dispenser accessible to patients and visitors. Staff advised patients if they needed to drink any water before their appointment to improve the visibility and positioning of the internal anatomy.
- Patients were sent information with instructions about fasting before the scan. For those patients who were insulin-dependent, the service ensured patients who were monitored during and after scanning to ensure they maintained a normal blood glucose level if needed to be nil by mouth prior to their investigation.

Pain relief

- The service did not provide pain relief to patients. Staff contacted referring clinicians and referred patients back to them for pain relief if necessary. Staff informed us they encouraged patients to bring their own medication and during the scan ensured patients were comfortable throughout the procedure.

Patient outcomes

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

- The unit manager ran an audit programme which monitored patient outcomes and effectiveness of policies and procedures. Local audits were completed monthly and submitted to the host trust for monitoring. The agreed key performance indicators included but were not limited to referral to scan time, image quality, image recall audits, patient satisfaction and "did not attend" rates.
- An image recall audit was conducted to identify issues resulting in patients being called back to perform additionally scans. In the 12 months before our inspection, the service recorded six image recalls however, only one patient was recalled because of missed pathology. Lessons learnt were shared with staff at staff meetings. For this scenario radiographers were reminded to check the IT systems for pathology before scanning.
- Service utilisation was monitored each month by the service manager to ensure safety and quality were not compromised by increase in activity or staffing shortages. From July 2018 to December 2018, the service scanned on average 905 patients a month. The throughput for December was lower than the previous months, which was attributed to staff shortages and the Christmas holidays.
- Princess Royal MRI Unit provided a scan only service. The Royal College of Radiologists "standards for learning from discrepancy meetings 2014" does not require a provider to have a discrepancy meeting if they do not report on scans. However, we noted that image quality was reviewed by the radiologists and senior radiographers which was in line with good practice. Each month a member of staff reviewed 10 scans and commented on the overall quality of the scan, whether the correct protocol was followed and if the image resolution was adequate. Any issues identified were discussed with radiographers during the staff meetings.

Competent staff

The service made sure staff were competent for their roles.

- All radiographers were registered with the Health and Care Professional Council (HCPC) and were required to complete continuous practice development to meet their professional body requirements. Staff were required to renew their membership every two years and we saw that all radiographers had successfully renewed their membership.
- We reviewed the personnel files for clinical and administrative staff including the referring doctors. We found they all had evidence of a recruitment, employment history and satisfactory references.
- The unit manager kept a record of all clinicians who were entitled to refer patients and proof of their qualifications. There was also a list of practitioners and operators under Ionising Radiation (Medical Exposure) Regulations (IR(ME)R), which listed what procedures each clinical staff was competent to perform.
- Clinical competencies were reviewed on an ongoing basis and we saw formal documentation to support areas of development. The service conducted an intravenous cannulation audit as part of its audit programme. Clinical staff were required to perform a minimum of three cannulations a month to

demonstrate competency. Staff were assessed against five standards including hand hygiene and maintenance of a sterile environment and equipment whilst cannulating. Results from the October 2018 report showed 80% of staff demonstrated their competency. Staff who had failed to achieve the required number of cannulations were bank or agency staff and did not provide cover for the service frequently.

- The unit manager told us they kept their competencies up to date by working one morning and one evening a week. We noted and staff told us that the unit manager was involved in the daily activities of the service including the scanning of patients.
- Managers appraised staff's work performance and held supervision meetings with them to provide professional development to support a safe service to patients. All staff had received an appraisal in the last 12 months including the unit manager. The unit manager's appraisal was conducted by the regional manager and this had last been completed in March 2018.
- We reviewed two examples of appraisals for clinical and administrative staff which were aligned to the corporate and unit's objectives to support staff development. Staff were encouraged to express an interest in additional training that was not provided as part of the mandatory training programme. A clinical assistant told us Alliance Medical Limited had supported them to complete an intravenous cannulation course as it was relevant to their role and helped improve the efficiency of the service.
- The unit manager was the service's radiation protection supervisor (RPS) and had completed the core of competence course on radiation protection for radiation protection supervisors. The RPS's role was to ensure that the organisation remained compliant with the arrangements made under the Ionising Radiation Regulation 2017 (IRR17). In addition, they ensured that the local rules and local working instructions were adhered to.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients.

- The unit worked closely with the host trust providing a smooth pathway for patients. We saw effective communication between services and there were opportunities for staff to contact referrers and the radiologists for advice and support.
- We observed positive interactions and collaborative working between staff of all levels within the unit.
- Staff told us when inpatients from the host trust were scanned, there was an effective handover of clinical care and this was documented to support continuity of care.

Seven-day services

- Princess Royal MRI unit was open Monday to Sunday. The service operated from 8.00am to 8.00pm on one machine with a second scanner operating from 9.00am to 5.00pm Monday to Friday. If staffing allowed, the service would operate both MRI scanners later during the week and at weekends to increase capacity if required.
- The DXA scanner was opened one day a week, on a Monday from 9.00am to 5.00pm depending on the volume of referrals received.
- The service had access to an on-call radiologist 24 hour a day.

Consent and Mental Capacity Act

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

- Staff followed the service policy and procedures when a patient could not give consent. The service scanned 38 children and young people between the ages of 13 and 17 in the 12-month period to our inspection. Children and young people attending the service were assessed to be Gillick competent by the referring clinician in line with the provider's consent policy and paediatric service standards. Where the child was not legally competent, those with parental responsibility where required to give consent. Where written consent was required for an examination, then a paediatric consent form was obtained from the referrer.
- Staff demonstrated a good understanding of the relevant consent and decision-making requirements of legislation and guidance, including the Mental

Capacity Act 2005. Mental Capacity Act awareness training was not a mandatory training requirement for all staff. At the time of this inspection all staff had not completed this training. However, they were aware of what to do if they had concerns about a patient and their ability to consent to the scan. They were familiar with processes such as best interest decisions.

- All staff were aware of the importance for gaining consent from patients before conducting any procedures. We saw verbal consent was obtained when staff went through the patient safety questionnaire with patients and signed the form to confirm this.

Are diagnostic imaging services caring?

Good

We rated it as **good.**

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

- We spoke with four patients during our inspection and the feedback was positive. One patient on the unit told us "the staff have been marvellous" and another told us that it was their first time using the services and they were given all the information prior to their appointment and the staff had been attentive and caring.
- Following each scan, patients were invited to complete a patient satisfaction survey via email. Results of these survey were displayed within the unit. Overall responses were positive with 96% of patients stating they would recommend the service to family and friends. A further 75% of patients said they were very satisfied with their overall experience.
- The service had a privacy, dignity, and respect policy. During the inspection we noted staff working in accordance with the policy. The radiographers kept patients' privacy and dignity ensuring they were covered up until the point of scanning. The radiographer communicated with the patients through the intercom throughout the scan to ensure the patient was comfortable.
- The service had a chaperone policy that was in date and we saw posters displayed throughout the unit informing patients that they could have a chaperone present for their scan. A chaperone is a person who serves as a witness for both a patient and clinical staff as a safeguard for both parties during a medical examination or procedure.

Emotional support

Staff provided emotional support to patients to minimise their distress.

- We observed a patient who had come in for a scan and suffered from anxiety and claustrophobia. Staff talked to the patient and discussed the process thoroughly. The service offered the room they used for cannulation as a quiet area and performed scans in a 'feet first' position into the scanner. This was beneficial as it meant that the patients' head would not need to enter the scanner and therefore would dramatically lower the expectation or experience of claustrophobia.
- Staff provided constant reassurance throughout the scan, they updated the patient on how long the next scan was and how long they had left. The radiographer communicated with the patient through the intercom throughout the scan to ensure the patient was comfortable. This was observed throughout the inspection.
- The staff we spoke with described how important providing emotional support for patients was especially when they receive a life changing diagnosis and felt providing support to patients as an important part of their job.
- Staff offered patients ear plugs to protect their ears from the noise of the MRI scanner.
- The service allowed patients to bring their own music to listen to during the scan, which helped minimise their distress.

Understanding and involvement of patients and those close to them

Good

Diagnostic imaging

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

- Staff communicated with patients and their relatives in a way that they could understand. Patients were given enough time to ask questions and we observed this. Staff took time to explain the procedures and answer all questions.
- Patients and families were given verbal and written information. Information leaflets were displayed for patients and visitors to read. The topics of these included patient information, infection prevention and control and MRI.
- The service allowed for a parent, family member or carer to remain with the patient for their MRI scan. If this was necessary, the carer would complete the safety questionnaire to ensure they were eligible to be in the scanning room.

Are diagnostic imaging services responsive?

Good

We rated it as **good.**

Service delivery to meet the needs of local people

The service planned and provided services in a way that met the needs of local people.

- The unit was located off the main hospital on the lower ground floor with its own entrance and was easy to find and was well signposted. Information was provided to patients in the form of appointment letters before appointments and included a map and directions on how to find the unit.
- The service was located near established routes, with a bus stop a short distance away. Patients travelling by car had access to a car park however, parking spaces were limited.
- The service was open seven days a week with the opening hours aimed to support accessibility for all. Choices of appointments were offered to meet the needs of the patient and depending on the protocol and availability, some patients could have their scan on the same day the referral was made.
- The Alliance Medical Limited website provided useful information about the service including downloadable patient safety questionnaires to complete before attending their appointment.
- All patients were informed of when they could expect to receive the results from their scans.
- Staff told us that the service scanned children and young people no younger than 13 and they were attended to by staff who had training in Paediatric Immediate Life Support (PILS) and were safeguarding children level 3 trained.

Meeting people's individual needs

The service took account of patients' individual needs.

- Access for disabled people was managed well. There was enough space to manoeuvre and position a person using a wheelchair in a safe and sociable manner. This included two changing rooms of different sizes, one of which could accommodate a wheelchair.
- Patients were screened during the booking stage to ensure reasonable adjustments were made before their appointments. Patients had access to a hoist to provide a safe and effective patient transfer. Staff were trained to use the hoist as part of their mandatory training.
- The service ensured that it was accessible for all. Although they did not have equipment for bariatric patients, the MRI scanner could take a patient weighting up 250kgs. In the event a patient could not be safely scanned, the service referred them to the nearest open MRI service that could accommodate the patient within the Alliance Medical Limited group.
- The service could provide patient information leaflets in a range of formats and languages. In addition, staff told us they could provide information leaflets in Braille for patients with a visual impairment.

- The service offered additional support to help patients and their families. For example, patients could access interpreting and translation services to better understand and be involved in their care and treatment.
- Patients had complained that the doors were too heavy and not wheel chair friendly. The service changed the doors to automatic with a push button for wheel chair users.

Access and flow

People could access the service when they needed it. Waiting times from referral to scan were in line with good practice.

- The service reported no cancellations and 27 delayed procedures during the period November 2017 to October 2018. The majority were due to equipment breakdown. In the event that an appointment was cancelled due to any unexpected issue, the patients' appointment was rebooked as soon as possible. A patient we spoke with confirmed this and said their appointment was rescheduled promptly.
- The service did not audit such delays. Appointments ran to time; staff would advise patients of any delays as they signed in or waited at the waiting area.
- Staff told us the service blocked out two hours a day for inpatients and urgent outpatient referrals. If no appropriate appointments were available, either a routine appointment would be deferred (with that patient offered another appointment as soon as possible and at their convenience) or the request would be accommodated with the knowledge that the service would over-run. In the second scenario all patients affected were be kept informed of the reason and length of any delay, which we observed during our inspection.
- Referrals were prioritised by clinical urgency and added on to the host trust IT system. Staff told us the referring clinician indicated the urgency of the referral by stating whether it was urgent, routine or 62-day cancer pathway referral appointment. Once the referral was vetted, the examination was appointed with due regard to urgency.
- The service had contractual key performance indicators agreed with the host trust. The contract was in line with the NHS six weeks diagnostic waiting times. The service recorded breaches in turnaround times to monitor performance and generally met their targets. However, records showed for November 2018, 14% of inpatients were not scanned within 24 hours of receiving the referral. This was due to an unusually high volume of inpatients. The service managed to scan all inpatients within 3 days.
- The service actively monitored "did not attend" (DNA) rates. Staff reported a low DNA rate as the service was provided at times that were convenient to the patient. From July 2018 to January 2019 the rate was 4% which was attributed to patient illness. Administrative staff told us if a patient missed an appointment attempts were made to contact the patient and reschedule the appointment. When patients were unreachable, the administrative staff referred the patient back to the referring clinician who was responsible for following up the patient.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

- Leaflets were available in the waiting area titled 'Compliments, Concerns, and Complaints'. The leaflets gave instructions to patients on how they could complain or raise concerns to the provider. We noted that NHS patients were directed to complain to the Parliamentary and Health Service Ombudsman and for self-funding patients there was information about the Independent Sector Complaints Advisory Service (ISCAS).
- Patients we spoke to knew how to make a complaint or raise concerns. Staff told us they would refer patients to the compliments, concerns and complaints leaflet should they wish to raise one.
- During the period November 2017 to October 2018, the service received three complaints, all of which were upheld. These were dealt with as part of the formal complaints process. Complaint themes included staff communication, and cancelled appointments. Learning from complaints was shared at team meetings and via the risk bulletin.

- The unit manager was responsible for investigating all complaints in line with Alliance Medical Limited corporate complaints policy.
- We reviewed three complaints in their entirety. Responses were provided in a timely way, were clear, thorough and all parties that should have contributed to the investigation did so.

Are diagnostic imaging services well-led?

Good

We rated it as **good.**

Leadership

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.

- Staff spoke positively about senior leaders of Alliance Medical Limited. Although they did not see them regularly, they felt they had the right level of support from them and would feel comfortable approaching them if they had concerns.
- The local leadership consisted of the unit manager, who was supported by a lead radiographer and lead administrator. Clinical members of the leadership team led by example and maintained their clinical competency and skills by working as part of the scanning team.
- The unit manager was knowledgeable about the service. They understood the day to day challenges and future developments of the service.
- Staff spoke in positive terms about the visibility and approachability of the local leadership team. They said they felt free to raise any issues with them directly and told us they were confident any concerns would be addressed properly.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action.

- The service's aims were to provide high standard of diagnostic imaging to meet the needs of the hospital, referrers, and their patients as well as those of Alliance Medical national accounts and contract agreed patients.
- Alliance Medical Limited had a set of values which included; "collaboration, excellence, efficiency and learning" which were displayed on the corporate website.
- Staff we spoke with understood what the vision and values for Alliance Medical Limited were and told us their work contributed to achieving the vision.

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

- Staff we spoke with told us they felt proud to work for the service and they enjoyed the work they did within the unit. Throughout our inspection, staff spoke in positive terms and commented about how they felt appreciated, respected, valued, and supported by the unit manager and fellow colleagues. Staff said working for the service had a very 'family feel' and many of them had worked there since the service opened.
- From our observations we noted positive interactions amongst staff during the inspection. We saw the team communicated well with each other and with patients and saw a cohesive approach to working in a busy service.
- Alliance Medical Limited collected and published Workforce Race Equality Standards (WRES). WRES data is used to help providers to close the gap in workplace experience between white and black and ethnic minority (BME).
- Alliance Medical Limited's last WRES report was published in July 2018 and found there was a significant increase in the proportion of recorded ethnicity data since 2016 from 13.5% to 82%. The organisation could make a meaningful analysis across the most of the nine WRES indicators. For example, workforce indicator seven: Percentage believing that Alliance Medical provides equal opportunities for career progression or promotion had increased for

both white and BME staff from the 2017 to the 2018 survey. The percentage for white staff increased for 70% to 75%, while BME staff increased from 69% to 76%.

Governance

The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.

- Princess Royal MRI Unit had an established unit structure that supported governance and ensured clear lines of responsibility. The unit manager was the lead for governance and quality monitoring and reported to the regional director and liaised with the central quality and risk team.
- The unit manager produced monthly performance reports which were shared with the host trust to monitor and review key point indicators. Performance was shared with staff and staff told us the reports were valuable as they we made aware of how the service was performing against set targets and implement changes where issues were highlighted. For example, the service had identified an increase in the "did not attend" rate for patients attending at the weekend. In addition, they recognised patients attended at the weekend had reduced mobility. This was particularly difficult as there were less staff available at the weekend to help with patient transfers. Staff were now contacting the patients to confirm their appointments and their mobility status to ensure there were enough staff present or to offer a weekday appointment.
- The unit manager attended monthly manager meetings at the organisation's headquarters. Corporate messages from this meeting were shared with local staff at the monthly meetings.
- Staff meetings occurred on a regular basis and had a set agenda. Meetings were minuted and issued to all staff so those not in attendance could consider topics discussed. There was evidence that learning from incidents was included in discussion, as were operational risks, workforce challenges, updates to policies and other topics relevant to staff within the unit.

Managing risks, issues and performance

The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.

- The unit had a local risk register and was subject to an annual quality assurance review (QAR), which was aligned to national guidance in support of a safe and effective service. Actions from the QAR report and other audits were monitored locally and at corporate level.
- The unit manager kept a record of service specific risks. The likelihood and the impact of the risks were considered and the likelihood and impact to the service if the risk occurred. All risks had controls put in place to reduce the likelihood of the risk occurring. The service had a risk assessment system, which was clearly identified and managed risks, with a process of escalation onto the corporate risk register.
- The local risk register had 25 risks at the time of our inspection. The top risk related to delivering contrast medium and the adverse reactions associated. This risk was rated as low with a score of eight. The unit manager told us they were responsible for reviewing the register and updating it if policies changed or an event had occurred that required the risk to be downgraded or escalated.

Managing information

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

- Information governance formed part of the mandatory training programme. Records showed 75% of staff had completed the training, which did not meet the organisation's target of 90%. However, staff we spoke with understood their responsibilities regarding information management.
- There were systems to ensure staff had access to information they needed to deliver effective care to patients in a timely manner. There were enough computers in the unit to enable staff to access the systems when they needed to. Staff had individual login information to access the service's IT systems.

- Staff ensured confidential data was kept secure from unauthorised persons. We saw staff locking their computer screens when they were not in use or away from the desk.
- The service ran a paperless system which staff said had increased efficiency and organisation. Staff told us they could easily collate data and turn this into meaningful data to improve the quality of care and the service they provided.
- Alliance Medical Limited was accredited with ISO27001 and were audited against the standard on a rolling programme. ISO27001 is an international standard for information security management system. This demonstrated that the organisation was following information security best practice and provided independent verification that information security was managed in line with international standards.
- Scans could be reviewed remotely by referrers to give timely advice and interpretation of results to decide appropriate patient care.

Engagement

The service engaged well with patients and staff to plan and manage appropriate services, and collaborated with partner organisations effectively.

- All staff received newsletters called "Risky Business" via email. The newsletter informed staff of developments at other sites within the Alliance Medical Limited group, incidents, risks, learning and performance information.
- Additionally, every three months the unit manager shared a brief from the managing director. This allowed staff the opportunity to feedback areas they think were important to them, to support the service.
- There was ongoing patient engagement through the use of patient surveys however, the uptake rate was low. Patients were invited to complete a survey via email and from March 2018 to January 2019 the uptake rate varied between four and ten percent. Staff had attributed this to patients providing old email addresses that may have not been in use or patients forgetting to complete the survey after they had left the unit. The service had recently introduced paper surveys that could be completed on site to increase the completion rate.
- We saw posters displayed in the unit with example of changes the service had made as part of the 'You said, we did' initiative. Recently the service had improved the information provided in the appointment letters they sent out to patients as a result of the feedback they had received. Changes had been made to the unit map to make it clearer for visitors to find.
- The service maintained good working relationships with the host trust and referrers. Staff told us communication with the host trust was good and they were informed of any changes that may affect the service at the earliest opportunity. For example, if there was to be an increase of referrals, the service was warned so they could adapt their shifts accordingly.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things went well or wrong, promoting training, and innovation.

- The service promoted continuous learning. Staff told us they were provided with opportunities to attend additional training which would help them in their roles. The notice board in the staff room displayed an application for a breast MRI study day. Staff were encouraged to apply and attend such courses with the aim to bring learning to the team.
- Junior staff told us the service supported their development and extended the scope of their roles. The service had increased the competency of clinical assistants by training them to cannulate. This had increased their job satisfaction whilst making better use of radiographer's time in a busy unit.
- We spoke with a clinical assistant who had recently started an apprenticeship. The service manager told us they offered further training to clinical assistants with the aim to reduce turnover in this valuable staff group.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should consider placing additional controls and physical barriers, restricting unauthorised access to the MRI units and improving the safety of patients and visitors entering the unit.
- The provider should consider removing the carpeted flooring in the DXA room, to meet the requirements of Health Building Notice (HBN) 00-09: Infection control in the built environment.
- The provider should consider recording contrast media administered for the scan in all patient care records.