Churchtown

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Churchtown is operated by Bump of Churchtown Ltd. The service provides ultrasound scans for self-paying pregnant women including gender scans or three-dimensional and four-dimensional scans of their baby.

We inspected this service using our comprehensive inspection methodology. We carried out the short-announced inspection on 23 January 2019.

To get to the heart of patients' 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.

Services we rate

We rated it as **Good** overall because:

- Staff completed mandatory training appropriate for their roles.
- Staff understood how to recognise a safeguarding concern and how to signpost to other agencies.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- The service had suitable premises and equipment and looked after them well. The scan machine was serviced annually.
- Staff knew how to escalate concerns about women and signposted them appropriately to their booked NHS trust hospital.
- The service provided care and treatment based on national guidance. Audits had been completed to monitor outcomes for women.
- The service understood how to assess whether a woman had the capacity to consent to the scan and would not scan if the woman lacked capacity.
- The service cared for women with compassion. Feedback from women confirmed that they were treated well and with kindness.
- We observed positive interactions between staff and families.
- The service provided self-pay care in a way that met the needs of local women. Some individual patient needs could be met, such as visual impairment. Women could access the service when they needed it.
- The service had a "philosophy" that was displayed on the website and had a strategy for the future. There was an open culture and the manager strived to make continuous improvements.
- The service managed and used information well to support all its activities, using secure electronic systems.
- The service was committed to improving services by promoting training, innovation with plans to expand the service.

However;

- Not every woman was able to use the service, such as if not able to understand English.
- The service had a system to identify risks, however; the document seen on inspection, had not been fully completed, with no dates for review.
- The service had policies in place, however; these were not dated, including no dates for review, and not all were referenced to good practice or national guidelines.

Following this inspection, we told the provider that it that it should make improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Summary of findings

Ellen Armistead

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 	Bump of Churchtown provides ultrasound scans for self-paying pregnant women. Diagnostic imaging was the only core service provided at this service. In the twelve months prior to inspection, there were 1,301 scans carried out. We rated safe, caring, responsive and well-led as good. We did not rate effective because we do not have enough information to make a judgement. Staff had completed mandatory training and had the skills to carry out their roles. Care was delivered in line with national guidance and any concern was shared with ta local NHS service. Women were positive about care provided. There were plans to expand the service.

Summary of findings

Contents

Good

Churchtown

Service we looked at
; Diagnostic imaging

Summary of this inspection

Background to Churchtown

Churchtown is operated by Bump of Churchtown Ltd. The service opened in 2016. It is a private service close to Southport, Merseyside. The service primarily serves the communities of the Southport area. It also accepts patient referrals from outside this area across the North West of England.

The service has had a registered manager in post since 2016.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and a second CQC inspector. The inspection team was overseen by Judith Connor, Head of Hospital Inspection.

Information about Churchtown

The service was registered to provide the following regulated activities:

- Diagnostics and Screening procedures.

During the inspection, we visited the service and spoke with the registered manager, who is the owner, and is a qualified practising diagnostic radiographer with a post graduate diploma in sonography. The owner is supported by a part-time receptionist. We spoke with two women who were using the service and four relatives. During our inspection, we reviewed 10 sets of women's consent form records as well as feedback from women.

There were no special reviews or investigations of the service by the Care Quality Commission at any time during the 12 months before this inspection. The service had not been inspected before.

Activity (January 2018 to December 2018)

In the twelve months prior to inspection, there were 1,301 scans carried out.

Track record on safety

There were no never events.

There were 22 incidents in total. These included 18 incidences where the heart beat could not be detected, two incidences where the baby could not be viewed in the uterus (womb) and two where the sonographer considered the baby needed to be reviewed.

There were no incidences of meticillin-resistant staphylococcus aureus.

There were no incidences of meticillin-sensitive staphylococcus aureus.

There were no incidences of clostridium difficile.

There were no incidences of escherichia coli.

There were no complaints.

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:

- Staff had completed mandatory training appropriate for their roles.
- Staff understood how to protect patients from abuse and the service signposted to other agencies in the event of a concern. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- The service had suitable premises and equipment and looked after them well. The scan machine was serviced as part of an annual contract.
- Staff knew how to escalate concerns about women and signposted them appropriately to their booked NHS hospital trust or GP.
- Staff kept records of women's attendance in secure password protected electronic systems that included the scan machine.
- The service managed patient safety incidents well. The sonographer recognised incidents and reported them appropriately.

Are services effective?

Not sufficient evidence to rate

- The service provided care and treatment based on national guidance.
- The service completed audits to monitor outcomes for women and used the findings to improve care at the service.
- The owner, who was the registered manager, was a practising qualified diagnostic radiographer with a post graduate qualification in sonography.
- The service was available Tuesdays to Saturdays with evening appointments on Wednesdays.
- The service understood how to assess whether a woman had the capacity to consent to the scan and would not scan if the woman lacked capacity.

Are services caring?

Good

We rated it as **Good** because:

Summary of this inspection

- The sonographer cared for women with compassion. Feedback from women confirmed that they were treated well and with kindness.
- Emotional support was provided to women and their families to minimise their distress in the event of bad news.
- The sonographer involved those close to women during the scan and any other care.

Are services responsive?

Good

We rated it as **Good** because:

- The service provided self-pay care in a way that met the needs of local women.
- Some individual patient needs could be met, such as visual impairment.
- Women could access the service when they needed it. There was no waiting times and appointments could be made flexibly for families.
- The service encouraged women to provide feedback about the service and had not received any complaints.

However

- There was no information in formats other than standard English or an interpreter service. There was no access for wheelchairs.

Are services well-led?

Good

We rated it as **Good** because:

- The service had a “philosophy” that was displayed on the website and had plans for the future.
- There was an open culture and the manager strived to make continuous improvements.
- The service had a governance framework that included recruitment checks for additional staff.
- The service managed and used information well to support its activities, using secure electronic systems.
- The service engaged well with women to plan and manage the service, and contacted other organisations appropriately.
- The service was committed to improving services by promoting training and innovation and had plans to expand the service.

However

- The service had a system to identify risks, however; they had not been fully completed, with no dates for review.
- The service had policies, however; these were not dated, including no dates for review, and were not always referenced.

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	Good	Good

Good

Diagnostic imaging

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

Are diagnostic imaging services safe?

Good

We rated it as **good.**

Mandatory training

Both staff members completed e-learning training in areas relevant to support their role.

The registered manager, who carried out the scans had completed training for modules including fire safety, equality and diversity and information governance. The part-time receptionist had completed modules including challenging behaviour, lone working, bullying and whistleblowing.

Safeguarding

There were no notifications of safeguarding incidents reported to the CQC between January 2018 and December 2018.

There was a safeguarding vulnerable adults and children policy that included signposting to the local safeguarding teams and links to guidance to follow that included a flow chart process. There were no dates included of when policy came into operation or a date for the review of the policy.

The registered manager understood their role and responsibility in safeguarding and knew how to raise matters of concern appropriately.

Safeguarding training was completed by both staff members via e-learning. The registered manager, who was the sonographer, had completed levels one and two for adults and children. The receptionist completed safeguarding level one for adults.

There were no safeguarding posters displayed, in any area for staff or public to view. This information could signpost women to appropriate support if there was a safeguarding concern.

Cleanliness, infection control and hygiene

There were no incidences of meticillin-resistant staphylococcus aureus, meticillin-sensitive staphylococcus aureus, clostridium difficile or escherichia coli reported by the service between January 2018 and December 2018.

The reception area, corridor and scan room were visibly clean and well organised. A toilet was available for staff and public use with a hand washing area. Hand gel sanitizers were available in the scan room and waiting area. The sonographer was observed using hand gel before providing patient care and was ‘arms bare below the elbow’ in the scan room.

Daily cleaning schedules were in place and completed to show when last cleaned. A weekly domestic clean was completed.

We observed that the abdominal probe, for the machine, and the scan room couch were cleaned between women with clinical wipes.

All waste was disposed of as domestic waste as no clinical waste was generated.

Good

Diagnostic imaging

Staff had completed mandatory training for infection prevention and control within the twelve months prior to inspection.

Environment and equipment

The service was located in a grade two listed building that was located on a main road of a village.

Staff and families accessed the building by the front door into the reception and waiting area. This was free from clutter, well-lit and had adequate seating, for families.

Between the waiting room and scan room, was a kitchen area and toilet facilities.

The scan room included a fire exit that was clearly marked and accessible.

Consumables including scan paper, scan gel and paper rolls for the scan couch were stored and available for use.

The service had a maintenance contract for the ultrasound scan machine. Records seen showed that the machine had been served in 2017 and 2018 as well as arrangements for any breakdowns. The scan machine settings conformed to the British Medical Ultrasound Society guidelines for non-diagnostic scanning.

Assessing and responding to patient risk

Women self-referred to the service via different routes that included enquiries via phone, website or social media.

The gestation of the pregnancy was confirmed with the woman, including their last menstrual period and a positive pregnancy test, to ensure that the scan was not booked too early. In addition, if the woman had symptoms of back pain or history of bleeding, the woman was signposted back to their local NHS hospital trust. An example was provided of a woman who said her pregnancy was more advanced that it was resulting in concerns for the sonographer and a need to consult the NHS hospital trust.

We observed the manager confirming the identity of the woman booked and how many weeks pregnant the woman was.

Environmental risk assessments had been identified, such as slips and trips, that were health and safety based for the centre.

A first aid box was available if needed. In the event of an emergency an ambulance would be called to escort a woman, or family member to the local NHS hospital.

In 2018 the sonographer had completed a Resuscitation Council accredited e-learning course for cardiopulmonary resuscitation and automated external defibrillation as part of mandatory training. A practical basic life support course had been completed in the NHS in 2017.

The consent forms available depended on which package of scans the woman had booked for. They were completed on an electronic tablet. The consent form included information about the potential risks and confirmation that the scan was not for clinical reasons. The website had a frequently asked questions section that included information about any potential risk to the woman and her baby as well as signposting to the British Medical Ultrasound Society for further information.

During the scan, we observed that the woman was advised that this was an extra scan and should continue with their routine antenatal appointments as planned. There was no written record of these scans, other than at the service; the reliance was on the woman to inform the trust.

The manager knew how to escalate concerns if the sonographer was not able to detect a heartbeat, a pregnancy in the uterus, or considered there may be an abnormality seen. The woman was informed verbally that they needed to consult the hospital they were booked with or her GP. Depending on how far the pregnancy had progressed they were advised to contact either their named midwife or the early pregnancy assessment unit if under 16 weeks pregnant. For pregnancies over 16 weeks they should contact either their named midwife or the delivery suite at the hospital.

The sonographer completed a written report, that was emailed to the woman so that they could present the report at the hospital or to their GP. If the sonographer was concerned that the pregnancy was not in the woman's womb, and may be ectopic, then the NHS hospital trust was also contacted by telephone.

The sonographer did not diagnose, in this role; the suspected findings needed to be confirmed in a NHS hospital trust setting where treatment could be given.

Good

Diagnostic imaging

Staffing

The service was staffed by the owner who was the registered manager and sonographer, and a part-time receptionist. The receptionist had been employed within twelve months of the inspection and received an induction at the time of appointment.

The service operated according to sonographer's availability and was closed for any annual leave or in the event of any sickness. If the sonographer was the only staff member, the front door was locked, including when in the scan room with families.

Records

Staff kept appropriate records of women's scans and consent forms.

Consent forms were completed with electronic signatures, on a tablet device. These were uploaded to the main computer and stored securely. Back-up systems were in place.

The scan machine was password protected to maintain confidential details of the woman. The date of the scan and the woman's date of birth were inputted into the scan machine as well as a name, for the baby, chosen by the woman. The service routinely carried out scans for women aged 18 years or above.

All scan pictures taken were copied to the woman's email or social media accounts as requested. The machine was cleared of all images every three months.

Incidents

The registered manager recognised incidents and reported them appropriately.

Between January 2018 and December 2018, there were 22 women referred to their local NHS hospital trust. Of these, there were 18 women where the fetal heart beat could not be detected, there were two women who had ectopic pregnancies (baby not seen in the womb) and two where an abnormality was suspected.

All women were able to be transported by those close to them except one woman who was transported via an ambulance when the service opened as an extra precautionary measure.

The sonographer did not receive feedback from NHS trusts following incidents, although women contacted the service with the outcome. The sonographer understood the duty of candour. 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.

Are diagnostic imaging services effective?

Not sufficient evidence to rate

Evidence-based care and treatment

The service followed guidance including the National Institute for Health and Care Excellence and the British Medical Ultrasound Society.

Policies had been developed at the service in line with national guidance and current practises.

The receptionist had been required to read policies as part of the induction process.

Patient outcomes

The manager reviewed the quality of the service by seeking feedback from women following the scan to check that there were no concerns about the service provided.

Between January 2018 and December 2018, the service carried out an audit of gender scans to monitor the accuracy of the gender being correct. A request was posted on to a social media site that requested feedback, from women about the accuracy of their gender scans. There were 85 women who responded and all babies were the same gender as told during the scan at the service, showing a 100% accuracy rate.

Competent staff

The registered manager and owner was a qualified diagnostic radiographer (2008) with a post graduate diploma in sonography (2016). Certificates of qualifications were displayed at the service. The manager confirmed membership of the society of radiographers and current registration with the Health and Care Professions Council.

Good

Diagnostic imaging

The manager was in contact with peers regarding any notifications of any updates or changes in practice.

The part-time receptionist had been employed for less than a year and had, therefore; not received an annual appraisal yet.

Multidisciplinary working

When the service opened, if a concern was noted during a scan, the manager contacted the woman's local NHS hospital to discuss the concern directly. The manager found that hospital staff preferred a written report, therefore; unless the concern was considered urgent, the report was sent to the woman to pass to the hospital or her GP.

Seven-day services

The service was available five days a week, from Tuesday to Saturday, with evening appointments on Wednesdays.

Consent and Mental Capacity Act

The registered manager understood their role and responsibilities under the Mental Capacity Act 2005.

We observed the manager obtaining verbal consent prior to any care.

Each woman was required to complete a consent form on an electronic tablet prior to a scan.

We reviewed consent forms, for 10 women; all had been electronically signed and dated appropriately.

The manager told us that any woman who presented as not having capacity to consent, would not be scanned. Similarly, a woman who did not understand English would not be able to have a scan as interpreters were not available.

The manager gave an example of a woman with a visual impairment. The consent form details were read out loud to the woman and understanding confirmed prior to consent. As the consent form was electronic, the font size was also enlarged.

Are diagnostic imaging services caring?

Good

We rated it as **good.**

Compassionate care

The manager cared for women with compassion. Feedback from women confirmed that they were treated well and with kindness.

Women described care as positive throughout the process. The manager introduced themselves and communicated well to ensure they fully understood the procedure.

Women and their families were escorted to the scan room by the manager. The scan room door was closed, when a woman was undergoing the scan to ensure privacy and dignity for the procedure.

We observed a woman during a scan. We observed the manager confirming the well-being of the women before and during the scan and checking comfortable.

The scan included measurements and sound of the baby's heart beat as well as four dimensional images of the baby. It was explained that this scan was extra to their NHS antenatal scans and that antenatal care should continue as planned with the NHS. There was good interaction between the sonographer and the family and time given to see a selection of images.

Women were encouraged to provide feedback about the service.

Thank you cards were displayed in the waiting room, one included: "we were so grateful for you staying later to see us so I could put my mind at ease."

A comments book was displayed in the reception area along with feedback sheets. One comment, from a woman included that: "we have been to different scanning places over the years and this is the friendliest and most relaxed experience we have had." Women received an email, following the scan that included a request for feedback, whether positive or not to help improve the service. Women responded via social media sites or the organisation's website.

Emotional support

The manager provided emotional support to women and their families when needed.

We observed the manager providing reassurance and comfort to families if anxious about the scan.

Good

Diagnostic imaging

No personal details were discussed outside of the scan room to maintain privacy at all times.

Appointments were scheduled so that only one family was present if the sonographer was the only staff member present. This meant if a scan identified any concerns, the sonographer could give time to the family in private.

In the event of another family being in the waiting area, on a busier day, such as Saturday, a distressed family could leave via the fire exit door in the scan room to avoid meeting other people.

Understanding and involvement of patients and those close to them

The manager involved women and their families in care provided.

Families were encouraged to ask questions and were given time to ensure they understood what was being said to them.

We observed the manager interacting positively with families and spoke to them sensitively depending on their need.

In the scan room, seating was available for family members and the images were displayed on a large screen so could be viewed by all in the room.

Are diagnostic imaging services responsive?

Good

We rated it as **good.**

Service delivery to meet the needs of local people

The service provided care for women, who self-referred and self-paid from the local area and across the North West of England.

Initial enquiries about the service, came via social media, telephone or the website.

The gestation of the pregnancy was checked, prior to appointments being confirmed to ensure the woman did not present too early in the pregnancy. The service booked appointments Tuesday to Saturday and also Wednesday evenings, although there was flexibility to accommodate requests.

Refreshments of hot and cold drinks and biscuits were available for women as well as toilet for public use. The service was located on a main road of a village, that was a bus route, where there were shops and cafes nearby.

Contemporary music was played whilst families waited. There were shelves displaying items (including their prices) that could be purchased such as gender- specific teddy bears and footballs, keyrings and photo frames.

As there was one sonographer, the service was closed for annual leave or any other absence. A telephone answering service was available for phone enquiries when the service was closed.

Meeting people's individual needs

The service responded to some individual needs although some women could not access the service.

The building was grade two listed which meant the layout was not suitable for wheelchair users. This was highlighted on the organisations website. Women needed to transfer onto the scan room couch independently as no hoist equipment was available. However, the service had seen women with reduced mobility, such as when using crutches.

The service did not see women who did not understand English as no interpreters were available and did not see women who lacked capacity to consent, such as with severe learning disabilities.

There was no hearing loop for women with a hearing difficulty, although the service had made adjustments for women with visual impairments.

The scan bed was suitable for women who weighed up to 30 stone although it was explained to woman, on booking that for larger women it was more difficult to see the baby.

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Access and flow

Women accessed the service according to their individual preference.

Good

Diagnostic imaging

Between January 2018 and December 2018, there were 1,301 scans that took place. To help prevent women from not attending, a £20 refundable deposit was taken at the time of booking.

There were no cancellations, for the same time period. There was no waiting list and appointments were made according to women's choice, including out of hours by special arrangement.

Complaints and compliments

The service sought feedback from women following scans. An automated email was sent to women to request they provide details of their experience. The organisations website also included details of how to complain if needed.

The service had a complaints policy that included signposting to an independent organisation if dissatisfied with the response.

Between January 2018 and December 2018, the service had not received any complaints; there were 94 compliments received.

The manager gave an example of a woman who thought the images were not as clear as expected. The manager explained that the scans were appropriate for the package obtained. Despite this, the manager repeated scans without extra charge.

Are diagnostic imaging services well-led?

Good

We rated it as **good.**

Leadership

The service had two staff members. One was the owner, who was also the registered manager and the sonographer; the other, was the part-time receptionist.

Vision and strategy

The manager told us about the vision and strategy of the service that included expansion plans and relocation to larger premises, although this was not recorded in a document.

The website included the "philosophy" about allowing women time for their appointments and welcoming any feedback to improve the service.

There were plans to expand the service that included re-locating to larger premises, near to the current location, and employing a second sonographer.

Culture

The manager promoted a positive and open culture that supported and valued the other staff member. They worked together as a team to support women and their families.

Governance

The service had a clinical governance and assurance policy. This included three main aims; to provide high standards of care, to be transparent, responsible and accountable and to constantly improve the service.

The registered manager, who was the owner, confirmed active registration with the Health and Care Professions Council and certificates of qualifications were on display. Details of public indemnity insurance were shared although not displayed. The service had been operating since 2016; the manager confirmed that an enhanced check had been completed, at that time with the disclosure and barring service.

For the receptionist, the service had carried out appropriate employment checks for the receptionist prior to taking up the position. The manager told us that a standard disclosure with the disclosure and barring service had been applied for. Confirmation of the status of application was forwarded from the manager.

Information regarding the cost of scans was available on the website, could be discussed during any telephone enquiries and were clearly displayed at the service.

The clinical governance and assurance policy stated that the service was Care Quality Commission accredited rather than registered.

Managing risks, issues and performance

The service had completed a "shop risk assessment", when the service began. These were documented in an electronic system.

We observed that these were health and safety risks where hazards were identified, the individuals who may

be harmed identified and what actions, if any, had taken place. However, there were no details about any further actions needed including staff responsible or dates for these actions included. The document did not include a date for review or include any organisational risks.

Managing information

The service used password protected electronic systems for consent forms, scanning reports and feedback, that were backed up. The only paper used was for anonymous feedback forms, the comments book and images printed and given to families.

Information governance was included in mandatory training.

The building included an alarm system that recorded movement. This was activated when the service was closed.

The services' clinical governance and assurance policy and information governance policy included reference to the Data Protection Act but did not reference the General Data Protection Regulation (2018).

Engagement

The service engaged well with the public requesting feedback from women by email, website social media platforms, comments book and anonymous feedback forms.

There was one other staff member employed as a receptionist, for Wednesday evening and Saturdays. The managed discussed the service directly with the receptionist as needed.

Learning, continuous improvement and innovation

The service was committed to improving services by encouraging feedback to promote learning from when things went well and when they went wrong.

Form an audit that was undertaken for women at fourteen and sixteen weeks pregnant, the service was offering an increased range of service offered, as included in the website.

In 2017, the service carried out an audit to see if gender could be identified from scans prior to 16 weeks of pregnancy. The 'nub theory' suggests that gender can be identified earlier in the pregnancy. Between 11 and 13 weeks, all babies are said to have a 'nub' between their legs and according to the theory the angle of the nub will indicate whether the baby will be aboy or a girl.

To test this theory, the sonographer scanned 100 women volunteers at 14 weeks pregnant, determined the gender but did not disclose to the women. The scans were repeated at 16 weeks pregnant to see if the gender was assessed as the same. It was found that there was 100% accuracy in determining the gender at an earlier stage of the pregnancy. This meant that the service now offered gender scans at 14 weeks of pregnancy.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

The service should consider displaying information about safeguarding in the public areas.

The service should consider information that is accessible in a range of formats including languages other than English.

The service should consider reviewing the environmental risk assessments and that they are completed appropriately.

The service should consider reviewing policies to ensure that dates of implementation, review and references to national guidance are included.

The service should consider re-wording reference to CQC in the governance framework as registered.