Ultrasound Plus Limited

Watford Clinic

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Inspected but not rated
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

Our rating of this location improved. We rated it as requires improvement because:

- The environment was well maintained but it was not always suitable for all types of care and procedures being provided. The service did have some processes for reporting, investigating incidents but there was a lack of evidence of lessons learnt being shared with staff.
- The systems and processes in place to ensure policies and guidelines were reviewed was not effective. The service did have some processes in place to monitor the effectiveness of care but did not use the findings to improve them. The service did not always make sure staff were competent for their roles.
- There was not an effective system for learning from complaints.
- There were some systems and processes in place to maintain the overall governance of the service, but these were not fully embedded. There was no evidence of that risks and the mitigating actions were discussed with the team. There was lack of systematic approach to continuously improve by learning from when things went well or wrong.

However:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. Staff managed clinical waste well. Staff assessed risks to patients, acted on them and kept good care records. Staff understood their roles and responsibilities to raise concerns and report safety incidents.
- Staff worked well together for the benefit of patients.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- The manager did have the right skills and knowledge to run a service. The service engaged well with patients. Staff felt respected, supported and valued.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Requires Improvement 	Our rating of this location improved. We rated it as requires improvement.

Summary of findings

Contents

Summary of this inspection

Background to Watford Clinic

Watford Clinic is operated by Ultrasound Plus Ltd. The service provides diagnostic imaging through ultrasound scanning only. The service provides diagnostic pregnancy, gynaecological, musculoskeletal and general ultrasound scans for private patients aged 18 and above in the Hertfordshire, Essex, London and surrounding areas. The service also provides diagnostic ultrasounds from their two satellite clinics in the following locations:

- Brentwood, Essex.
- Docklands, London.
- Harborne Road, Birmingham.

The service has a registered manager and was last inspected by the CQC in May 2019. The service was previously placed into special measures following the last inspection in May 2019. We also issued the provider with four requirement notices.

At this inspection of the service we found some improvements since the last inspection. The service is no longer rated as inadequate for any of the key questions or core services. Therefore, the decision was made to exit the service from special measures. However, due to the repeated regulatory breaches we issued a warning notice under Section 29 of the Health and Social Care Act 2008 on the 3 June 2021 and told the service it must improve by 2 July 2021. We will continue to monitor the service closely and may take further action, in line with our enforcement procedures if compliance is not achieved.

How we carried out this inspection

We inspected this service using our comprehensive inspection methodology. We carried out a short notice announced inspection on 27 May 2021.

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.

During this inspection, we visited the main location Watford clinic. We spoke with six members of staff which included sonographers, clinic coordinators, the governance consultant and the service manager, who was also the registered manager. During our inspection, we reviewed the records of eight patient records, and also reviewed policies and audits.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Our inspection Team

The team that inspected the service comprised a CQC lead inspector, another CQC inspector and a specialist advisor. The inspection team was overseen by Philippa Styles, Head of Hospital Inspection.

Summary of this inspection

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The provider must review their local governance arrangements to ensure the whole team are informed about performance, complaints, incidents, patient feedback, clinical issues, and audit results in a timely manner. HSCA RA Regulations 2014: Regulation 17 Good Governance (1)(2)(b)
- The provider must ensure there is an effective and documented system in place for managing and reviewing staff competency, and for implementing an effective clinical audit programme. HSCA RA Regulations 2014: Regulation 17 Good Governance (1)(2)(b).

Action the service SHOULD take to improve:

- The service should ensure that complaints' procedures are reviewed and there is an effective process to record lessons learnt from complaints.
- The service should ensure risks and mitigating actions are discussed with the whole team.
- The service should ensure staff appraisals and competency assessments are completed, reviewed, updated regularly and documented

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Requires Improvement	Inspected but not rated	Good	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Inspected but not rated	Good	Good	Requires Improvement	Requires Improvement

Requires Improvement

Diagnostic imaging

Safe	Requires Improvement
Effective	Inspected but not rated
Caring	Good
Responsive	Good
Well-led	Requires Improvement

Are Diagnostic imaging safe?

Requires Improvement

Our rating of safe improved. We rated it as requires improvement.

Mandatory training

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

Mandatory training was provided by a combination of e-learning and face-to-face training sessions, including basic life support, safeguarding adults and children level one and two, chaperone training, preventing radicalisation, Mental Capacity Act (MCA), mental health and mental capacity awareness, dementia awareness, health and safety, fire safety, infection, prevention and control, record keeping, information governance, conflict resolution, lone working, moving and handling, bribery and corruption, and equality and diversity.

There was a system in place for managing and monitoring staff compliance with mandatory training. This was an improvement from the last inspection in May 2019.

Mandatory training compliance target was set at 100%. At the time of our inspection, 100% of staff had completed their mandatory training. This was an improvement from the May 2019 inspection.

Following our inspection in May 2019, the service manager completed a training needs assessment to ensure all staff had completed mandatory training relevant and necessary to their role.

Safeguarding

Staff understood how to protect women 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.

The service had a safeguarding adult policy and safeguarding children policy in place, which included guidance on female genital mutilation (FGM). The safeguarding policy contained definitions of abuse, signs of potential abuse and

the definition of FGM. The policy contained up to date contact details for the local authority and clear guidance on the process staff should follow if they suspected abuse or harm. We reviewed both safeguarding policies, which referenced national guidance, it was dated July 2020 and had a review date of July 2021. This was an improvement from our last inspection.

All the staff we spoke with demonstrated they understood safeguarding processes and how to raise an alert. They could access support from senior staff if needed. Staff were aware of their responsibilities to protect vulnerable adults and children.

The service had a named safeguarding lead who was trained to level three safeguarding adults and children.This was in line with the recommendations from the Intercollegiate Document adult safeguarding: roles and competencies for health care staff (August 2018) or the Intercollegiate Document safeguarding children and young people: roles and competencies for healthcare staff (January 2019). The service also had access to a safeguarding lead who was trained to level four safeguarding adults and children. This was an area of improvement since the last CQC inspection.

Safeguarding children and vulnerable adults formed part of the mandatory training programme. Staff we spoke with told us they had received safeguarding training. Records we reviewed during the inspection showed that 100% of staff had completed adult and children's safeguarding training to level two. This was in line with the recommendations from the Intercollegiate Document adult safeguarding: roles and competencies for health care staff (August 2018) or the Intercollegiate Document safeguarding children and young people: roles and competencies for healthcare staff (January 2019).

The service had an up to date chaperone policy. Staff were available for any patient requiring or requesting chaperoning. Scan records showed chaperones were offered for transvaginal scans and would be present for the scan if the patient requested for a chaperone. Transvaginal ultrasound scan was a type of pelvic ultrasound used to examine female reproductive organs. All patients that had a transvaginal scan would be asked to sign a disclaimer form if they declined a chaperone to be present.

All clinic coordinators had received chaperone training as part of their mandatory training to take a chaperone role. This was an improvement since the May 2019 inspection.

Safety was promoted through recruitment procedures and employment checks. Staff had Disclosure and Barring Service (DBS) checks undertaken at the level appropriate to their role. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

Cleanliness, infection control and hygiene

Staff kept themselves, equipment and the premises clean. They used some control measures to prevent the spread of infection.

The service had an updated infection prevention and control policy, which set out staff responsibilities in relation to infection prevention, including hand hygiene.

Infection control training formed part of the mandatory training programme for all staff. At the time of our inspection all staff were 100% complaint with their training.

Requires Improvement

Diagnostic imaging

During our inspection, we observed staff were bare below the elbows even when not working clinically. Bare below the elbow national guidelines are for all staff working in healthcare environments to follow to reduce the risk of cross contamination between patients.

Examination couches, chairs and pillows had wipeable covers and we saw disinfectant cleaning wipes throughout the service.

Staff followed best practice guidance for the routine disinfection of ultrasound equipment. The ultrasound transducer was decontaminated with disinfectant wipes between each patient and at the end of each day.

Personal protective equipment (PPE) such as disposable gloves and aprons were readily available for staff to use.

In line with Covid-19 guidelines for infection prevention and control, the service always asked all patients and accompanying person to wear a face covering. Staff also took the temperature of the patient and the person accompanying.

Handwashing facilities were not available within the scanning room at the Watford Clinic. However, staff had access to a hand washing sink in the washroom next door and hand sanitising gel was also available. We observed staff using hand sanitising gel during our inspection. The World Health Organisation's (WHO) 'How to hand rub' posters were also displayed throughout the service and hand sanitiser was visible and readily available.

Most scans undertaken by the service were non-invasive, however the service did undertake transvaginal scans and blood tests. At the time of our site inspection, although the absence of handwashing facilities in the scanning room was on the risk register, there was no risk assessment in place to help identify mitigating actions.

The scanning room had carpeted flooring which is not in line with infection, prevention and control best practice. This was also a concern highlighted at our last inspection in May 2019. The carpeted flooring had not been risk assessed but was on the corporate risk register. Spillage kits were available within the service for staff to use to safely clean bodily fluid spillages. The infection prevention and control policy also detailed how bodily fluids spillages should be cleaned and precautions to be undertaken.

Following the site inspection, we were provided with an updated infection prevention risk assessment whichidentified the risk for the absence of a handwashing facilities and the carpeted flooring in scanning room. The risk assessment detailed the risk and the mitigations in place to reduce the risk and/or harm.

The service had a daily cleaning schedule. We reviewed the cleaning schedule for the month of May, and they were all completed appropriately. Staff were aware of the schedule and completed it daily to demonstrate the equipment and environment had been cleaned and stocks replenished.

The scanning room had a curtain to maintain patient privacy and dignity. However, the curtain was not on the cleaning schedule and there was no evidence of when the curtain had been changed or cleaned. Following our feedback, we received an update that this has been added to the infection prevention risk assessment and that the curtain would be removed and cleaned every month.

The service completed a monthly infection prevention and control observational audit to demonstrate compliance with the infection control policies and practices. We reviewed the audit results for March, April and May which showed compliance.

Requires Improvement

Diagnostic imaging

Environment and equipment

The environment was well maintained but it was not always suitable for all types of care and procedures being provided. Staff managed clinical waste well.

Watford clinic was situated on the ground floor of a shared building, with intercom access to the clinic. Facilities included a waiting and reception area, an ultrasound scanning room, a clinical room where staff could counsel patients who might have received bad news, and a washroom with a handwashing facility. Toilet facilities for patients were available in the main corridors. There was also an office area which the service used for day to day running of the service including storing of confidential data and receiving telephone bookings.

The waiting area was clear of clutter and contained suitable number of chairs to meet patient needs. The waiting area was Due to Covid-19 restriction the service asked patients to attend only five minutes before their appointment time.

The service had timed appointments and asked patients/individuals to attend only five minutes prior to their appointment to minimise wait times in the clinic and maintain social distancing. This meant there was only one patient and one person accompanying them in the waiting area. The service had removed all magazines from the waiting area in line with Covid-19 guidance. A water fountain was available for patients to use.

The scanning room was warm with seating for those accompanying the patients for their appointment. The room contained a stand-alone ultrasound system and a separate monitor that displayed the images from the scanning machine.

There were processes in place to ensure equipment was serviced in accordance with the manufacturer's guidance. All the equipment we checked, was within its service date.

The service only had a small number of consumables which were kept in locked drawers within the office. These were all in date and stored as per manufacturer recommendation.

The scanning room had carpeted flooring, which was not in line with infection, prevention and control best practice. At the time of our inspection this was on the risk register however there was no risk assessment completed to show what mitigations were put in place to reduce any potential risk. Following our inspection, the registered manager provided us with an updated infection control risk assessment which included the risk of having the carpeted flooring and mitigation that were in place. The mitigation included the availability of spillage kits within the service and staff were trained to use these to safely clean any bodily fluid spillages.

Waste was handled and disposed in a way that kept people safe. Staff used the correct system to handle and sort different types of waste and these were labelled appropriately.

Sharps management complied with Health and Safety and the Sharp Instruments in Healthcare Regulations 2013. We saw sharps containers were used appropriately and they were dated and signed when brought into use.

There was a range of fire extinguishers, which were strategically placed. All fire extinguishers

Assessing and responding to patient risk

Requires Improvement

Diagnostic imaging

Staff completed and updated risk assessments for each woman and removed or minimised risks. Staff knew what to do and acted quickly when there was an emergency.

The service had systems and processes in place to refer women to the local NHS trust or their GP if the scanning procedure indicated unexpected findings. This was an improvement since our last inspection May 2019.

Staff signposted women to the A&E, GP, Midwife or other clinicians, if they reported experiencing symptoms such as vaginal bleeding or pain.

Due to the nature of service provided, there was no emergency resuscitation trolley on site. The service performed low risk ultrasound scans. In the event of a medical emergency or patient collapse, staff called 999. In addition, all staff were trained in adult basic life support.

Staff used the 'pause and check' checklist devised by the British Medical Ultrasound Society (BMUS) and the Society and College of Radiographers. These checks ensured the right patient received the right scan of the right anatomical area. We observed staff completing these checks during our inspection. We observed three scans and saw that patient identification was verified prior to the start of the procedure.

Each patient's allergy status was documented on their medical questionnaire to alert sonographers to any known allergies. During our inspection, we observed the sonographer asking all patients about allergies. The service had both latex and non-latex covers for the transvaginal ultrasound probes and would select the cover according to the response from the patient.

Administrative staff sometimes locked up the building on their own at night and there was a process in place to mitigate any potential risks. This was an improvement since our last inspection as a lone working policy and risk assessment had been implemented to mitigate the risk of staff working alone or in isolation.

Staffing

The service had sufficient staff of an appropriate skill mix, to enable the effective delivery of safe.

Usual daily staffing consisted of one sonographer and one clinic coordinator, with the registered manager as support by telephone or on site. The registered manager sometimes provided support as a clinic coordinator in order to cover for leave and/or staff sickness. Staff confirmed that the staffing structure for the satellite sites was also one sonographer and one clinic receptionist, supported by a manager.

The service employed three part time and one full time clinic coordinators. They were responsible for managing enquiries, appointment bookings, supporting the sonographers during ultrasound scan procedures, acting as chaperone when required and printing scan images.

The service employed six sonographers on a zero-hour contract. They were all experienced sonographers and worked substantively for the NHS or other independent health care providers. Appropriate employment checks were undertaken, and qualifications of sonographers were recorded in their personnel files.

The registered manager told us that staff worked flexibly to ensure all scanning sessions were covered. The service did not use bank or agency staff.

Requires Improvement

Diagnostic imaging

Records

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

The service had an up-to-date records policy in place for staff to refer to. The policy detailed staff responsibilities and documentation standards, information governance and the retention of records, in line with guidance.

Patient records and information was kept secure and only authorised staff had access to the information. All staff received training on information governance as part of their mandatory training.

Patients completed a medical questionnaire upon arrival. Sufficient information was obtained from the patient prior to their scan appointment, such as medical history including allergy status, investigation required, general practitioner details and details of pregnancy for obstetric scans.

During pregnancy scans, the sonographer completed a wellbeing report and paper scan report during the appointment. This was given to the patient. A copy of the scan report was also stored at the service, in case they needed to refer to it at any time. For non-pregnancy scans, reports and images were given to patients following the scan appointment. Patients were advised to share the reports with their GP, other healthcare professional or hospital

Medicines

The service did not store, prescribe or administer any medicines.

Incidents

The service did have some processes for reporting, investigating and learning from incidents. Staff understood their roles and responsibilities to raise concerns and report safety incidents.

The service had an up-to-date incident reporting policy and procedure in place to guide staff in the process of reporting incidents. Staff understood their responsibilities to raise concerns, to record safety incidents, and investigate and record near misses.

The service logged incident on a daily clinic sheet which had a section to record any incidents that may have occurred on the day. These forms were regularly reviewed by the registered manager.

The service did not report any never events in the twelve months prior to our inspection. A never event is a serious incident that is wholly preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all providers.

In accordance with the Serious Incident Framework 2015, the service did not report any serious incidents in the twelve months prior to our inspection.

Requires Improvement

Diagnostic imaging

Staff could describe the process for reporting incidents. Staff told us that they would call the registered manager and notify them of any incidents, and they would also log the incident in the daily clinic sheet. Staff told us they did receive any feedback about incidents verbally from the registered manager. The service did not undertake team meetings to discuss any lessons learnt.

Staff we asked, were aware of the Duty of Candour (DoC) regulation. The DoC 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 individuals. Clinical staff we spoke with understood the DoC process and the need for being open and honest with patients when errors occurred. At the time of our inspection, they had not reported any incidents that met the threshold for the duty of candour regulation.

Are Diagnostic imaging effective?

Inspected but not rated

We do not currently rate diagnostic imaging services for effective, however we found:

Evidence-based care and treatment

Systems and processes in place to ensure policies and guidelines were reviewed were not effective. The service provided care and treatment based on national guidance and but did not always use audits to evidence of its effectiveness.

The service had policies in place. We reviewed policies, including infection prevention and control, incident reporting, record keeping, consent, safeguarding, complaints and lone working which were all up-to-date and reflected national guidance.

Ultrasound scanning protocols had review dates and referenced national guidance. For example, we saw protocols were in place for obstetrics, gynaecological, abdominal, renal tract, kidney and musculoskeletal ultrasounds.

Policies, procedures were in place; however, these were not personalised to the service. The obstetric scanning protocol regarding obstetric measurements (for example, femur length and head circumference) kept referring repeatedly to an 'Obstetric and Gynaecological Ultrasound' book. The book was not available in the service and therefore staff would not be able to refer to it. The lone working policy talked about working in the community and patient's home. We were therefore not assured the systems and process in place to review and ratify policies and procedures were effective.

The service had a clinical audit programme in place to review practice against national guidance. An internal peer review audit based on the British Medical Ultrasound Society (BMUS) was completed however there was no audit protocol written up and no consolidated audit results, just individual scan audit records. The BMUS guidelines recommend that these local peer review audits should be undertaken in conjunction with discrepancy meeting. No Discrepancy meetings were set up or planned at the time of our inspection. The BMUS guidelines also state that the audit scores should be recorded on an appropriate database. This was not being done and there was no consolidated report of findings or trend analysis done. Therefore, the peer review audit process was not being effectively used to review, learn and improve the service and individual's performance.

Diagnostic imaging

Paper copies of policies were stored in a policy folder and staff knew how to access them. Staff told us that they were informed by email from the registered manager when policies were updated by the service.

Sonography staff demonstrated a good understanding of national legislation affecting their practice. Sonographers followed the 'As Low as Reasonably Achievable' (ALARA) principles. This was in line with national guidance (Society and College of Radiographers (SCoR) and BMUS, Guidelines for Professional Ultrasound Practice (December 2018)).

Staff adhered to the 'Pause and Check' checklist, which is designed as a reminder of the checks that need to be made when any ultrasound scan is undertaken and also provides assurance that the operator has the correct patient and correct part of the body was scanned.

Nutrition and hydration

Due to the nature of service provided, food was not routinely offered. However, a water cooler was available to patients and visitors in the waiting area and hot drinks could be provided if required.

Staff had access to a kitchen to offer hot drinks to patients and those accompanying them.

Pain relief

Staff assessed and monitored patients regularly to see if they were in any pain during the procedures. We observed staff frequently asking patients if they were comfortable during their procedure.

Patient outcomes

The service had some processes in place to monitor the effectiveness of care but did not use the findings to improve them.

The service completed quarterly peer review audits to review quality of scans. These were reviewed by the lead sonographer and the registered manager. However, outcomes of the audit were not formally recorded or shared with the team. The BMUS guidelines recommends that local peer review audits should be undertaken in conjunction with discrepancy meeting. The BMUS guidelines also state that the audit scores should be recorded on an appropriate database. This was not being done and there was no consolidated report of findings or trend analysis done. Staff told us that they received individual feedback about their scan images, however these meetings were not documented.

Competent staff

The service did not always make sure staff were competent for their roles.

All staff underwent a local induction upon commencement of employment, which included role-specific training provided by the registered manager. All staff completed an induction checklist to confirm they had read the service policies and procedures.

The service had an induction and competencies checklist for new clinic coordinators which had to be completed before they commenced a clinic on their own. New staff shadowed established clinic coordinators until they felt competent to be signed off.

Requires Improvement

Diagnostic imaging

Established sonographers supported new sonographers to the service to ensure the new member of staff was competent at using the ultrasound machine and completing the scans. However, this was not documented. The service did not have a formal assessment and/or sign off of sonographers' professional scan competencies. There was no effective system in place for managing and monitoring to ensure clinical staff were competent for their roles

All staff received annual appraisal. This was completed with the registered manager and documented in the personnel files for staff. The appraisal process for the sonographers was top down and did not give the staff the opportunity to review their performance and raise training requirements. In addition, the registered manager did not ask the sonographers to provide their appraisals from their substantive roles. Competency assessment for the scans the sonographers performed was not include in the appraisal process.

All the sonographers employed by the service were registered with the Health and Care Professions Council (HCPC) or they were registered on the Society of Radiographers (SoR) voluntary register for Sonographers. Those registered with the HCPC met the regulatory standards to ensure the delivery of safe and effective services to patients.

The registered manager was responsible for completing blood tests within the service and had undertaken venepuncture training in November 2020.

Staff undertaking lead roles within the service were adequately trained or competent to provide effective advice and guidance to staff. For example, the safeguarding lead for the service had completed safeguarding level three training that is appropriate for a safeguarding lead role. The infection, prevention and control lead had completed infection control training appropriate for their role. This was an improvement since the last inspection in May 2019.

The registered manager ensured staff had the right qualifications and experience to do their job when they started their employment. We reviewed the staff personnel records for the clinic coordinators and sonographers. They all contained evidence of a recruitment and selection interview, employment history, identification, disclosure and barring service (DBS) checks and one employment reference.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients. However, there was no evidence of the service working with other providers to improve the pathway for patients to local services.

All staff we spoke with told us that they worked well as a team. The registered manager, sonographers and clinic coordinators worked together for the benefit of patients. We observed a positive working relationship and a relaxed environment to put women and their partners at ease.

The service did not have systems and processes in place to communicate and refer to the local hospitals or the patient's clinician in the event of further examination and or treatment being required. However, sonographers would contact health professionals with consent from the patient and follow the processes in place to refer patients to the local NHS trust or their GP if the scanning procedure indicated unexpected findings.

Seven-day services

The service provided appointments seven days a week from 8.30 am to 9.30 pm to patients across three satellite sites and main Watford clinic location, so they could access the service at a time that suited them.

Requires Improvement

Diagnostic imaging

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

We reviewed eight patient records which demonstrated that written documented consent was obtained prior to the patient's procedure.

All staff we spoke with were clear in their responsibilities with obtaining and documenting consent.

Patients received written information with a copy of a consent form to read when attending the planned scan appointment. Patients we spoke with told us that prior to the scan the sonographer explained the procedure and referrals to other service if potential anomalies were found.

The sonographer gained a written consent from all women using the service prior to their scan and would also complete an additional consent for any intimate scans such as transvaginal scans.

All staff completed training in mental capacity act (MCA), mental health and mental capacity awareness as part of their mandatory training.

Are Diagnostic imaging caring?

Good

Our rating of caring stayed the same. We rated it as good.

Compassionate care

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

We spoke with four patients about various aspects of their care. Feedback was consistently positive about the kindness and care they received from staff.

We observed staff treating patients with dignity, courtesy and respect. Staff introduced themselves prior to the start of a patient's imaging scan, interacted well with patients and included patients during general conversation.

Staff ensured patient privacy and dignity was maintained at all times.

Patients we spoke with described staff as caring and kind. Staff demonstrated a kind and caring attitude to patients. This was evident from what we heard from the registered manager and feedback provided by patients.

Staff told us that they talked to patients who were anxious and discussed the process thoroughly. Patients we spoke with told us that staff explained the scanning process and what to expect in a way that was clear and easy to understand.

Requires Improvement

Diagnostic imaging

The service carried out their own online feedback survey. All patients were sent an email within a week of their appointment asking for feedback about the service. The feedback invited patients to rate the service and provide more detailed feedback. Although the number of written feedbacks received was small, these were generally positive and was discussed at the quarterly management meeting.

Emotional support

Staff provided emotional support to patients to minimise their distress.

Patients told us staff were professional and supported them well. They considered their privacy and dignity had been maintained throughout their scan.

Patients told us that staff provided ongoing reassurance throughout the scan, they updated them on the progress of the scan and explained what was being seen on the image.

Due to Covid-19 restrictions, the service only allowed one person to accompany the patients during their scans.

Staff recognised that providing emotional support to patients was an important part of their role. Staff told us of how they supported patients who had potential concerns identified from the scan. There was a quiet room to discuss difficult matters when the need arose. Patients could stay with a sonographer or the clinic coordinator after receiving bad news.

Understanding and involvement of patients and those close to them

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

Staff actively included women and those close to them to be involved in the scanning process. Patients told us that staff provided care to them and involved those close to them.

The service had enough room and chairs in the scanning room, which enabled those accompanying them to be involved in the scanning procedure, they were able to see the images of the scan and could ask questions.

Patients we spoke with told us that they had received enough information before and during the appointment. They also said staff were open and invited any questions before and after the scan.

Are Diagnostic imaging responsive?

Good

Our rating of responsive improved. 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.

Requires Improvement

Diagnostic imaging

The service only provided private ultrasound scans and did not complete any imaging on behalf of the NHS or other private providers.

The service provided pregnancy scans for women from five to 40 weeks of pregnancy. A variety of packages were available to patients to complement their NHS pregnancy scans.

The service also offered a range of general ultrasounds including gynaecological, musculoskeletal, abdominal and urinary tract.

The service provided evening and weekend appointments to accommodate the needs of women who were unable to attend during the daytime on weekdays. Patients could choose which site they wanted their ultrasound scan.

Staff greeted patients when they entered the building. Patients were able to access a comfortable waiting area, toilet facilities and water cooler.

The service's website gave people useful information about the service it provided, its other clinic sites, what to expect when having a scan and how to book an appointment.

Meeting people's individual needs

The service took account of patients' individual needs.

The service was located on the ground floor of the building and had ramp access for people that required wheelchair access.

The facilities and premises were suitable for the service delivered. A separate toilet was provided, which was suitable for people living with a disability. There was ramp access to the building. The scanning room had an adjustable couch, which staff used to support patients with limited mobility.

Information leaflets were available for patients on the service's website on what the scan would entail and what was expected of them prior to a scan.

The service offered pregnant women a range of option for baby keepsake and souvenirs which could be purchased as part of their scan package.

Access and flow

People could access the service when they needed it.

Patients self-referred to the service for pregnancy scans, general ultrasound scans including gynaecological, musculoskeletal, abdominal and urinary tract. The service provided information on their website about the price of the scanning packages.

The service did not have a waiting list. The average time from point of booking to scan appointment was 24 to 48 hours. Patients could access the service at a time to suit them and were offered a choice of location and appointment date to suit their needs.

Requires Improvement

Diagnostic imaging

Scan results were given at the end of each scan. A wellbeing report, which included an image and report, would be given to the women immediately after the pregnancy scans. Similarly, patients attending other ultrasound scans were provided with the image of the scan and a report at the end of the scan.

Learning from complaints and concerns

The service had systems in place for people to complain and to manage complaints.

The service had an up-to-date complaints policy for staff to refer to in the event of a complaint. The policy set out the responsibilities of staff and gave detailed directions of how a complaint should be investigated. This was an improvement since the last inspection in May 2019.

The registered manager was responsible for investigating and responding to complaints. We reviewed the two complaints the service received between February and April 2021. The complaints were investigated and responded to in line with the policy. The manger told us all complaints were responded to and closed within 14 working days as set out on the policy. However, we could not confirm this as the closing date was not recorded in the complaints record. At the time of the inspection there were no open complaints.

Staff explained how complaints were managed and told us that lessons learnt from complaints were shared verbally by the registered manager and actions implemented. We did not see evidence of lessons learnt or shared learning from the complaints.

A complaint poster was displayed in the scanning room which directed patients to contact the service to make a complaint.

Are Diagnostic imaging well-led?

Requires Improvement

Our rating of well-led improved. We rated it as requires improvement.

Leadership

The manager of the service had the right skills and abilities to run the service providing high-quality sustainable care.

The service had a registered manager who provided day to day management of the service and was also the nominated individual.

The manager of the service had completed all mandatory training and any other additional training that was specific for their roles. This was an improvement since the last inspection.

The registered manager took the lead roles within the service such as safeguarding and infection control and had completed the necessary training to fulfil these roles. For example, they had completed safeguarding level 3 training for both adult and children in line with the recommendations from the Intercollegiate Document adult safeguarding: roles and competencies for health care staff. This was an improvement since the last inspection.

The registered manager was visible and approachable. Staff told us the manager was friendly and approachable, and they felt confident to discuss any concerns they had with them. Staff told us the manager frequently supported the team when clinic coordinators were on leave and off sick from work.

During our inspection the manager told us that they had just recruited someone to a role of a deputy manager who would oversee the day to day running of the clinics, provide support for staff and deputise for the manager.

Following our inspection, the registered manager told us that they intended to recruit a clinical lead to oversee the clinical governance, support the sonographers and improve the leadership of the service.

Vision and strategy

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

The service had a three year strategic plan and vision (2021 to 2023) in place which was to provide a high quality ultrasound scan service which was effective, safe and ensures a positive patient experience.

The strategic plan sets out the first year, 2021, was intended to strengthen the governance and oversight systems and processes in place. This included; ensuring that the policies and procedures are fit for purpose and reflect how the service operates, implementing a system of organisational learning through effective scrutiny of incident reporting, complaints, litigation and Safeguarding.

At our previous inspection in May 2019 the service did not have a documented vision and strategy in place. Therefore, this was an improvement.

Culture

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

Staff were consistently positive when describing the culture within the service. They felt supported by the manger and colleagues within the service.

During our inspection we saw that staff interacted and engaged with each other in a polite, positive and supportive manner.

Staff reported feeling supported by the manager, describing them as ‘accessible and supportive’. Staff told us they enjoyed working in the service.

During our inspection and subsequently through our post inspection feedback letter, we informed the manager there were areas of the service that required improvement. The registered manager responded positively to this feedback and put some actions in place, demonstrating an open culture and a desire to improve.

Requires Improvement

Diagnostic imaging

Staff understood their responsibility to be open and transparent with patients and told us apologies would always be offered to patients and any concerns rectified.

Governance

There were some systems and processes in place to maintain the overall governance of the service, but these were not fully embedded.

Following our inspection in May 2019, the manager brought in a governance consultant to support establishing the governance systems and processes for the service. They also sourced an external company to review, update and write new policies and procedures for the service.

The manager, with the governance consultant reviewed new policies and procedures at the quarterly management meeting. All policies and procedures were in date. However, some of the policies and procedures that were signed off at the management meeting were not personalised to the service. For example, the lone working policy talked about working in the community and patient's home. Therefore, we were not assured that the process in place for reviewing, updating and ratifying policies and procedures were effective.

The clinical protocols were also reviewed at the management meeting. The protocols were up to date, had review dates and reflected best practice. However, the Obstetric Protocol kept referring repeatedly to an 'Obstetric and Gynaecological Ultrasound' book. The book was not available in the service and staff would not be able to refer to it. Therefore, we were not assured that the process in place for reviewing protocols were effective and fully embedded.

The manager updated all staff with any changes in policy, procedure, or clinical protocol through email. Staff confirmed this and we also saw evidence. This was an improvement since the last inspection where there was no process in place for updating staff with changes.

The service did not have a formal assessment or sign off process the professional scan competencies of sonographers. There was no effective system in place for managing and monitoring to ensure clinical staff were competent for their roles. In addition, the service did not keep any equipment training records for the sonographers that operated the ultrasound scanner.

There were limited processes in place for lessons learnt from incidents, complaints and audits. The registered manager and staff told us any learning would be directed to the individual. The service carried out internal review peer audits based on the British Medical Ultrasound Society (BMUS) but there was no audit protocol written up and no consolidated audit results, just individual scan audit records. Audits were not formally reported into the management or staff meetings and there was no formal sharing of the audit results with the sonographers as a group. However, we were not assured learning was shared with other staff to improve quality and safety across the service.

Informal meetings took place between the manager, sonographers and clinic coordinators however, we were unable to review contents of discussions as these were not minuted.

The service completed appropriate recruitment checks prior to employment to ensure staff had the skills and experience needed for their roles. We reviewed the personnel records for staff and found all required information was available, such as employment reference, disclosure and barring service (DBS) checks, full employment history, evidence of qualifications and professional registration.

Requires Improvement

Diagnostic imaging

Managing risks, issues and performance

There were some systems in place for managing risks but there was no evidence of risks and the mitigating actions were discussed with the team.

The service had a risk register in place which was reviewed quarterly at the management meeting. However, the service did not have a risk assessment in place for the risks identified in the risk register. For example, the risk register identified the absence of the handwashing facility and the carpeted flooring in the scanning room as risk. However, there was no evidence of risk assessments carried out to mitigate any potential risks. This was an area of concern that was identified at the May 2019 inspection. Following this inspection, we were provided with an updated infection prevention risk assessment which identified the risk for the absence of a handwashing facilities and the carpeted flooring in the scanning room. The risk assessment detailed the risk and the mitigations in place to reduce the risk and/or harm.

The manager was fully aware of the main risks within the business and could explain the mitigations that had been put in place.

The service had a business continuity plan in place to outline how the service would deal with situations that could potentially disrupt the service. For example, the registered manager told us that they would utilise satellite locations in the event one of the locations was not available.

Managing information

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

Information governance training was mandatory for all staff and at the time our inspection were 100% complaint with this training. This was an improvement since the last inspection. Staff we spoke with were aware of the requirements of managing a patient's personal information in accordance with relevant legislation and regulations.

Staff had access to the information they required to undertake their roles. All staff had access to policies and procedures.

The service used secure electronic systems with security safeguards to maintain confidential patient information. Ultrasound images for baby scans were saved onto a memory stick from the main scanner for images to be printed. All images were deleted from the memory stick as soon as the image was printed. Images for baby scans were kept on a back up computer which was password protected and accessible to the manager.

The service had clear processes for managing information. Images were kept for 12 months after the scan appointment and the service kept consent forms securely within a locked drawer and archived the consent paperwork after 12 months in accordance with data protection guidance.

The manager told us the service was in the processes of moving to a secure cloud system to store and back up the images taken.

Engagement

The service engaged generally well with patients. There was limited staff engagement.

Requires Improvement

Diagnostic imaging

Patient satisfaction surveys were sent automatically to patients to give feedback about their experience within a week of the scan appointment. The manager told us the feedback was monitored monthly using an online feedback platform. We saw evidence of the feedback was discussed in the quarterly management meeting and used to drive service improvements.

Staff engagement was limited. Staff fed back they enjoyed working for the service, however due to the way the sites are set up, staff did not have many opportunities for team working. The service did not have any staff meeting in the last 12 months prior to our inspection

Learning, continuous improvement and innovation

The manager was committed to improving the service by learning from when things went well or wrong but did not have systematic approach to continuously improve.

The service completed a peer review audit for image and report quality. However, the outcome was not documented or shared or used as a measure to improve quality and performance of the service.

The service manager demonstrated a commitment to improve during and following the inspection. For example, the manager was open to the feedback that we gave following the inspection and provided us with assurance for some the concerns raised. The service had a three year strategy and vision, which has been initiated in 2021with the specific intent of strengthening the governance and oversight process to ensure continuous improvement in a timely manner.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The provider must review their local governance arrangements to ensure the whole team are informed about performance, complaints, incidents, patient feedback, clinical issues, and audit results in a timely manner. HSCA RA Regulations 2014: Regulation 17 Good Governance (1)(2)(b) • The provider must ensure there is an effective and documented system in place for managing and reviewing staff competency, and for implementing an effective clinical audit programme. HSCA RA Regulations 2014: Regulation 17 Good Governance (1)(2)(b).

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures	S29 Warning Notice **Regulation 17, (1)(2)(a)(b), Good governance, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**