Mediscan Healthcare Ltd

The Oaks Clinic

Inspection report

3 Forest Road
Loughton
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Date of inspection visit: 30 June 2021
Date of publication: 13/09/2021

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	Good
Are services safe?	Good
Are services effective?	Inspected but not rated
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

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

- 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. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and were committed to improving services continually.

However:

- The service should consider updating its website as the information presented did not accurately reflect the services being offered.
- The service should consider keeping records to demonstrate it is auditing medication stocks.
- The service should consider documenting its business continuity arrangements.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good 	Our rating of this service improved. We rated it as good. See overall summary for more information

Summary of findings

Contents

Summary of this inspection

Background to The Oaks Clinic

The Oaks Clinic is operated by Mediscan Healthcare Limited. The service opened in 2010. It is a private clinic in Loughton, Essex and primarily serves the communities of Essex and Greater London but also accepts patient referrals outside this area. The service operated evening clinics three days a week and clinics on Saturdays. All care and treatment was provided on a privately funded basis. The service saw on average 40 patients a week.

It provides the following services:

- Early pregnancy viability scans
- First Trimester screening for Down Syndrome
- Reassurance Scans
- Gender assessment scans
- Anomaly scans
- Foetal wellbeing scans
- Growth Scans
- Uterine artery Doppler scans
- Cervical assessment scans
- Antenatal investigations including amniocentesis and chronic villus sampling
- Cervical smear tests
- Inserting intrauterine devices
- Fertility monitoring and treatment
- Gynaecological assessments

The service has had the same registered manager in post since 2011.

The clinic is registered to provide the following Regulated Activities:

- Diagnostic and screening procedures
- Family Planning
- Maternity and midwifery services
- Treatment of disease, disorder and injury

The service was last inspected in March 2020 where it was found to require improvement overall. Enforcement action, including the issuing of requirement notices and a warning notice were imposed on the service under the relevant regulations in the areas of Safe and Well-led.

The purpose of this inspection, carried out in June 2021, was to follow up on the previous areas of improvement and re-rate both Safe and Well Led. Our findings demonstrated that the service had complied with the previous requirement and enforcement actions and improvements had been made and embedded within the running of the service.

How we carried out this inspection

During the inspection, the inspection team:

- Visited the clinic;

Summary of this inspection

- spoke with the registered manager and clinic manager;
- reviewed client care and treatment records;
- looked at a range of policies, procedures and other documents relating to the running of the service.

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.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service 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 SHOULD take to improve:

- The service should consider keeping documented records of its medicine stock audits.
- The service should consider updating its website to ensure information about the services being offered is up to date.
- The service should consider documenting its business continuity arrangements

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Good	Not inspected	Not inspected	Not inspected	Good	Good
Overall	Good	Inspected but not rated	Good	Good	Good	Good

Good

Diagnostic imaging

Safe	Good
Well-led	Good

Are Diagnostic imaging safe?

Good

Our rating of safe improved. We rated it as good.

Mandatory training

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

Staff received and kept up-to-date with their mandatory training. Records provided during the inspection confirmed this.

The mandatory training was comprehensive and met the needs of patients and staff. Records demonstrated that mandatory training included training which was required by law such as health and safety and fire awareness. The service also provided training which was deemed mandatory to ensure the safe running of the service such as safeguarding, infection control and complaint handling.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Training records demonstrated that the registered manager had received training on all these subjects.

Managers monitored mandatory training and alerted staff when they needed to update their training. All staff were subject to an annual appraisal and records provided confirmed these had taken place within the past 12 months.

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.

Staff received training on how to recognise and report abuse, appropriate for their role. Training records showed all staff were trained to level 2 adults safeguarding and the registered manager was trained in level 3 safeguarding children.

Staff kept up to date with their safeguarding training. There was a system to alert managers and staff when they needed to update or refresh their training.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. A policy dated 20 March 2020 was in place and contained relevant and up to date information. Staff said they felt confident to raise issues with the local authority and seek level 4 trained advice and guidance. The registered manager gave examples of how they

had been involved in discussions relating to people who had accessed their service. They were aware of risks to children who were part of a patient's family and would take action if concerns were raised about their safety as well. However, it was rare that the service would come into contact with children. The registered manager was aware of how to identify and act on concerns relating to domestic violence and had received training in this regard.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Clinical areas were clean and had suitable furnishings which could be wiped clean such as leather couches all which were clean and well-maintained.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. During our previous inspection in March 2020, these records were not in place however improvements had been made with records confirming for the past six months regular cleaning had taken place.

Staff followed infection control principles including the use of personal protective equipment (PPE). The service had taken into account advice and guidance issued to ensure its infection control principals met the national standards to manage risk in relation to the Covid-19 pandemic. A new policy had been developed, hand gels, personal protective equipment (PPE) and antibacterial wipes had been procured and were in use at the time of the inspection. Social distance requirements had been considered and the clinic environment was designed to meet this requirement.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Records from January to June 2021 confirmed this.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The design of the environment followed national guidance. There was a waiting room, clinic room and toilet within the setting. These were designed to allow for patient flow and to promote privacy and dignity within the clinic.

Staff carried out daily safety checks of specialist equipment. Records from January 2021 to June 2021 confirmed this took place for the services probe (only piece of specialist equipment in place). The service provided records to confirm that this piece of equipment had been serviced in April 2021. Portable Appliance Testing (PAT) was also carried out which demonstrated the equipment met electrical safety standards. This was monitored through an equipment log.

The service had enough suitable equipment to help them to safely care for patients. Equipment stocks were checked during the inspection. This including syringes, speculums, swabs and covid testing kits. There was ample supply and all pieces were in date. All equipment was single use. Improvements had been made to the way in which the service monitored and controlled substances hazardous to health (COSHH). These were locked in a cupboard and records, risk assessments and data sheets were easily accessible and up to date.

Good

Diagnostic imaging

Staff disposed of clinical waste safely. The service kept records of their waste disposal and clinical waste. Receipts from April 2021 to June 2021 were provided to demonstrate this. Sharps bins were in use throughout the site and these were labelled and dated correctly.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration

Staff responded promptly to any sudden deterioration in a patient's health. A Collapse Policy dated 20 March 2020 was in place. This supported the services policy of calling 999 should a patient become seriously unwell whilst they were utilising the service. The registered manager was trained in basic life support and confirmed they would initiate treatment in line with this training whilst they waited for paramedic support.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Patient records confirmed that risks in relation to the patient condition were assessed as part of the referral and initial assessment process. Following our last inspection, the service had made improvements to its chaperone process. Chaperone guidelines dated 05 May 2020 were in place and every patient was offered a chaperone when accessing the service. A record of response to this question was documented and stored within the patient record.

Staff knew about and dealt with any specific risk issues. This included identifying any physical, emotional or mental health conditions which the service needed to be aware of whilst caring for the patient. The registered manager confirmed that should they have concerns about a person's mental or emotional wellbeing they would liaise with their GP.

The service understood risks in relation to radiation exposure and the scan machine was set up to meet ALARA (as low as reasonably achievable) standards. Doppler assessments were avoided in the first trimester and scan times were monitored via the ultrasound machine to ensure they did not exceed recommended times.

Staff shared key information to keep patients safe when handing over their care to others. The service had direct referral arrangements into the local NHS Trust for emergencies such as diagnosed or suspected ectopic pregnancies or pre-eclampsia. A pathway was also in place for the management of cervical smears. Should a test result come back abnormal, the registered manager would write to the GP so further investigations could be arranged. This was supported by a clinical guideline dated 20 March 2020.

Staffing

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

The service was small with only two staff employed this being the consultant gynaecologist and obstetrician (also the registered manager) and the office manager. If the registered manager was sick, then clinics would be rearranged. The service did not utilise bank or agency staff. The registered manager took part in the recommended number of ultrasound sessions per week to ensure their skills remained up to date and safe.

Records

Good

Diagnostic imaging

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

Patient notes were comprehensive, and all staff could access them easily. Two sets of patient records were reviewed, and these were easily available, clear and completed appropriately. Improvements had been made to the way in which the service sought consent, specifically in relation to explaining ultrasound procedures. Risks and benefits were now clearly communicated, and all patients signed consent forms. Three forms were reviewed, and these were documented and stored appropriately in the patient record.

Records were stored securely. All records were stored on an encrypted and secure electronic records management system. The registered manager understood records retention requirements.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The service did not hold controlled drugs. All medications on site were held in a secure lockable cabinet. All of these medications were checked during the inspection and found to be in date. Medications included lidocaine and paracetamol to support patients having an intrauterine device fitted. The registered manager confirmed that medication was stock checked and a list of the medication in stock was presented, however, there was no documented record to confirm regular stock checking took place.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. The registered manager confirmed that instructions were given to patients when prescribing medicines, and records confirmed that patients were asked about allergies before any medications were given. Medications were reviewed on each patient contact with the service.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. The registered manager was a prescriber and issued private prescriptions. Records were seen which confirmed prescribing took place as per national guidelines including reference to the appropriate General Medical Council (GMC) number.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. The service was aware of the National Patient Safety Alert (NPSA) and the Medicines and Healthcare products Regulatory Agency systems and had signed up to receive relevant alerts. There had been no medicine safety issues or concerns in the past year.

Incidents

The service managed patient safety incidents well. Staff recognised circumstances which would constitute an incident or near miss and knew how to report them appropriately. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. The registered manager and office manager were both well versed on what circumstances would constitute a reportable safety incident. They were able to describe the process for reporting and investigation in line with their internal policy dated 12 May 2020. The service was part of the National Reporting and Learning System (NRLS).

Good

Diagnostic imaging

The service had no never events or serious patient safety incidents in the 12 months preceding the inspection.

Staff understood the duty of candour. They were open and transparent and aware of the requirement to give patients and families a full explanation if and when things went wrong. The registered manager was aware of their responsibilities in relation to Duty of Candour and a policy statement, included within the safeguarding policy dated 20 March 2020, was in place. There had been no incidents that met the threshold for duty of candour within the 12 months preceding our inspection.

Staff received feedback from investigation of incidents, both internal and external to the service. The registered manager and clinic manager confirmed that should an incident take place they would sit down together and discuss the incident and develop improvements together. The registered manager was also a consultant obstetrician and gynaecologist working within the NHS and they confirmed that should there be any learning within that setting which was applicable to their service, they would look to share this information internally also.

Are Diagnostic imaging well-led?

Good

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

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients. The service was managed clinically by the registered manager who was a General Medical Council registered obstetrician and gynaecology consultant. The clinic manager was responsible for the day to day management of the service. These were the only two staff employed by the service. Training and appraisal records from 2020/2021 demonstrated both members of staff had the training and skills to undertake their roles. Staff were welcoming and approachable and understood priorities for the service which included keeping up to date with new technologies and continuing to provide a quality service.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services. The registered manager talked to us about their future plans. This was to continue to provide a quality service to the patients it served. There were no plans to expand or change service provision. These plans were documented within the services Statement of Purpose dated August 2020. Staff were able to talk to us about how they planned to stay informed of research, new technologies and developments within the fields of medicine that they worked within. This included staying up to date with emerging guidance and research and by being part of specialist networks, continuing to meet continuing professional development (CPD) requirements and engaging with the NHS.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work. The service had an open culture where patients, their families and staff could raise concerns without fear. The provider promoted equality and diversity and understood the needs of individual

patients. This was demonstrated during our discussions with members of staff where they confirmed that the service was accessible to all people, the registered manager was knowledgeable about how to support people with learning or physical disabilities. Records confirmed training has been undertaken in a number of areas including, autism and equality and diversity. The service had access to interpreters to support people whose first language was not English. Patient feedback was encouraged and from our review of complaints, of which there had been two in the previous 12 months, the provider had responded sensitively and appropriately. Both members of staff were open in their discussions with us and were keen to engage with the inspection process demonstrating transparency and integrity.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Many improvements had been made since our last inspection. The provider was able to provide documented systems such as risk and audit management which were now embedded within the day to running of the service. A quality audit of patient satisfaction for the past year was presented to us and we noted that themes had been analysed. Feedback was generally positive. Negative feedback related mainly to parking provision for the service. Other audits in place included gender accuracy, the use of antenatal screening and predicted vs actual birthweight. Audits dated March 2021 were provided and we noted that the service was performing well. The registered manager was also subject to annual audits undertaken by The Fetal Medicine Foundation to assess the quality and accuracy of their first trimester screening processes.

A Clinical Governance Policy dated 01 May 2020 was in place which described the processes followed by the service to ensure appropriate oversight of the quality and safety of the service. We saw that the service operated in line with the policy from the records we reviewed.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. We spoke to the staff about their plans for unforeseeable events such as sickness and IT failure and plans were in place to deal with these. The service contracted an IT service who ensured patient records were backed up and accessible. In the event the registered manager was sick, clinics would have to be re-arranged. There was a process in place to ensure that patients were contacted in a timely fashion to rearrange appointments. Fire escape plans were in place and on display at the service.

The service had in place a risk register dated March 2021. This was comprehensive and service specific. Risks identified included parking, needle stick injury and slips trips and falls. All risks had been appropriately assessed and mitigating actions taken where these were identified.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required. There had been no externally reportable incidents in the 12 months preceding our inspection. Staff were aware of their responsibilities in relation to this and through discussions were able to identify circumstances where this would be appropriate, for example in line with CQC notification requirements, safeguarding concerns and data protection incidents.

Good

Diagnostic imaging

The service was paper free, all records were stored in a secure electronic format. During the inspection, staff were able to access information as required. Staff understood their responsibilities in relation to GDPR and Data Protection more widely. The service was registered with the Information Commissioners Office (ICO). A policy dated 20 March 2020 was in place to support this.

However, the service website was not up to date. It did not accurately reflect the services on offer. The service would benefit from updating this to ensure people looking to access the service have the most up to date information about what services they could access.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. Engagement was appropriate to the level and scope of service provided. The registered manager worked within the NHS and kept up to date with emerging initiatives which could improve the services on offer and there was evidence to demonstrate the service had worked with local authorities where concerns had been raised about people who had been in contact with the service. The service was private it did not contract any of its provision out to other organisations. Patient feedback was actively sought, and the provider took account of this and made changes to improve experience. For example, based on feedback the service had begun to send out text reminders to patients.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research. The registered manager attended various events and conferences to maintain their CPD and consider innovations within the industry which may benefit the service. The service had recently (2019) invested in a new ultrasound machine due to improvements and innovations in image quality.