The Original Window to the Womb

Quality Report

261 Derby Road
Bramcote
Nottingham
NG93JA
Tel: 0115 877 6945
Website: www.theoriginalwttw.co.uk

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

The Original Window to the Womb is operated by The Original Window to the Womb Limited. The service is delivered from a baby scan studio in Nottingham four days a week and a satellite studio in Sheffield once or twice a month. The service provides non-diagnostic 2D, 3D and 4D scans, gender identification scans and keepsake images for pregnant women. The service accepts self-referred, self-funded women between the ages of 18 and 45 years of age

We inspected the service using our inspection framework for 'independent single speciality providers of keepsake/ souvenir baby scans using diagnostic ultrasound equipment'.

We inspected this service using our comprehensive inspection methodology. We carried out the short notice announced inspection on 07 June 2019.

To get to the heart of peoples' 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

Our rating of this service stayed the same. We rated it as **Good** overall.

We found the following areas of good practice:

- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide a safe service.
- The service had adequate well-maintained equipment and the facilities were clean, comfortable and appropriate for the service being delivered.
- Suitable wellbeing checks were carried out before scans were performed, systems and processes were in place to escalate care in the event of a scan anomaly or medical emergency.
- Personal information was managed well, records were completed fully and information was stored securely.
- Procedures were in place to report and investigate incidents, staff were aware of the duty of candour and there was a culture of openness and honesty. 'How to complain' information was easily accessible to clients and the public.
- Scans were carried out in line with evidence-based guidance and recommended standards and the service kept up to date with changes and developments in ultrasound scanning. The service monitored outcomes appropriate to the procedure.
- The team delivering the service worked well together and understood each other's roles. Referral pathways had been developed in collaboration with other health services and staff had easy access to other health care professionals if needed.
- Information was available in different formats so women were able to make informed choices about the type of scan they wanted and any possible risks and side effects.
- The team were passionate about delivering a positive experience to women and their families. Women and their families were treated in a caring way with dignity and respect. Everyone attending the scan was involved in the experience. Women could contact the provider following the scan if they had any concerns.
- The service was easy to access, reasonable adjustments had been made so women with a disability and their families could access the service. Information was available in different languages.
- Appointments were available in the evening and weekends, there was no waiting list or cancellation of appointments.

Summary of findings

- Managers had the skills and abilities to run the service, were visible and were supportive towards staff. They were committed to delivering the vision and values of the service and promoted a positive culture that valued staff.
- Governance processes reflected the service being delivered, most risks were identified, assessed and managed and plans were in place to manage unplanned emergencies.
- Managers considered feedback from staff and clients and proactively sought to develop and make improvements to the service.

We found the following areas of outstanding practice:

- Feedback from women who used the service and those who were close to them was continually positive about the way staff treated them. There was a strong visible person-centred culture, staff were highly motivated and inspired to offer care that was kind and promoted dignity.
- Women could access the service and appointments in a way and at a time that suited them. Technology was used innovatively to ensure timely access to support and care.

We found the following areas of practice that required improvement:

- The provider did not have a defined list of mandatory and statutory training.
- General Data Protection Regulation (GDPR)2018 was not included in the information governance policy.
- The provider should ensure that electrical wiring in the staff/kitchen room should be housed safely.
- The provider did not use a practitioner checklist for ultrasound examinations as recommended by the British Medical Ultrasound Society.
- The provider should ensure that products subject to Control of Substances Hazardous to Health should be stored in a locked cupboard at all times.
- The service had systems in place to identify risks but they were not always effective. We identified some risks during our inspection and raised these with the provider. The provider took immediate action to eliminate or reduce them.

Following this inspection, we told the provider that it should take some actions, even though a regulation had not been breached, to help the service improve.

Nigel Acheson
Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good 	The service was safe, effective, caring, responsive and well led.

Summary of findings

Contents

Good

The Original Window to the Womb

Services we looked at
Diagnostic imaging

Summary of this inspection

Background to The Original Window to the Womb

The Original Window to the Womb is operated by The Original Window to the Womb Limited. The service opened in 2003. It is a private studio in Bramcote, Nottinghamshire with a satellite studio in Sheffield. The studios primarily serve the communities of Nottinghamshire and South Yorkshire and any other women willing to travel from outside these areas.

The service is registered for the regulated activity of diagnostic and screening procedures and has had a registered manager in post since 2003.

The service provides 2D, 3D and 4D baby scans from 16 weeks of pregnancy to women aged 18 – 45 years. The service provides baby gender identification scans and keepsake images.

2D ultrasound gives imaging in two dimensions and still pictures.

3D ultrasound gives images in three dimensions and still pictures.

4D ultrasound gives images in four dimensions, shows baby's movements and live recordings.

The service was last inspected in February 2014 when it met all the required standards.

We inspected this service using our comprehensive inspection methodology. We carried out the short notice announced inspection on 07 June 2019.

Our inspection team

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

Information about The Original Window to the Womb

The main studio in Nottingham is located on the ground floor of a commercial complex on a main road in Bramcote with easy access and ample parking. The studio consists of a reception and waiting area, scan room, viewing room, toilets and kitchen/staff room. We inspected all these areas. The service is registered to provide the following regulated activity:

- Diagnostic and screening procedures.

During the inspection, we spoke with four staff including the registered manager, director, scan buddy and sonographer. We spoke with three clients and one relative. During our inspection, we reviewed three sets of client records.

There were no special reviews or investigations of the studio ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected once, and the most recent inspection took place in February 2014 which found that the service was meeting all standards of quality and safety it was inspected against.

Activity (November 2018 to November 2019)

- In the reporting period November 2018 to November 2019 the studio performed 1,826 baby scans.
- The service employed two directors, one manager, one assistant manager and contracted with four self-employed sonographers.

Track record on safety

- No never events.
- No clinical incidents.
- No serious injuries.
- Two complaints.
- 30 compliments.

Summary of this inspection

Services provided at the studio under service level agreement:

- No service level agreements in place.

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:

- All staff had mandatory training in key skills.
- Staff understood how to protect clients 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 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.
- Staff completed and updated risk assessments for each client. They kept clear records and asked for support when necessary.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right procedure.
- Staff had access to up-to-date, accurate and comprehensive information about clients'.
- The service had processes in place for reporting and investigating accidents and incidents.

Are services effective?

We rated it as **Not rated**:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Sufficient refreshments were available for clients and their families.
- Managers monitored the effectiveness of the service and used the findings to improve.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held meetings with them to provide support and monitor the effectiveness of the service.
- Staff of different kinds worked together as a team to benefit clients.
- Staff understood how and when to assess whether a woman had the capacity to make decisions about their care.

Are services caring?

Good

We rated it as **Good** because:

Summary of this inspection

- Staff cared for clients with compassion. Feedback from clients confirmed that staff treated them well and with kindness.
- Staff provided emotional support to women and their families when necessary.
- Staff involved women and those close to them in decisions making.

Are services responsive?

Good

We rated it as **Good** because:

- The service planned and provided services in a way that met the needs of local people.
- The service took account of clients' individual needs.
- People could access the service when they needed it.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Are services well-led?

Good

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

- Managers in the service had the right skills and abilities to run a service providing high-quality sustainable care.
- The service had a vision for what it wanted to achieve.
- Managers across the service promoted a positive culture that supported and valued staff.
- The service improved service quality and safeguarded high standards of care by creating an environment for good.
- The service had systems in place to identify risks.
- The service collected, analysed, managed and used information to support all its activities, using secure electronic systems with security safeguards.
- The service engaged well with clients, staff and the public.
- The service was committed to improving services by learning from when things went well or wrong, promoting training and innovation.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Good

Diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are diagnostic imaging services safe?

Good

We rated it as **good.**

Mandatory training

The service provided mandatory training in key skills but did not have processes in place to check that staff had attended mandatory training updates.

- The provider did not have a defined list of mandatory training against which they could assess compliance of staff. However, the managers and directors had attended or completed on line a range of mandatory training and we saw the relevant certificates including first aid, basic life support. safeguarding, and health and safety.
- The sonographers attended mandatory training though their NHS employer and the registered manager asked for evidence of this each year. We saw evidence of the sonographers completed NHS mandatory training records.
- We were assured that staff had completed mandatory training in safety systems and practices, but a more robust system of mandatory training checks needed implementing.

Safeguarding

Staff understood how to protect clients 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 registered manager was the safeguarding lead responsible for ensuring systems were in place to raise and escalate safeguarding concerns.
- The service had a child protection policy in place. The policy described the responsibilities of staff in relation to child protection and contained contact details for the local safeguarding service. However, it did not mention female genital mutilation or child sexual exploitation. The service did not scan women under 18 years of age. There was also a comprehensive safeguarding adults' policy in place.
- Following our inspection, the provider submitted an updated policy which included reference to female genital mutilation and child sexual exploitation.
- All staff had a minimum of level three child and adult safeguarding training and we saw evidence of this in the training file. Staff understood how to raise a safeguarding concern and knew where to find the contact details for local safeguarding services.
- We saw posters about child abuse and domestic violence displayed in the studio describing how to raise a concern.
- All staff had disclosure and barring service (DBS) checks which were repeated every three years. DBS checks enable organisations in the public, private and voluntary sectors to make safer recruitment decisions by identifying candidates who may be unsuitable for certain work, especially that involving children or vulnerable adults. We saw copies of the DBS checks in the staff files.

Cleanliness, infection control and hygiene

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

Good

Diagnostic imaging

- The registered manager was the lead for infection prevention and control. An infection control policy was in place which described infection prevention and cleaning schedules for all areas including the ultrasound machine and transducer. A transducer is a device that produces sound waves that bounce off body tissues and make echoes. The transducer also receives the echoes and sends them to a computer that uses them to create a picture.
- All areas were visibly clean. A nominated individual was responsible for the cleanliness of the scan room this included cleaning and maintenance of the ultrasound machine, couch and sink. We saw the cleaning schedule had been completed on the day of our inspection.
- Staff in the scanning room were 'bare below the elbows' and used antibacterial hand gel to clean their hands between clients.
- We saw the sonographer cleaning the ultrasound transducer as described in the policy before the first scan and after every subsequent scan. Couch covers, pillow cases and modesty sheets were changed between each client.
- Cleaning equipment was stored in the kitchen/staff room. Control of substances hazardous to health products were not stored in a locked cupboard, we raised this with the manager during the inspection. The cupboard was upgraded and made lockable immediately after our inspection. The is a statutory instrument that states general requirements on employers to protect employees and other persons from the hazards of substances used at work by risk assessment, control of exposure, health surveillance and incident planning.
- Biohazard cleaning equipment was also available. Biohazard cleaning equipment is designed to effectively and efficiently clean up spillages of bodily fluids such as vomit or blood.

Environment and equipment

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

- The environment of the studio was suitable to deliver the service. The studio was easily accessible and had ample parking. Adjustments had been made for wheelchair users. The waiting areas and scan rooms were family friendly and conducive to a relaxed and pleasant experience. An area of the waiting room had been organised for children with a selection of toys.
- The reception desk was in the waiting area but located far enough away from seating so confidential information could not be overheard.
- The scan room included comfortable seating for family and friends, lighting was dimmed to improve the image clarity.
- The ultrasound machine was less than a year old and of the highest specification which meant that high quality 2D, 3D and 4D images could be taken. A second machine was available for back up, we saw the service and maintenance schedules for both machines which were in line with the manufacturer's guidelines. There were two screens in the scan room, so everybody had a good view of the scan images. Following the scan women and their families could view the images in the viewing room to select which images they would like to take away with them.
- All eight pieces of electrical equipment we inspected had been serviced which meant that they were safe and had been properly maintained.
- All the fire extinguishers were due for renewal on the 06 June 2019, we pointed this out to the manager who told us they would purchase replacement extinguishers straight away. We saw evidence following our inspection that all the fire extinguishers had been replaced and staff had been trained in their use. The smoke detectors were tested monthly and we saw the completed checks recorded in a log sheet. We pointed out some potential fire safety hazards in the staff/kitchen. There appeared to be some miscellaneous items in the stair well and some electrical wiring not housed correctly. Following our inspection, the provider cleared the stair well so that it was no longer a fire hazard.
- Following our inspection, the provider contacted the local fire service to arrange a fire risk assessment, we saw the completed assessment which stated that no actions were required.
- Following our inspection, the provider arranged for an electrician to review the wiring in the staff/kitchen area.
- The ultrasound equipment was only used by the sonographers and they were qualified and experienced in its use. A manual was available for reference
- Appointments were usually limited to ten minutes as per British Medical Ultrasound Society (BMUS) best

practice guidance and followed the Health Physics Society, as low as reasonably achievable (ALARA) principles as outlined in the guidelines for professional ultrasound practice 2017 which means the ultrasound machine was pre-set to the lowest level frequency sound waves as possible.

- Two first aid boxes were available, one in the staff/ kitchen and one in the scan room. We checked one of the boxes which was within its expiry date and contained suitable dressings to administer first aid. There was always a trained first aider on duty, we saw the certificates of the members of staff trained to deliver first aid, one member of staff had attended paediatric first aid training.
- There was an adequate stock of consumables including personal protective equipment, couch covers antiseptic wipes and hand gel.

Assessing and responding to client risk

Staff completed and updated risk assessments for each client. They kept clear records and asked for support when necessary.

- Women attending for a scan must have had their diagnostic hospital scan first before the provider would carry out a souvenir scan. Women were asked to bring their NHS pregnancy records with them to the studio, so the babies due date could be confirmed, and the sonographer knew who to contact if there were any anomalies with the scan. The hospital notes also alerted the sonographer to any pre-existing medical conditions. The provider did not perform scans on women who were less than 16 weeks pregnant in line with British Medical Ultrasound Society guidelines.
- The provider made it clear in the information given to women before their scans that the service was not a substitute for the routine NHS pregnancy screening programme and that they should continue with their NHS appointments. In addition, information was given on the safety of scans referencing the Advisory Group on Non-ionising Radiation report February 2010.
- We did not observe the sonographer using a practitioner checklist for ultrasound examinations as recommended by the British Medical Ultrasound Society.
- The sonographer told us it was rare for women to feel or become ill during the scan. However, in the event of a medical emergency the provider's procedure was to administer basic life support and call the 999-ambulance service, this was clearly documented in the emergency action plan.
- The scan package included a basic wellbeing check of the baby. During the scans, we observed the sonographer pointing out the foetal heartbeat, position of the placenta and position of the baby during the scan.
- A referral pathway was in place to refer women to their booking hospital in the event that the ultrasound scan revealed any anomalies such as multiple pregnancies or foetal abnormalities. The pathway included contact details for six major hospitals and a referral form. This meant that women were signposted to the correct service to manage their onward care.
- The service detected two foetal deaths in the reporting period. In both cases staff followed the pathway referral process in place for foetal abnormality which involved referring the back to the woman's booking hospital.

Staffing

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

- The service employed a manager, assistant manager and two directors. There were four self-employed sonographers used by the service one of whom was the lead sonographer and training lead. The sonographers had worked for several years with the provider and also worked in other local NHS hospitals.
- The provider had an induction programme in place which included use of the equipment, environment and familiarisation with policies and procedures.
- The manager and assistant manager acted as receptionists. One of the directors acted as a scan buddy whose role was to describe what was on the screen and answer any questions so the sonographer could concentrate on the scan. There was always a receptionist, scan buddy and sonographer on duty so therefore no lone working.
- The sonographers covered each other in the event of unplanned absence which meant that it was rare for a scan session to be cancelled. We saw the sonographer rota which was planned for the rest of the year 2019.

Records

Good

Diagnostic imaging

Staff had access to up-to-date, accurate and comprehensive information on clients' care and treatment.

- The service had an information governance policy in place which supported staff in the management of personal identifiable information according to the Data Protection Act 2018. The service was also compliant with the General Data Protection Regulation (GDPR) 2018 as detailed in the terms and conditions, but this legislation was not included in the information governance policy.
- There were both paper and electronic records held at the studio. Paper records were stored in a locked filing cabinet and computers were password protected which meant that information was stored securely. The service only kept minimal, need to know information about clients which enabled them to be able to find scan information if needed in the future.
- Sufficient information was obtained from women prior to scan this included number of weeks pregnant and the age of the woman. However, the service did not ask about allergies. We highlighted this to the manager who said they would include it in the terms and conditions document. Following our inspection, we saw a copy of the revised terms and condition document which included a question about allergies.
- The paper record consisted of a one-page foetal wellbeing report which included mums and partners names, the date of the scan, the baby's due date and the baby's gender. The baby's and placenta position were also noted with any other relevant information. In the records we reviewed we saw they were completed legibly and accurately.
- The electronic information consisted of the scan images stored on the ultrasound machine. The images were labelled with three identifiable pieces of personal information, the date of the scan, the mothers and fathers names and the due date of the baby which meant they could be retrieved for further review if necessary. The images were stored for three months and then deleted.
- Information was not routinely shared with the woman's GP unless a referral pathway was required following the identification of a scan anomaly.

Medicines

- The service did not stock or dispense any medicines.

Incidents

The service had processes in place for reporting and investigating accidents and incidents.

- The health and safety policy included guidance for staff on the recording and reporting of accidents and incidents and an accident report form. However, the provider had identified no serious incidents in the reporting period. The manager told us they would investigate reported incidents and share any learning identified from the investigation with staff.
- The type of scans performed at the studio were extremely low risk and very unlikely to cause an incident. Occasionally, the scan was unsuccessful due to the position of the baby and in this case the woman would be asked to come back to the studio for a repeat scan free of charge.
- The provider also explained to women that gender scans were not 100% accurate. However, in the reporting period all gender scans had been accurate.
- Staff we spoke with were aware of the duty of candour. The service had a duty of candour policy in place which described to staff the principles of duty of candour and when it should be applied. The duty of candour is a regulatory duty that requires providers of health and social care services to disclose details to clients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This includes giving them details of the enquiries made, as well as offering an apology.
- The provider did not have a system in place for reviewing and responding to patient safety alerts from the Medical and Healthcare Products Regulatory Agency (MHRA). However, following our inspection, the provider contacted the MHRA to be added to their mailing list for the alerts.

Are diagnostic imaging services effective?

We rated it as **not rated**:

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

- Care and treatment was delivered in line with legislation, standards, and evidence-based guidance including British Medical Ultrasound Society (BMUS) guidelines and other expert professional bodies such as the Health Physics Society and the Advisory Group on Non-Ionising Radiation (AGNIR). We saw these referenced in policies and information leaflets.
- The ultrasound machine at the Nottingham studio was the highest specification incorporating high definition, live software for more realistic scan images. The service used smart phones and social media to promote their service and review feedback from clients. The Original Window to the Womb website contained clear information about the scan packages and women could book an appointment on line.
- The provider reviewed BMUS and Society and College of Radiographers (SCoR) newsletters, website and publications for the latest developments in the field of ultrasound and encompassed these in policy and procedure.

Nutrition and hydration

Sufficient refreshments were available for clients and their families.

- Cold drinks and snacks were available from a vending machine.

Pain Relief

- Not applicable to this service.

Outcomes

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

- The service had systems in place to review the quality of the scan images. The sonographers reviewed each other's scans as part of the annual appraisal process and reported on clarity of the images, technological aspects and use of the ultrasound machine. We saw evidence of this in staff personal files. Once a year, a sonographer not employed by the provider reviewed a selection of scans from each of the sonographers employed by the provider as an additional quality assurance measure.
- The service collected information on the accuracy of the gender scans, in the reporting period gender scans were 100% accurate.
- If anomalies were identified during the scan, women were referred immediately back to their booking hospital and the sonographer would contact the relevant service at the time to inform them of the findings.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held meetings with them to provide support and monitor the effectiveness of the service.

- Staff working at the studio had the right skills and knowledge to deliver effective care. All sonographers working at the studio were registered with the Health and Care Professions Council (HCPC) and the Society and College of Radiographers (SCoR) they also worked in local NHS hospitals. A condition of registration with the HCPC is maintenance of an up to date continuing professional development (CPD) record and production of self-reflective analysis on current practice. We saw up to date copies of CPD records in the training files showing the sonographers had taken part and completed areas of training and study days relevant to the role.
- The ultrasound machine at the Nottingham studio was less than a year old and the sonographers had all attended a training session delivered by the manufacturers specialist training team when it was installed. One sonographer took the lead for updating the others on new techniques or changes to the ultrasound machine.
- The provider also had access to an external senior sonographer who could give additional support and guidance to the sonographers if required. The sonographers told us this was reassuring but they had never had to use it.
- The provider carried out annual appraisals and we saw copies of these in the staff files. Staff told us they could raise anything with the manager during the appraisal including any training and development needs. The manager told us that because the team delivering the service was small and worked closely together issues of poor performance were addressed dynamically at the time they were identified. However, she said issues of poor performance rarely occurred.

Multidisciplinary working

Good

Diagnostic imaging

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

- The team at The Original Window to the Womb worked well together, the directors, manager and assistant manager could fulfil the roles of receptionist, scan buddy and image printer, the roles were interchangeable. All staff had worked together for some years which meant they understood each other's roles and communicated well with each other. This was obvious during our inspection.
- The sonographer told us there was always a scan buddy to accompany them whist the scan was taking place this meant the sonographer was able to concentrate on the scan whilst the buddy gave explanations and answered any questions.
- Staff did not routinely communicate with GP's and health care professionals unless there was a scan anomaly in which case they had clear referral pathways and direct access to the relevant persons. Sonographers would complete a referral form with a scan report and also contact the relevant person by telephone. We saw a copy of the referral pathway which gave clear information about referral criteria and contact details.
- Staff told us they had proactively worked with the local acute hospitals in the development of the pathways, the sonographer we spoke with told us that the referral pathway meant there was a good rapport between the hospitals and the service which had a positive impact on the effectiveness of the referral for the woman.
- Staff we spoke with told us where they would go to find the contact details for safeguarding services.

Seven-day services

- The service did not operate seven days a week but did operate on Saturday and Sunday and in the evening which was convenient for working women.

Health Promotion

- We did not see any evidence of health promotion materials such as smoking cessation leaflets however, the sonographer and scan buddy took opportunities to advise women to attend their NHS antenatal appointments and follow the advise of their midwives.

Consent and Mental Capacity Act

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

- The service had documented information about the Mental Capacity Act and described how this would apply to women attending for baby scans. Due to the nature of the service it was highly unlikely that women who lacked capacity would be attending for bay scans but there was clear guidance for staff on what they should do if they suspected someone was not capable of understanding the procedure. The sonographers had attended Mental Capacity Act awareness training in their NHS positions.
- It is not a legal requirement to obtain written consent for ultrasound examination however it is good practice to ensure that clients are fully informed about the procedure, so they can give verbal consent. Women were given written terms and conditions and information about the procedure to read which clearly explained the purpose of the scan. They signed to confirm they had understood and agreed with the documents.
- Written information included ultrasound safety and the effect of ultrasound on the unborn baby. The information was taken from The Advisory Group on Non-Ionising Radiation's report February 2010 and BMUS guidelines which meant that women were able to make an informed decision about whether to proceed with the scan or not.
- Consent to share information with other health care professionals was only sought when referral was required due to the identification of a scan anomaly.

Are diagnostic imaging services caring?

Good

We rated it as **good.**

Compassionate care

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

- The studio had a very welcoming, friendly, family orientated ambience. Staff spoke to women and their

families in a sincere and caring way. They interacted with women and their families in a respectful and considerate manner, staff told us they worked hard to make the whole process enjoyable for the family.
- Although the reception area was in the same room as the waiting area, discreet conversations could be had without being overheard. The manager told us that if someone wanted a confidential conversation they could use the image viewing room.
- The sonographer only exposed the area of the woman's body that was necessary to perform the scan. Towels were provided to protect clothing from the gel and used to wipe off the gel at the end of the scan.
- Feedback forms were available in the waiting area and staff encouraged clients to complete them.

Emotional support

Staff provided emotional support to women and their families when necessary.

- Generally, souvenir baby scans are a positive experience for women and their families. However, occasionally the sonographer identified an anomaly with the scan which required referral back to the booking hospital for further investigation. Staff told us that when this happened they were very sensitive about how they imparted the information being open and honest but trying to minimise the distress for the woman and family as much as possible.
- Staff told us they allowed extra time when this happened for the woman and her family to ask questions and compose themselves. The provider also gave contact details for Ante Natal results and Choices (ARC) a national charity. ARC offers non-directive information and support to parents before, during and after antenatal screening; when they are told their baby has an anomaly; when they are making difficult decisions about continuing with or ending a pregnancy, and when they are coping with complex and painful issues after making a decision, including bereavement.

Understanding and involvement of women and those close to them

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

- Women chose to self-refer for souvenir baby scans. Sufficient information was given for them to be involved in any decisions about the scan procedure. Scan packages and the cost was clearly displayed on the providers web site.
- We observed three separate baby scans, the women and their families asked questions throughout the scan and the scan buddy checked they understood what they were seeing on the screen. Information was given in a way that was easily understood by a lay person.
- Friends and family were welcome to be present at the scan, there was space for five extra persons in Nottingham and seven extra persons in Sheffield studio. The scan buddy involved all present family and friends in the scan experience including children and siblings.
- The Original Window to the Womb offered a help line from 09.00 to 17.00 hours seven days a week to answer queries from any women who had concerns following their scan and a live chat line was available on the website.
- We saw information regarding safeguarding from abuse clearly displayed where women and their families could see it.

Are diagnostic imaging services responsive?

Good

We rated it as **good.**

Service delivery to meet the needs of local people

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

- The studio was an appropriate environment for the purpose. It was conveniently located, with ample parking and had comfortable seating, toilets, reading material and a vending machine offering light refreshments.
- There was wheelchair access into the studio and room to manoeuvre a wheelchair once in the studio.
- The provider allowed assistance dogs into the studio and the scan room. assistance dog

Meeting people's individual needs

The service took account of clients' individual needs.

Good

Diagnostic imaging

- Reasonable adjustments had been made so that women with a physical disability and their families could access the service on an equal basis to others.
- Computer technology was used to assist people with communication needs. There was an on-line chat facility, and the service used sound cloud an online audio distribution platform, so clients could listen to recordings of service specific information.
- The website included a frequently asked questions section with a range of useful responses for example one question was 'can my baby be hurt in any way'. The reply was based on British Medical Ultrasound Society (BMUS) guidance and a link to the BMUS website was also included in the answer.
- Information was available in Polish, French, Spanish and Hindu and the provider used a computerised translation system for any other non-English speaking clients.
- We observed that women and their families were given ample time to ask any questions during and after the scan.

Access and flow

People could access the service when they needed it.

- The service offered flexible appointments, including evenings and weekends, additional sessions could be organised if more appointments were required. The appointment system was easy to use, women could book on line or contact the studio directly.
- The service did not have a waiting list and there were no cancellations in the reporting period. Appointments ran to time except when the scan took longer than usual due to the position of the baby and when this happened women in the waiting room were informed about the delay.
- The result of the scan was given at the time so there was no waiting time. Where 4D scans were not of good quality due to the position of the baby women were invited back for a second scan free of charge.
- In extreme weather conditions women were offered an alternative appointment if they did not want to travel.

Learning from complaints and concerns

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

- The service had a complaints policy in place which described the complaints management process, information and learning from complaints was shared with staff at management and staff briefings. How to complain notices were displayed in the waiting area and information about how to complain was also documented on the information sheet and on the web site.
- There had been two complaints in the reporting period which were managed by the registered manager in line with the service policy. The complaints had both been about wrong gender identity. However, when the complainants had been invited back to the studio for a further scan the complaints were not upheld as the original scan had been accurate.

Are diagnostic imaging services well-led?

Good

We rated it as **good.**

Leadership

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

- Managers were involved in the day to day running of the service and were therefore highly visible to staff. Staff we spoke with told us they found managers approachable, supportive and easy to talk to.
- Managers had been involved in the setting up of the service so had developed the skills, knowledge and experience necessary to manage the challenges to quality and sustainability.
- Managers we spoke with discussed challenges to the business and how they were planning to combat these.

Vision and strategy

The service had a vision for what it wanted to achieve.

- The service had a clear vision and set of values. These were displayed on the website and included in their statement of purpose.
- The vision statement was - 'The Original Window to the Womb is committed to providing high quality, efficient and compassionate care to our clients and their families, through the safe and efficient use of ultrasound

imaging technology'. The vision was underpinned by a set of values, focus on the client, treat everyone with respect privacy and dignity, be honest and fair, respect and support diversity, safety, and expert staff.

- The vision and values were developed by the management team in collaboration with the sonographers. During our inspection, we saw staff demonstrate the vision and values in everything they did.
- The provider did not have a formal written strategy in place but during our inspection they described how they were striving to achieve the vision in a challenging competitive market.

Culture

Managers across the service promoted a positive culture that supported and valued staff.

- Staff we spoke with told us they felt valued by managers and that the studio was a good place to work. Managers respected staff particularly in relation to their other work and commitments, staff told us management were very accommodating and understanding when they needed to take leave or unplanned absence.
- Managers took the wellbeing of staff into account. The Health and Safety Law poster was displayed in the staff room and a health and safety risk assessment had been completed November 2018.
- During our inspection, all staff we spoke with appeared to be open and honest and answered our questions willingly. During the scans we observed staff being open and honest in their responses to the questions asked by women and their families.
- The provider had a duty of candour statement in place and staff had received awareness training in the subject.

Governance

The service improved service quality and safeguarded high standards of care by creating an environment for good.

- The registered manager was the lead for governance and quality monitoring. Matters of governance were discussed at a monthly meeting attended by the management team. We saw evidence of agendas and minutes of the meeting.
- The service had an appropriate range of policies and procedures in place easily accessible to staff. During our inspection we noted that the policies and procedures were not dated and did not have a review date. This meant we could not be sure when they were written or reviewed. We raised this with the registered manager who told us they were reviewed annually. Following our inspection, the registered manager added the relevant dates to all the policies and procedures.
- Governance issues and updates were shared with staff at the briefing meeting held at the beginning of each scan session.
- Recruitment and employment checks for staff were not stored in a methodical manner, although most of the checks had taken place as required by schedule 3 of the HSCA 2008 (regulated activities) regulation 2014 we were not assured that all the information was complete. We discussed this with the registered manager and following our inspection the staff files were improved and any missing information obtained.
- The service had suitable public liability insurance in place which included the sonographers.

Managing risks, issues and performance

The service had systems in place to identify risks but they were not always effective. We identified some risks during our inspection and raised these with the provider. The provider took immediate action to eliminate or reduce them.

- The provider had systems in place for identifying, recording and managing risks. We reviewed the annual risk assessment for the service completed November 2018. Risks had been identified in some areas and actions taken to mitigate or reduce the risk. For example, new flooring for the viewing room.
- The provider completed an annual environment and equipment audit covering all areas, equipment, cleanliness, first aid equipment, fire equipment, policies, procedures and processes. The audit identified any risk areas and improvement actions if required . We saw the completed audit for 2018.
- The induction programme included familiarisation with the providers policies and procedures and information about updated policies and procedures was shared at the briefing meeting which took place prior to each scan session.

Good

Diagnostic imaging

- The service had an emergency action plan in place which detailed the actions staff should take in the event of an unplanned event such as evacuation of the building, disruption to power and water supplies, fire and severe weather.
- One of the directors was responsible for implementing health and safety policies and staff had attended health and safety awareness training.

Managing information

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

- All personal information was managed in line with the Data Protection Act 1998 and the General Data Protection Regulations. Staff managed information according to the provider policy and had attended information governance training. The registered manager was the data controller for the service.
- Women were provided with the terms and conditions of the service prior to their scan which they signed to say they agreed and understood. Information about pricing was clear on the providers website. During our inspection we observed that women and their families were not encouraged or put under any pressure to purchase additional merchandise.
- The website advertised the service in line with advertising legislation and professional guidance.

Engagement

The service engaged well with clients, staff and the public.

- The provider gathered client's views and experiences from social media and from feedback forms which were available in the waiting area. In the reporting period 72 feedback forms were completed. All but two were overwhelmingly positive, two commented on insufficient seating in the waiting area which was rectified by the provision of additional seating. The current Facebook score for the service was 4.9 out of 5.0 based on 433 comments.
- The provider was also collaborating with other local services providing services for mums and babies these included a local photographer and a baby equipment retailer.
- Staff discussed the service provision as needed and made suggestions during the briefing at the start of each ultrasound session.

Learning, continuous improvement and innovation

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

- The provider demonstrated a commitment to improving the service by responding to feedback from clients, commissioning high specification, state of the art equipment and ensuring the sonographers received regular updates and training on the ultrasound machine.
- The provider was planning an annual team time out day for all staff to review the current service and identify potential service improvements.
- The provider was a member of the manufacturers ultrasound machine club which meant they benefited from e mail updates, product educational videos and tips and tricks to ensure they were utilising the machine to the best of its ability.
- The registered manager took immediate and effective action to address most of the concerns we raised during our inspection.

Outstanding practice and areas for improvement

Outstanding practice

- Feedback from women who used the service and those who were close to them was continually positive about the way staff treated them. There was a strong visible person-centred culture, staff were highly motivated and inspired to offer care that was kind and promoted dignity.
- Women could access the service and appointments in a way and at a time that suited them. Technology was used innovatively to ensure timely access to support and care.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should have a defined list of mandatory and statutory training for all staff working at the studio.
- Information about the General Data Protection Regulation (GDPR)2018 should be included in the information governance policy.
- The provider should ensue that electrical wiring in the staff/kitchen room should be housed safely.
- The provider should consider implementing a practitioner checklist for ultrasound examinations as recommended by the British Medical Ultrasound Society.
- The provider should ensure that products subject to Control of Substances Hazardous to Health should be stored in a locked cupboard at all times.