

Precious Glimpse - Roundhay






Quality Report

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

Ratings

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

Overall summary

Precious Glimpse Roundhay (1-7064428704) has been operational since July 2019 and is a franchise of Precious Glimpse Limited (Ltd). The service provides non-diagnostic transabdominal ultrasound scans, to self-paying members of the public, that are over the age of 18 years. Their scanning service includes early scans from seven weeks gestation onwards, 2D, 3D, 4D baby keepsake scans and gender scans.

The service is based in Leeds, close to public transport and nearby parking. The registered manager is the individual provider and currently the only member of employed staff.

We inspected this service using our comprehensive inspection methodology and carried out an unannounced inspection on 18 November 2019.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's

Summary of findings

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.

The main service provided by Precious Glimpse - Roundhay was baby keepsake scanning.

Services we rate

We rated this service as **Requires improvement** overall because:

- Whilst staff had completed mandatory training in most core subjects, these did not include information governance or health and safety at work.
- The service did not always use control measures well, to protect service users themselves and others from infection.
- The design, maintenance and use of facilities, premises and equipment did not always keep people safe.
- The service did not have robust systems in place to manage all risks to women and their babies.
- Current risks concerning lone working were not sufficiently mitigated.
- There was limited assurance the service always provided care and treatment based on national guidance and evidence-based practice.
- The consent policy was not detailed and did not reference the Mental Capacity Act (2005).
- The service had a limited complaints policy and it was not always easy for people to give feedback and raise concerns about care received.
- Leaders did not always ensure that policies and documentation reflected best practice guidance and mirrored practice at the service.
- The service had limited systems and plans to identify risks and eliminate or reduce them.

- The exclusion policy in place did not include a robust risk assessment requirement for each woman attending the service.
- Digital information systems were not always secure.
- The service had a vision for what it wanted to achieve but required a long-term strategy with targets.
- Information about costs of services was unclear.

However, we also found that:

- Staff understood how to protect service users from abuse and knew how to contact other agencies to share concerns.
- The service had enough competent staff, and systems in place to assess and manage risks to women and their babies.
- The service had procedures in place to manage service user safety incidents.
- Staff monitored feedback from service users.
- Staff responsible for delivering care worked with other services to support users.
- Staff treated service users with compassion and kindness, respected their privacy and dignity, provided emotional support and took account of their individual needs.
- Staff supported and involved service users and those close to them to understand their condition and make decisions about their care.
- The service planned and provided care in a way that met the needs and preferences of local and individual people. Women could access the service when they needed it and received care promptly.
- Leaders were approachable in the service for service users and those close to them.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with three requirement notices with actions they must complete, that affected Precious Glimpse Roundhay. Details are at the end of the report.

Summary of findings

Ann Ford

Deputy Chief Inspector of Hospitals (North)

Summary of findings

Our judgements about each of the main services

Service

Diagnostic imaging

Rating

Requires improvement



Summary of each main service

The service provided at this location was diagnostic and screening procedures. We rated this core service as requires improvement overall. The service did not have robust systems in place to manage all risks to women and their babies. Most policies were appropriate although some did not reflect current legislation and national guidance and did not always mirror practice at the service.

We saw evidence to confirm staff were sufficiently skilled and qualified to deliver safe and effective care and treatment to individuals using the service.

There were sufficient systems to safeguard adults and children.

Summary of findings

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Requires improvement 

Location name here

Services we looked at

Diagnostic imaging

Summary of this inspection

Background to Precious Glimpse - Roundhay

Precious Glimpse Roundhay (1-7064428704) is operated as a franchise of Precious Glimpse Ltd, by Precious Glimpse – Roundhay. The service has been registered since July 2019. It is a private service in Leeds, Lancashire. The service primarily serves the communities of the Leeds area. It also accepts service users on a self-referral basis from outside this area.

The service has had a registered manager in post since July 2019.

We have not inspected this service previously.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and another CQC inspector. The inspection team was overseen by Sarah Dronsfield, Head of Hospital Inspection.

Information about Precious Glimpse - Roundhay

The service had one ultrasound scanning machine and is registered to provide the following regulated activities:

- Diagnostic and screening services.

During the inspection, we visited all areas of the service and observed one ultrasound scan procedure. We spoke with the registered manager (provider) who was also the operator of the ultrasound scanning equipment. We spoke with service users and reviewed service user feedback. We also spoke with service users who had given their consent to be contacted after the inspection, by telephone.

There were no special reviews or investigations of the clinic ongoing by the CQC at any time during the 12 months before this inspection. This was the service's first inspection following registration with CQC.

Activity (July 2019 to October 2019)

In the reporting period 4 July 2019 to 25 October 2019, there were 601 scans performed.

Track record on safety

- Zero never events (never events are serious patient safety incidents that should not happen if providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event), or serious incidents.
- Zero duty of candour notifications (the duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify people who use the services (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person).
- Zero safeguarding referrals.
- Zero incidences of healthcare acquired infections.
- Zero unplanned urgent transfers of a patient to another care provider.
- Zero number of cancelled appointments for non-clinical reason.

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?

We had not inspected this service previously. We rated it as

Requires improvement because:

- Although staff completed mandatory training in most core subjects, these did not include information governance or health and safety at work.
- The service did not always use control measures well, to protect service users themselves and others from infection. For example, Staff were not bare below the elbows when scanning women.
- We saw an infection prevention and control policy statement dated June 2019 and infection prevention and control policy, dated August 2019. However, the infection prevention and control policy statement was not localised to reflect practice at Precious Glimpse – Roundhay. It contained information about management of clinical infectious and cytotoxic waste streams, which the service did not use.
- The design, maintenance and use of facilities, premises and equipment did not always keep people safe. For example, helium gas was not stored securely to prevent unauthorised access. The scanning room was not lockable and had no privacy curtain. The couch was not height adjustable and may be difficult for smaller women or those living with a disability.
- The service did not have robust systems in place to manage all risks to women and their babies.
- Current risks concerning lone working were not sufficiently mitigated.

However:

- Staff understood how to protect service users from abuse and knew how to contact other agencies to share concerns. Staff had training on how to recognise and report abuse.
- There were enough staff to meet the needs of the service.
- Staff kept appropriate records of service users' treatment, using electronic systems and paper records.
- The service had procedures in place to manage service user safety incidents.

Requires improvement



Are services effective?

We had not inspected this service previously. We rated it as **Not rated** because:

Summary of this inspection

- There was limited assurance the service always provided care and treatment based on national guidance and evidence-based practice.
- The consent policy was not detailed and did not reference the Mental Capacity Act (2005).

However:

- Staff monitored feedback from service users.
- Staff were competent for their role.
- Staff responsible for delivering care worked with other services to support users.
- The service had systems in place to ensure staff followed national guidance to gain service users' consent. Staff had received training on the Mental Capacity Act (2005).

Are services caring?

We had not inspected this service previously. We rated it as **Good** because:

- Staff treated patients with compassion and kindness.
- Staff provided emotional support to service users to minimise their distress.
- Staff supported and involved service users and those close to them to understand their condition and make decisions about their care.

Good



Are services responsive?

We had not inspected this service previously. We rated it as **Good** because:

- The service planned and provided care in a way that met the needs of local people.
- The service was inclusive and took account of most service users individual needs and preferences.
- Women could access the service when they needed it and received care promptly.

However:

- The service had a limited complaints policy and it was not always easy for people to give feedback and raise concerns about care received.

Good



Are services well-led?

We had not inspected this service previously. We rated it as **Requires improvement** because:

Requires improvement



Summary of this inspection

- Leaders did not always ensure that policies and documentation reflected best practice guidance and mirrored practice at the service.
- The service had limited systems and plans to identify risks and eliminate or reduce them.
- The exclusion policy in place did not include a robust risk assessment requirement for each woman attending the service.
- Information about costs of services was unclear.
- Digital information systems were not always secure.

However:

- Leaders were approachable in the service for service users and those close to them.
- The service had a vision for what it wanted to achieve but required a long- term strategy with targets.
- Staff were focused on the needs of service users receiving care.
- Staff actively and openly engaged with service users.





Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Diagnostic imaging

Safe	Requires improvement 
Effective	
Caring	Good 
Responsive	Good 
Well-led	Requires improvement 

Are diagnostic imaging services safe?

Requires improvement 

We rated this service as **requires improvement**.

Mandatory training

Staff completed mandatory training in most core subjects. However, mandatory core subjects did not include information governance or health and safety at work.

The service mandatory training policy identified core subjects to be completed by staff. These included safeguarding adults and children, fire safety, mental capacity act, infection prevention and control and first aid. However, the mandatory training policy did not identify health and safety at work training or information governance training as a requirement and we did not see evidence that staff had completed health and safety at work or information governance training.

We saw certificates of completed safeguarding vulnerable adults level two, safeguarding children level two, basic and advanced first aid, fire safety awareness, fire extinguisher awareness and infection prevention and control in health and social care. All these modules were completed on-line.

Safeguarding

Staff understood how to protect service users from abuse and knew how to contact other agencies to share concerns. Staff had training on how to recognise and report abuse.

Staff at the service completed on-line safeguarding vulnerable adults level two and safeguarding children level two training, in October 2019.

There was a safeguarding policy which contained the contact details for the local authority safeguarding teams.

We observed a safeguarding book kept in a locked drawer at reception for staff to record any safeguarding concerns where these were identified. However, there were no details of safeguarding concerns recorded in the book and the service had not made any safeguarding referrals since registration with CQC in July 2019.

The service exclusion policy excluded young women under the age of 18 from ultrasound scan services. We observed women that booked by telephone were asked to confirm they were over 18. In addition, we observed service users completed a waiver form which required them to state their date of birth. Service users we spoke with all confirmed they were asked their date of birth at the point of booking.

Staff we spoke with told us if a service user looked to be under the age of 18, they were asked to provide photo identification. If they did not provide this, they were not permitted to have a scan.

The registered manager confirmed they were the only employee at the service and had a current Disclosure and Barring Service (DBS) certificate, which was provided to CQC at registration.

Cleanliness, infection control and hygiene

The service did not always use control measures well, to protect service users themselves and others from infection.

Diagnostic imaging

We saw an infection prevention and control policy statement dated June 2019 and infection prevention and control policy, dated August 2019. However, the infection prevention and control policy statement was not localised to reflect practice at Precious Glimpse – Roundhay. For example, it contained information about management of clinical infectious and cytotoxic waste streams, which the service did not use.

The infection prevention and control policy was not detailed and stated, ‘all staff at Precious Glimpse are aware of what steps to take to minimise the risk of infection’. However, we observed staff were not bare below the elbows when performing scans. This prevented effective hand washing and meant there was a risk of cross infection.

Staff did not have access to handwashing facilities in the scanning room but used hand gel prior to scanning. There was a wash hand basin in the toilet, situated opposite the scan room. Service users we spoke with told us they observed staff using hand gel before and after scanning. Non-latex gloves were available for staff to wear during scans if required.

Waste bins were pedal operated and contained an appropriate liner.

There were separate buckets for cleaning toilet areas and general floors. All floors were tiled and easy to keep clean.

A risk assessment for legionella was completed in June 2019.

Stocks of alcohol hand cleansing gel were locked away and we saw the associated control of substances hazardous to health (COSHH) risk assessment for this product.

We observed staff cleaned gel from the ultrasound transducer head with paper towels and antibacterial wipes after use.

A paper towel covered the treatment couch during scans and was replaced after each use. Staff used antibacterial wipes to clean the couch after use. The chairs had wipe-clean surfaces.

The premises appeared visibly clean and were free from clutter. We saw a checklist of cleaning duties in the premises and equipment policy. Staff managed cleaning duties daily and service users we spoke with told us the facilities were clean.

There had been no incidences of healthcare acquired infections at the service since it opened.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe.

The service premises were on the ground floor. The main entrance was at street level with a ramp to the door. There were fire exits to the front and rear of the premises. External signage was clear and there was free car parking nearby.

There was an unlocked store room which contained a large canister of helium gas for filling balloons. The canister was stored on the floor. Although this room was not immediately accessible from the waiting area, the store room was not locked to prevent unauthorised access.

The scan room had two doors which were kept unlocked; one from the reception area and the other door allowed access to the rear storage areas of the premises. There was no privacy curtain.

There was a large viewing monitor, a scanning machine, wipe clean seating and a couch. All were in good order. However, the height of the couch was not adjustable, and this may be difficult for smaller pregnant women and those living with a disability.

The service had a large waiting area with a reception desk, a scan room, a single toilet for staff and service users and two store rooms.

The waiting area was light and spacious, with potted plants. There were three comfortable sofas, which had wipe clean upholstery. There was gentle music playing, which provided a soothing ambience.

There were family friendly images on the walls and a display of baby-souvenir items for sale, such as soft toys, which could have a recorded fetal heartbeat inserted.

Diagnostic imaging

These were all CE marked. CE marking is a certification mark that indicates conformity with health, safety, and environmental protection standards for products sold within the European Economic Area (EEA).

The store room which contained cleaning equipment, was locked.

Most of the equipment we saw was newly purchased and there was an annual servicing agreement in place for the leased ultrasound scanning equipment.

Portable electrical appliances we saw had been safety tested and were labelled to show when the next test was due.

We saw a fire procedure poster displayed prominently. Fire exit routes were signposted, free of obstructions and fire extinguisher appliances had been serviced recently. Staff had received fire extinguisher awareness training.

Assessing and responding to patient risk

The service did not have robust systems in place to manage all risks to women and their babies.

We saw a template 'scan check form' completed by staff after each scan. Staff explained this was to ensure concerns raised by either the service user or the staff were logged and acted upon effectively. However, the document was not localised to Precious Glimpse – Roundhay. These forms were not audited formally, therefore we were not assured the provider was able to demonstrate how the service monitored quality.

Service users we observed booking in, were asked to complete their initials, signature and date on a waiver form prior to having a scan. This form asked women to confirm they were in good health and had no new or ongoing health concerns they needed to make the service aware of. We received a variable response when we asked women if they received a copy of the form.

The waiver also stated the service followed CQC guidelines and as low as reasonably achievable (ALARA) recommendations, for length of scans and frequency of ultrasound sound waves. However, CQC does not provide any guidelines regarding ultrasound scanning. This meant the information on the waiver form was incorrect and could be misleading.

We saw a first aid box, but all contents were out of date in 2018. This meant we were not assured robust checking systems were in place to ensure equipment was always suitable for use when required. We brought this to the attention of staff at the time.

The service had a first aid at work policy. This stated local arrangements were in place for summoning emergency services in the event of a major illness or life-threatening situation but did not specify what these arrangements were. However, staff we spoke with told us they always carried their mobile telephone and would call an ambulance. Although this was not reflected in the policy.

We saw evidence that staff had completed online basic and advanced first aid courses in accordance with the first aid at work policy. However, the policy suggested all staff were also trained in immediate life support and staff we spoke with explained this was not correct.

Website information and the waiver form confirmed scans were non-medical, for bonding and souvenir purposes only. They were not intended to replace routine NHS antenatal scans and services.

We saw a referral policy, which had contact details for the local early pregnancy unit. In addition, we saw a flow chart which described actions to take in the event staff needed to escalate concerns about possible pregnancy abnormalities.

The exclusion policy described specific criteria excluding women from having a scan. For example, disclosures of heavy bleeding and cramping, requests for medical diagnosis or intervention, intoxicated individuals and those displaying verbal or physical intimidation or aggression. However, this did not include a robust risk assessment requirement for each woman attending the service.

During inspection we observed staff directed a caller to a medical sonography service, because they did not believe the service was appropriate in their case.

Health Protection Agency (HPA) current guidance states, although there is no clear evidence that souvenir baby scans are harmful to a foetus, service users must decide for themselves if they wish to have a scan and balance the unknown risk. The consent process and information

Diagnostic imaging

on the waiver form took this guidance into account and referred to national institute for health and care excellence (NICE) and British medical ultrasound society guidance.

Staffing

Current risks concerning lone working arrangements were not sufficiently mitigated.

There were enough staff to meet the needs of the service.

The door to the premises remained unlocked and the waiting area was unattended whilst staff were conducting scans. We saw a risk assessment for lone working with an action plan to install a secure entry system. However, we did not see a lone working policy which described current arrangements in place to keep staff and people using the service safe.

The registered manager was the sole employee at the service and there were no vacancies. However, they told us they received help with housekeeping and production of photo prints occasionally. We saw photo identification and a DBS certificate for this person on file.

Records

Staff kept records of service users' treatment, using electronic systems and paper records.

Digital images were generated by the scanner, which was password protected. Images were downloaded via a memory stick and transferred to a computer prior to printing. Staff we spoke with explained the memory stick was erased after download, but we saw images retained on the computer, which was not password protected.

This meant data was potentially accessible to unauthorised persons. We brought this to the attention of the manager, who after inspection, provided assurance the images were deleted, and the computer was password protected.

Service users completed a paper waiver form at the time of their appointment. This stated terms and conditions and identified the service user's consent for the scan procedure.

The forms were stored in a file behind reception and then transferred to a lockable filing cabinet. Staff we spoke with explained these forms would be shredded after 36 months.

Incidents

Staff did not receive health and safety training.

The service had procedures in place to manage service user safety incidents.

We saw a safety policy which stated all staff completed a health and safety at work course at the start of their employment. However, this training was not identified in the mandatory training policy and staff did not provide evidence of completion.

The service also had an incident policy, which gave examples of what constituted reportable incidents and how to record them. We saw the service had not recorded any incidents since opening. The incident policy did not cover transfers to NHS providers.

Staff we spoke with understood the principles of the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with gave an example of when they had explained to a woman, they had not detected a fetal heartbeat.

Are diagnostic imaging services effective?

We do not currently rate the effective domain

Evidence-based care and treatment

There was limited assurance the service always provided care and treatment based on national guidance and evidence-based practice.

British medical ultrasound society guidance advises scans in pregnancy should not be carried out for the sole purpose of producing souvenir videos or photographs.

Diagnostic imaging

However, staff we spoke with explained the scanning machine was set in accordance with ALARA recommendations, for length of scans and frequency of ultrasound sound waves.

We saw an operational procedure for all types of scan provided at the service. However, this was not referenced to any best practice such as ALARA.

The infection prevention and control policy did not reflect current NICE guidance. For example, it did not advise staff to be bare below the elbows when giving direct care, to enable effective hand washing and reduce the risk of cross infection.

Women were advised regarding the need to drink water prior to their scan to enable a better image of their baby. Staff provided water at their appointment if this was requested or needed.

Patient outcomes

Staff monitored feedback from service users.

Staff recorded information about the number and type of scans performed each month.

We saw and heard positive feedback from service users about quality and experience of service.

The service had been operating for six months and had not audited any outcomes during that period.

Competent staff

The service ensured staff were competent for their role.

Staff we spoke with explained they had received five months training to use the ultrasound scanner, which included 'hands on training'. We saw completed and signed- off competency forms for early scan, 4D and gender scan procedures. Staff had also correctly completed a quiz at the end of each module to test their knowledge.

Staff we spoke with recognised they may need practical and emotional support periodically because they were the only employee of the service. This support was provided as required, by the franchisor. For example, staff described monthly phone calls to discuss marketing, how they were feeling in terms of confidence as a new franchisee and any recent difficult cases, such as women with no fetal heartbeat.

Multidisciplinary working

Staff responsible for delivering care worked with other services to support users.

The service linked with the local NHS maternity services with consent of service users, where there was an identified need.

Seven-day services

Information on the Precious Glimpse – Roundhay website indicated the service was open every day and opening times were advertised as 'open 24 hours a day'.

The website appointment booking button directed the user to a social media page, where the opening hours were listed as 9.30am to 7.30pm and published posts advertised 'late night appointments.' The manager explained they flexed business hours to suit service users because the service was new and still being established.

In the event an appointment could not be accommodated, the contingency was to direct the service user a Precious Glimpse Ltd location if possible.

Consent and Mental Capacity Act

The service had systems in place to ensure staff followed national guidance to gain service users' consent. Staff had received training on the Mental Capacity Act (2005).

We saw a consent policy. However, this was not detailed and did not reference the Mental Capacity Act (2005).

Staff had not received any training in consent. However, a precise of the ultrasound scan procedure was noted on the waiver form, in accordance with on-line NHS guidance. Service users read this prior to providing written consent. Staff we spoke with explained the service saw only medically fit women and did not perceive there had been any service users who lacked capacity or had a need relating to their mental health.

We saw evidence that staff had completed on-line mental capacity level 2 training.

Diagnostic imaging

Are diagnostic imaging services caring?

Good



We rated caring as **good**.

Compassionate care

Staff treated patients with compassion and kindness.

We observed staff welcomed service users on arrival. They engaged well and communicated with sensitivity and understanding.

Scans were performed in a closed room and we observed the scan was carried out with minimal exposure of the women to ensure dignity. However, the door was not locked during scans and we did not see a privacy curtain to protect women from view should someone enter the room.

Staff spoke calmly and explained what was happening during the scan and what was observed on the monitor.

We observed that staff checked the woman was comfortable during their scan.

Service users we spoke with during and after the inspection all told us the care they had received was excellent.

Service users were able to choose their images on a computer in the main waiting area. The monitor was facing outward and the images were visible to others in the reception area. We brought this to the attention of staff at the time. After inspection we were provided with assurance placement of the desk and monitor had been addressed appropriately.

Emotional support

Staff provided emotional support to service users to minimise their distress.

Staff we spoke with were aware of emotional needs of women during their appointments and provided encouragement and reassurance to reduce anxieties about the scan procedure.

Staff supported women and their partners appropriately when choosing scan images, so they did not feel rushed.

Staff we spoke with gave specific examples of how they supported women if they needed to communicate any concerns and appointment times allowed for flexibility if this arose. For example, staff explained they would communicate in a calm and clear way and service users could leave via the rear door if they felt upset. We observed how staff were sensitive and supported a service user who had experienced a positive scan result after having lost a pregnancy in the past.

Understanding and involvement of patients and those close to them

Staff supported and involved service users and those close to them to understand their condition and make decisions about their care.

We observed staff made sure that service users and those close to them felt able to ask questions about their care and provided sufficient time to do so.

Information about the different scan options were available on the Precious Glimpse – Roundhay website and associated social media page.

Feedback from service users indicated they were happy with the service they had received and felt supported throughout.

Are diagnostic imaging services responsive?

Good



We rated responsive as **good**.

Service delivery to meet the needs of local people

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

The premises were located close to the centre of Leeds. The premises were situated on the ground floor, with a reception area, scanning room, adequate storage and a single toilet.

The scan room had a new ultrasound machine, suitable chairs, a treatment couch and a large wall-mounted monitor to view images.

Diagnostic imaging

There was a monitor next to the computer in the waiting area for service users to choose their scan pictures.

Meeting people's individual needs

The service was inclusive and took account of most service users individual needs and preferences.

The service was accessible via a ramp, for people that used a wheelchair and people with pushchairs.

The toilet doorway was wide enough to allow wheelchair access. However, the facility had not been formally risk assessed to establish if modifications such as grab rails were required to be fitted. In addition, the couch in the scan room was not height-adjustable. Accessing the couch may be difficult for smaller pregnant women and those living with a disability.

Staff we spoke with explained they would respond to different individual needs on a case by case basis, although these were not identified at the time of booking.

The Precious Glimpse - Roundhay website and associated social media page were in English language format. Staff we spoke with explained they could access on line interpretation services if needed.

Staff had not completed any equality and diversity training but had some awareness of different individual needs.

Access and flow

Women could access the service when they needed it and received care promptly.

Bookings were made directly by telephone and via the Precious Glimpse – Roundhay website. Opening times were advertised as 'open 24 hours a day'. The website booking button re-directed the user to a social media page, where the opening hours were listed as 9.30am to 7.30pm and published posts advertised 'late night appointments.' This meant we were unclear about the times the service was operational.

Service users we spoke with told us they received an appointment time that was convenient for them and the appointments ran to time.

Appointments were 15 minutes duration and had a gap of 15 minutes between to ensure service users did not feel rushed.

The service had a system in place to allow service users to have a re-scan when required. For example, if the baby was not clearly visible due to its position.

No planned appointments were cancelled or delayed for a non-clinical reason such as breakdown of equipment.

Learning from complaints and concerns

The service had a limited complaints policy and it was not always easy for people to give feedback and raise concerns about care received.

We saw a complaints policy. The policy was limited and stated the feedback forms had details of how to contact a named director of Precious Glimpse Ltd (the franchisor), to register a complaint.

We observed service users were asked to complete a feedback form while waiting for photographs to be printed. However, the feedback forms we saw did not have the director's name or contact details. The form directed the complainant to either phone the same number they had used to book their scan or leave contact details on the feedback form, for a call back. The phone number of the service was not on the form and we did not see any other information on display at the service about how to make a complaint.

Staff we spoke with explained they encouraged service users to discuss any dissatisfaction with them in the first instance.

We found that the complaints policy stated incorrect information and signposted complainants to the regulator rather than the independent complaints ombudsman.

The complaints policy stated complainants would receive full feedback on the outcome of their complaint 'within a reasonable timeframe'. However, the policy did not indicate what the timeframe was.

There was also a facility on the social media page for service users to leave feedback and a 'recommend Yes/ No' button.

The service had received zero complaints since opening.

Are diagnostic imaging services well-led?

Diagnostic imaging

Requires improvement 

We rated well led as **requires improvement**.

Leadership

Leaders were approachable in the service for service users and those close to them.

The registered manager was sole employee of Precious Glimpse – Roundhay. They explained this would be the case until the service became fully established with an income stream.

The registered manager explained they had previously managed three locations for brain injury services and had experience of CQC regulation and inspections.

Vision and strategy

The service had a vision for what it wanted to achieve but required a long-term strategy with targets.

The business aimed to provide pregnant women and their families with an experience of 2D, 3D & 4D live HD scans, Including a bonding experience for families.

We saw a business plan for the service. However, this predominately related to the setup of the business, rather than the long term strategy. There was no timescale identified in the plan.

Culture

Staff were focused on the needs of service users receiving care.

Staff were approachable and focused on providing good quality services.

During the inspection when we shared information about areas of the service where improvements may need to be made, the registered manager was positive in response to this.

Governance

Leaders did not always ensure that policies and documentation reflected best practice guidance and mirrored practice at the service.

The service had a clinical governance policy. However, this did not describe a structured governance framework to support the delivery of good care the service aspired to.

Seven policies and documents we saw were not localised and did not mirror practices at Precious Glimpse-Roundhay. For example, the Infection prevention and control policy and manual did not reflect current NICE guidance for those giving care, to be bare below the elbows and described waste streams that the service did not use.

The disabled access policy we saw contained incorrect information. For example, it stated those living with a disability that needed to use toilet facilities were directed to facilities at a nearby retail premises.

The scan check form used to document issues and concerns after each scan, alluded to other Precious Glimpse Ltd locations and not Precious Glimpse – Roundhay.

The first aid policy did not specify the local arrangements for summoning help in an emergency and stated the incorrect level of life support training staff received at the service.

Policies were not version controlled and we saw different versions of policies prior to inspection and on file at the service.

The documented daily checks form did not include calibration of the scanning equipment. The procedure described on the form was not localised. For example, it directed staff to the directors of the franchise if there were stock check issues. However, the franchisee management policy we saw stated 'all Precious Glimpse franchisees are fully responsible for their day to day procedures'.

The waiver form referred to CQC/ALARA guidance and recommendations for length of scans and frequency of ultrasound sound waves. However, CQC does not provide such guidance.

The procedure for making a complaint was unclear. There was no information displayed at the service informing service users how to raise a concern or make a complaint, other than on the waiver form. Service users we spoke with told us they were not sure they received a copy of the waiver form after signing it.

Diagnostic imaging

Managing risks, issues and performance

The service had limited systems and plans to identify risks to eliminate or reduce them.

We saw a risk assessment for lone working and an action plan to implement suitable and sufficient controls, to reduce risk. However, there was no lone working policy.

The service did not have a risk register in place.

There was an exclusion policy in place, but this did not include a robust risk assessment requirement for each woman attending the service.

The service opened in July 2019. It was still being established, therefore audit activities were not routine practice. However, the provider reviewed feedback from service users regularly.

We saw risk assessments for fire, environment, COSHH and legionella.

Managing information

Digital information systems were not always secure. Information about costs of services was unclear.

The service had a management of records policy, which referred to requirements under General Data Protection Regulation (GDPR) 2018.

However, the policy also stated digital records were not held at the service, which was incorrect. For example, staff we spoke with told us names, estimated due dates and digital images were kept on it for a period of 12 months before being erased.

The scanner was password protected. Scan images were transferred to a data stick and then to a computer at

reception for service users to choose their images. Although data on the data stick was then erased, we saw the downloaded digital images were retained on the computer. We made staff aware of this at the time and after inspection, we received assurance it was password protected and digital images had been erased.

Information on the Precious Glimpse – Roundhay website was clear about the services provided but not clear about costs. For example, we saw information about offers posted in July 2019. Users had to click on ‘make appointment’ to be directed to the social media page for more detailed information. This page provided package details but indicated ‘price varies’. In addition, there was no information on display at the service regarding costs of scan packages and gift items. Staff we spoke with explained this information was available on the website but changed frequently. This meant service users may not be clear about fees and costs prior to making a booking.

Engagement

Staff actively and openly engaged with service users.

The provider engaged with service users through the service’s web site and social media accounts, to promote its services. The provider monitored feedback from service users via feedback forms and social media comments.

Learning, continuous improvement and innovation

The service was still being established. Staff we spoke with explained they were keen to improve services where required and were receptive to opportunities to do this.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **MUST** take to improve

- The service must ensure the infection prevention and control policy and policy statement are localised and reflect practice at Precious Glimpse – Roundhay.
Regulation 12.
- The provider must ensure mandatory training subjects include information governance and health and safety at work. **Regulation 12.**
- The provider must ensure the service always provides care and treatment based on national guidance and evidence-based practice. **Regulation 12.**
- The provider must ensure there is a comprehensive complaints policy and clear procedure to enable people to give feedback and raise concerns about care received. **Regulation 16.**
- The service must ensure that they have a risk register in place which identifies organisational concerns and action plans to mitigate risk. **Regulation 17.**
- The provider must ensure policies and documentation reflect appropriate legislation and best practice guidance. For example, Mental Capacity Act (2005) and NICE guidance. Reference to CQC guidance (which is incorrect), must be removed from the waiver forms. Policies must mirror practice at the service.
Regulation 17.
- The service must ensure that the clinical governance policy describes a structured governance framework to support the delivery of good care the service aspired to. **Regulation 17.**

Action the provider **SHOULD** take to improve

- The provider should ensure all policies and procedures are version - controlled and ensure there is a system in place, so that obsolete policies are not kept with current policies.
- The provider should ensure that scan form audits are undertaken formally, to demonstrate monitoring of quality.
- The provider should ensure the contents of first aid boxes are checked and within expiry dates.
- The provider should ensure costs of services are displayed clearly at the service.
- The provider should risk assess toilet facilities for people living with a disability and consider fitting fixtures to enable better accessibility.
- The provider should review arrangements to protect privacy and dignity of women during scans and consider fitting locks to the doors or installing a privacy curtain.
- The provider should review arrangements for safe storage of helium canisters in the store room and consider fitting a security lock.

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	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>The provider did not ensure the service had localised infection prevention and control policy and policy statement, which reflected practice at the service.</p> <p>The provider did not ensure staff received mandatory training in information governance and health and safety at work.</p> <p>The provider did not ensure the service always provided care and treatment based on national guidance and evidence-based practice.</p> <p>The provider did not ensure the service had a risk register in place which identified organisational concerns and action plans to mitigate risk.</p>
Regulated activity	Regulation
Diagnostic and screening procedures	<p>Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints</p> <p>The provider did not ensure there was a comprehensive complaints policy and clear procedure to enable people to give feedback and raise concerns about care received.</p>
Regulated activity	Regulation
Diagnostic and screening procedures	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p>

This section is primarily information for the provider

Requirement notices

The provider did not ensure policies and documentation reflected appropriate legislation and best practice guidance and mirrored practice at the service.

The provider did not ensure the service had a clinical governance policy which described a structured governance framework to support the delivery of good care the service aspired to.