Ultrasound-Care Scanning Services Ltd

Ultrasound-Care Scanning Services Ltd T/As Peek-a-Baby

Inspection report

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

Ratings

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

Summary of findings

Overall summary

We had not previously rated this location. We rated it as requires improvement because:

- The service did not always control infection risks well. Staff did not always use equipment and control measures to protect patients, themselves and others from infection.
- There was no hand washing facility in the scanning room and this meant staff had to leave the room to wash their hands between each patient.
- The service had some arrangements in place to assess and manage risks to women, however, the process for addressing the risk to individual women was not comprehensive.
- Access to electronic devices were not always encrypted to avoid data breaches, in the event of unauthorised access.
- Leaders did not always use systems to identify and escalate relevant risks. Governance processes were not always effective and we did not identify processes to review policies and risks on the risk register.

However:

- The service had enough staff to care for women and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well.
- Staff provided good care and treatment. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information.
- Staff treated women with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to women, families and carers.
- The service planned care to meet the needs of local people, took account of women' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of women receiving care.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Requires Improvement 	We had not previously rated this location. We rated it as requires improvement because: • The service did not always control infection risks well. Staff did not always use equipment and control measures to protect patients, themselves and others from infection. • There was no hand washing facility in the scanning room and this meant staff had to leave the room to wash their hands between each patient. • The service had some arrangements in place to assess and manage risks to women, however, the process for addressing the risk to individual women was not comprehensive. • Access to electronic devices were not always encrypted to avoid data breaches, in the event of unauthorised access. • Leaders did not always use systems to identify and escalate relevant risks. Governance processes were not always effective and we did not identify processes to review policies and risks on the risk register. However: • The service had enough staff to care for women and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. • Staff provided good care and treatment. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information. • Staff treated women with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to women, families and carers.

Summary of findings

- The service planned care to meet the needs of local people, took account of women' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of women receiving care.

Summary of findings

Contents

Summary of this inspection

Background to Ultrasound-Care Scanning Services Ltd T/As Peek-a-Baby

Ultrasound-Care Scanning Services Ltd T/As Peek-a-Baby is a private ultrasound clinic operated by Ultrasound-Care Scanning Services Ltd.

The service provides various 2D and 4D scans of babies before birth using 4D ultrasound scanning equipment and visual aids. They also offer early pregnancy scans, pregnancy reassurance scans and gender scans. The service had 6103 attendances in the 12-month period before our inspection.

The premises consisted of a reception, scanning room, printing room and kitchenette.

The provider has two other locations based in Birmingham and Bromsgrove.

The service is registered with CQC to undertake the regulated activity of diagnostic and screening procedures. This is the first inspection of Ultrasound-Care Scanning Services Ltd T/As Peek-a-Baby.

How we carried out this inspection

We carried out a comprehensive inspection of the service on 24 November 2021. The inspection team comprised of a CQC inspector and a CQC specialist advisor. We gave the service two working days' notice, because we needed to be sure it would be in operation at the time we planned to visit. We held an additional staff interview on 6 December 2021.

We spoke with six members of staff including the registered manager, senior staff, a sonographer, reception/chaperone staff. We spoke with four women and three relatives who were using the service at the time of our inspection. We reviewed a range of policies, procedures, patient records and observed patient care.

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

Areas for improvement

Action the service MUST take to improve:

- The provider must ensure staff control infection risks well. (Reg 12(2)(h)).
- The provider must ensure that the fire extinguisher is regularly tested/checked. (Reg 15(1d)(e)).

Action the service SHOULD take to improve:

- The provider should ensure staff document a comprehensive risk assessment for each individual patient.
- The provider should consider disposing the unused ultrasound machine stored in the scanning room.
- The provider should ensure that minutes of meetings identify all staff in attendance and contain sufficient detail to provide a clear understanding of what was discussed.
- The provider should ensure that risks on the risk register are assigned to a named person and include a review date.
- The provider should ensure all policies and procedures have an effective and review date.

Summary of this inspection

- The provider should ensure all electronic devices are encrypted to avoid data breaches, in the event of unauthorised access.

Our findings

Overview of ratings

Our ratings for this location are:

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

Requires Improvement

Diagnostic imaging

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

Are Diagnostic imaging safe?

Requires Improvement

We had not previously rated Safe at this location. We rated it as requires improvement.

Mandatory training

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

Staff received and kept up-to-date with their mandatory training. The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training included children's safeguarding, adult safeguarding mental health, information governance, Infection prevent and control (IPC), manual handling, health and safety, food handling and hygiene, fire safety, equality and diversity, conflict resolution and complaints.

Sonographers completed mandatory training with their substantive employer.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

The service had a safeguarding policy, however, the policy had no review date. The policy described the definition of abuse and neglect, who might be at risk, general indicators and what actions to take if staff suspected abuse. The policy was easily accessible in a folder and included contact details for safeguarding leads and the local authority.

Staff had received training in female genital mutilation (FGM) as part of their safeguarding training. Most staff we spoke with had a clear understanding about safeguarding, knew what the signs of abuse might be and where to access support if they had any concerns. However, one of the staff we spoke with could not demonstrate a clear understanding about safeguarding concerns.

Requires Improvement

Diagnostic imaging

Staff received training specific for their role on how to recognise and report abuse. All staff had completed at least level 2 safeguarding adult and children training. Senior staff and two sonographers had completed level 3 safeguarding adults training. One sonographer had completed level 3 safeguarding children training.

Staff followed safe procedures for children visiting the service. The service had safeguarding arrangements for 16 and 17 year old young females, who were asked to attend with a responsible adult.

The service displayed information in the toilets, regarding safeguarding from abuse. This reflected good practice, as it meant women and visitors could discreetly access important information.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff did not always use equipment and control measures to protect patients, themselves and others from infection.

Although most areas of the clinic were clean, we saw rubbish behind an ultrasound machine which was packed against the wall in the ultrasound room. Staff told us the machine was not in use but was stored in the room and we noted it was very dirty. We also noted that the console area of the main ultrasound machine was dusty.

We observed there were four fabric chairs and carpet flooring in the scanning room. The reception area also had some fabric chairs. These posed an infection risk as the fabric texture was not wipeable. The chairs and carpet could hold moisture with the potential for microbial growth. We also observed the scanning room had a mix of wool/linen curtains which also posed an infection prevention and control risk.

Following our inspection, the provider informed us they have removed fabric chairs from the scanning room and replaced it with wipeable surface chairs. They informed us they have also removed wool/linen curtains.

Visitors and staff had access to hand sanitising gel in the reception area and scanning room. We observed there was no hand washing facility in the scanning room and this meant staff had to leave the room to wash their hands between each patient. Staff had access to handwashing facilities in the bathroom and kitchenette. We noted staff did not wash their hands on one of the five patient care episodes observed.

All staff were bare below the elbow and had their hair tied back. Staff used personal protective equipment (PPE) including gloves and apron when carrying out scanning procedures. We noted the sonography staff did not wear a uniform. Although they used an apron, this was not changed after each patient episode observed.

We reviewed the use of ultrasound gel in the centre and saw two full and one partly full five litre bottles of sterile ultrasound gel stored in a cupboard in the scan room. We also saw 33 refilled bottles of gel in a cabinet and one refilled bottle on the ultrasound machine. The refilled bottles had no manufacturer label or expiry date. We observed staff use ultrasound gel from the refilled bottle placed on the ultrasound machine contrary to national guidance.

The UK Health Security Agency (UKHSA) (previously Public Health England (PHE) in its' guidance "Good infection prevention practice: using ultrasound gel" (published in January 2021 and updated on 10 November 2021) recommended the use of sterile ultrasound gel in single-use containers in a number of scenarios including for invasive procedures. Non-sterile ultrasound gel in single use and multi-patient use containers may be used for non-invasive procedures.

Requires Improvement

Diagnostic imaging

The guidance provided general principles for the safe use of ultrasound gel. For sterile gel, only unopened sachets and containers that are labelled as 'sterile' can be used, and this cannot be re-used once opened. Non-sterile ultrasound gel should not be decanted from a larger container into other bottles. In addition, only single use sachets or pre-filled multi-patient disposable bottles can be used. Once opened, non-sterile ultrasound gel bottles must be dated and disposed of when either empty, after one month or on expiry date, whichever comes first.

Staff confirmed they used sterile ultrasound gel from single-use sachets for transvaginal scans and we saw these stored in a cupboard in the scan room.

The service had an infection prevention and control policy, which provided guidance on appropriate infection control practice. The policy outlined the cleaning regime for each area of the unit and for specific equipment used within the unit.

Staff cleaned the ultrasound probe with sanitising wipes after each scan. They used disposable paper towel to cover the examination couch during the scan. They cleaned the couch with sanitising wipes and changed the towel after each scan.

Women were provided with information about COVID-19 restrictions at the time of booking and a declaration was completed for women visiting the clinic, which covered symptoms or known exposure and the COVID-19 status was recorded.

The reception area was separated into five zones to ensure staff could easily maintain social distancing between patient groups.

The service conducted monthly hand hygiene audits to monitor compliance with national standards. Hand hygiene audit from July to October 2021 showed staff compliance was in line with established guidelines.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment mostly kept people safe. However, fire extinguishers were out of date for testing.

The service had enough suitable equipment to help them to safely care for women.

The service had suitable facilities to meet the needs of women and their families.

The scanning machine was maintained and serviced under a maintenance contract. We noted the last test date for the ultrasound machine was on 2 November 2020 and this was due for testing in November 2021. Staff informed us they had booked the next test for 25 November 2021. Portable electrical appliances were tested and in date.

The service had a second ultrasound machine which was packed against the wall in the scanning room. Staff told us the machine was not in use but was stored in the room. The machine was last tested in 2019. We noted a build-up of clutter behind the machine.

Environment risk assessments including health and safety, fire and first aid facilities were in place. However, we noted there was no review date for the fire risk assessment. We saw evidence of bi-annual fire drills.

Fire extinguishers were accessible and stored appropriately. However, we noted they were last checked in 2019. Fire extinguishers should be checked annually in line with national guidelines. Following our inspection, the provider informed us they have booked a date for the fire extinguishers to be serviced.

Staff disposed of clinical waste safely. The service had a contract with a waste management company for the collection and disposal of hazardous waste.

Assessing and responding to patient risk

The service had some arrangements in place to assess and manage risks to patients, however, the process was not comprehensive.

Individual risk assessments were limited to a brief clinical history included on the ultrasound report. Women were required to sign the terms and conditions of service which required them to inform staff of any allergies, skin conditions or any other physical/mental conditions prior to the scan. However, we saw no evidence in women's notes (or from our observations of care) that staff checked women had no conditions to report before undergoing the scan.

Staff followed safety guidance when carrying out ultrasound scanning including using the 'Paused and Checked' checklist devised by the British Medical Ultrasound Society (BMUS). This guidance ensured sonographers carried out extra confirmation that they were about to carry out the correct procedure on the correct patient.

Scan reports were completed immediately after the scan had taken place. Women were given copies of their scan reports to share with their GP or other healthcare professional.

Staff made sure women understood that the ultrasound scans they performed were in addition to the routine care they received as part of their maternity pathway. Women were advised that the scans should not be taken as a substitute for the hospital ultrasound. This was included in the terms and conditions of the service.

Mandatory training records provided, showed all staff had completed basic life support training.

The service had a process for referring women in the event that their scan revealed any anomalies. In all cases of anomalies, staff informed women and advised them on actions to take. If urgent, women were advised to see their GP, midwife or go to the early pregnancy unit. In the event of life-threatening emergencies (for example, an ectopic pregnancy), staff informed us they would call an ambulance in line with the provider's medical emergencies policy.

We observed an episode of care where there was no visible gestation and the woman had experienced bleeding. Staff advised the woman to attend the early pregnancy unit (EPU) immediately and a copy of the images and scan report was given to the woman to take to the EPU. However, staff did not contact EPU directly and there was no further involvement from the service. This was not in line with best practice as the service could not demonstrate evidence of ongoing care.

Staffing

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

Requires Improvement

Diagnostic imaging

The care team comprised of sonographers and a team of reception staff/chaperones. There were four joint receptionist and chaperones and four sonographers. Senior staff informed us one of the sonographers was on leave until January 2022. The sonographers worked on zero-hour contracts and were booked into shifts according to the booking list.

The service did not use any bank or agency staff and at the time of our inspection, there were no vacancies. The service had a low sickness/ absence rate.

The service ensured all staff who worked for them had the necessary safety checks undertaken, including Disclosure Barring Service (DBS) and references during recruitment. We noted that DBS certificates presented for sonography staff had been obtained via their substantive employer. The provider informed us they have recently applied for DBS checks for all staff (including sonographers) and we confirmed this from the notes of a recent staff meeting.

Records

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

Records were comprehensive and all staff could access them easily.

The service kept electronic imaging records and paper records. Paper records included scan reports, consent forms, COVID assessments and completed terms and conditions of service.

We reviewed 15 records including gender scans, 4D scans and completed terms and conditions. Staff completed women's contact details, consent forms and scan reports. Records were signed and dated by staff.

Each record clearly identified the type of scan, gestation, expected date of delivery, measurements, estimated weight of baby, amniotic fluid and foetal heart movement. It also indicated whether the pregnancy involved singleton or multiple babies.

Paper records were stored in a locked cupboard. Images on the ultrasound machine were transferred on to a removable drive and stored in a secure cupboard. However, the removeable drive was not encrypted, which could compromise its security, in the event of unauthorised access.

Medicines

Staff did not administer or store medicines on the unit.

Incidents

Staff informed us they would record incidents in an accident book. However, there had been no incidents reported in the last 12 months to our inspection.

The duty of candour 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 were aware of their responsibility to apologise and be open and honest and share the information with the patient and their carers.

Requires Improvement

Diagnostic imaging

There was no incident requiring a duty of candour notification in the last 12 months.

Are Diagnostic imaging effective?

Inspected but not rated

We do not rate the effective domain in diagnostic and screening services.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Policies and procedures were developed in line with national guidance from the Society and College of Radiographers and the British Medical Ultrasound Society. For example, the service followed the 'as low as reasonably achievable' (ALARA) principles outlined by the Society and College of Radiographers. Where possible, the sonographers completed ultrasound scan within 15 minutes to help reduce ultrasound patient dose.

Policies and procedures were kept in a folder in the reception area and staff knew how to access them. However, the policies did not have a review date. We also noted that some of the scanning protocols we reviewed in the scanning room did not have an effective or review date. Therefore, we were not assured there were sufficient systems in place to update policies in line with national best practice.

Following our inspection, the provider informed us policies were reviewed on a yearly basis. They stated that many policies have not needed updating as there have been no changes to policies or procedures. They provided copies of updated policies including the chaperone policy, health and safety policy and risk assessment, and safeguarding policy and procedure.

The service had an audit programme to assure itself of the quality and safety of the clinic.

Nutrition and hydration

Women were informed about any nutritional information required for their scans. For example, women attending the unit for early pregnancy scans were advised to attend the unit with a full bladder. Water was offered to all pregnant women attending the clinic for an ultrasound scan, particularly for those scans which required a full bladder in line with the provider's policy.

Pain relief

Staff did not monitor pain levels as the procedure was pain free. However, staff ensured women were comfortable during their scan.

Patient outcomes

Requires Improvement

Diagnostic imaging

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. These included report audits, image audits and scan audits.

Report audits were conducted from a sample of 10 reports of each scan type chosen at random every three months. The reports were audited to ensure all writing was clear and legible. All reports must be dated and include the woman's details, sonographer's name and chaperones name.

Audits were completed on the baby scanning images to ensure that women received correct, and relevant information. Images were audited for presence of structures, measurements, quality of image, patients name, due date, date of scan, and name of clinic. Audits were also carried out on printed images to ensure that the quality of printing was of the highest standard. This quality audit was performed at every scan before the pictures were passed over to the woman. If staff felt that the print quality was not of the highest standard, the image was then reprinted to correct the error.

An audit of completed scans was carried out by the lead sonographer on a sample of two of each scan type, once every three months. The scan report, along with scan images were compared and reviewed for image quality, report quality and clinical quality.

We reviewed a sample of audits and noted outcomes were in line the provider's standards.

Managers used audit findings to make improvements to the service and shared outcomes with staff.

Competent staff

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

Managers gave all new staff a full induction tailored to their role before they started work. In addition, all reception staff had completed in-house chaperone training.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women. Sonographers were not required to be registered with the Health and Care Professions Council (HCPC), however, some of the sonographers working in the service were members of the Society of Radiographers and had registered with the HCPC. All sonographers had obtained qualifications in diagnostic ultrasound.

Managers supported staff to develop through quarterly appraisals of their work. However, sonographers who worked predominantly in the NHS and other independent health care service received their annual appraisal from their substantive employer.

The service had a clear performance management process. This included peer review of sonographer scans. The lead sonographer reviewed scans carried by each sonographer once every three months and provided feedback to each sonographer. We reviewed the most recent scan audits which showed sonographers had maintained a good standard for all patients.

Multidisciplinary working

Requires Improvement

Diagnostic imaging

Staff worked together as a team to benefit patients. They supported each other to provide good care.

There was good working relationship between staff members. The registered manager, directors, sonographers and chaperones/receptionists all supported each other.

Seven-day services

Key services were available five days a week to support timely patient care.

The service opened on Tuesdays, Wednesdays, Fridays, Saturdays and Sundays. Patients could book a same day appointment on the days the service was opened.

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on its website. The service provided leaflets for women which gave information on healthy lifestyles during pregnancy.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a woman had the capacity to make decisions about their care. However, they informed us they rarely saw patients with mental health needs.

All women received written information to read and sign before their scan. This included terms and conditions and a consent form. Women also completed a separate transvaginal consent form where relevant.

All staff were aware of the importance of gaining consent from women before conducting an ultrasound scan. The sonographer confirmed names and dates of birth prior to the scan and obtained verbal consent.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act 1983 and 2007, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Staff could describe and knew how to access policy on Mental Capacity Act and Deprivation of Liberty Safeguards.

Are Diagnostic imaging caring?

Good

We had not previously rated caring at this location. We rated it as good.

Requires Improvement

Diagnostic imaging

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

We spoke with four women and three relatives. They said staff treated them well and with kindness. Staff followed policy to keep patient care and treatment confidential. All women told us they would recommend the service. One woman had used the service during a previous pregnancy and said they had already recommended the service to other people. Staff were discreet and responsive when caring for patients. Staff took time to interact with women and those close to them in a respectful and considerate way. We saw that staff were engaging, friendly and professional.

The service did not carry out patient surveys. Staff informed us they encouraged women to complete a patient survey questionnaire prior to the COVID pandemic. However, this was discontinued since the pandemic and patients are now encouraged to leave a review on google and Facebook. Staff told us they reviewed feedback on monthly or bi-monthly basis and made changes were necessary. We saw the service received many positive feedback on its social media pages with most patients expressing satisfaction with their scan experience.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave women and those close to them help, emotional support and advice when they needed it.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. We saw that practical tips on breaking bad news in obstetric ultrasound was displayed within the scanning room.

The service provided women with information about charities which supported women following a miscarriage. Women were also provided with an information leaflet to guide them in the event of a miscarriage.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure women and those close to them understood their care and treatment. Women told us they were provided with clear instructions, information and a report following their scan.

Staff explained the procedure before and during the scan. Women and their families could view the scan on a screen and the sonographer gave explanations about what was happening throughout the scan.

Women informed us they were satisfied with the level of information staff provided.

Requires Improvement

Diagnostic imaging

Are Diagnostic imaging responsive?

Good

We had not previously rated Responsive at this location. We rated it 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 and the communities served. It also worked with local organisations to plan care.

Facilities and premises were appropriate for the services being delivered. The reception area was spacious with comfortable seating areas. The service had toilet facilities and baby changing facilities.

Staff responded to enquiries and appointment requests with a personal telephone call during which patients were provided with appropriate information about scan options and pricing. The service allowed women to attend with three members of their families or friends for support. Women could access same day, evening and weekend appointments.

Women confirmed they were able to book appointments on a date convenient for them.

The service worked with local charities which supported women following a miscarriage.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Women had access to information leaflets about their scans. These included information about baby scan packages, 4D scans and ultrasound care. The leaflets also provided information regarding the cost of each scan.

Staff had completed equality and diversity training which ensured women with protected characteristics received care free from bias.

Staff asked if women had any special needs or requirements during the booking process. Staff explained they could make adjustments for women with visual and hearing impairments and women who required translation services.

Translation services was planned in advance of a women's attendance. In the event that information is not provided in advance the service used web translation services.

Women could buy a range of baby keepsakes and souvenirs after their scan. These included photo frames, key rings, fridge magnets and thermal prints.

Access and flow

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

Requires Improvement

Diagnostic imaging

All women self-referred to the service. They could book an appointment via an online booking form on the website or a telephone call. Staff informed us the service also offered same day appointments were possible. Women told us they could book an appointment at a time and date convenient for them.

At the time of our inspection, the service did not have a waiting list. Women could book an appointment at a time to suit them. During our inspection, each woman was allocated a 15-minute slot and we noted seamless patient flow from arrival at the clinic to completion of scan.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Women, relatives and carers knew how to complain or raise concerns. People had access to the provider's complaint policy on the provider's website.

Senior staff informed us they dealt with any dissatisfaction from women whilst they were still in the clinic and this minimised the number of written complaints received. Staff were aware of the complaints procedure and how to escalate concerns.

In the event of a formal complaint, staff followed the complaint procedure which required the complaint to be escalated to the complaint manager. The service responded to complaints within 24 hours and aimed to resolve complaints within three days.

There had been one formal complaint between November 2020 to October 2021. This complaint was investigated in line with the complaint procedure. We saw evidence that managers shared feedback from the complaint with staff and learning was used to improve the service.

Are Diagnostic imaging well-led?

Requires Improvement

We had not previously rated Well led at this location. We rated it as requires improvement.

Leadership

Leaders were visible and approachable in the service for patients and staff. They supported staff to develop their skills. However, leaders did not demonstrate full understanding of the issues the service faced or how to manage them.

Diagnostic imaging

The leadership team consisted of the registered manager, who is a director of the organisation as well as four other directors. The registered manager led the organisation across three locations. One of the directors deputised for the registered manager and acted as the named contact in their absence. The three other directors were responsible for handling complaints, marketing and human resources. A lead sonographer was responsible for conducting peer review of sonographers and their practice.

At least one of the directors was physically present at the service four days a week.

Staff were positive about the leadership of the service. They informed us managers were visible and approachable. They felt well supported by the registered manager of the service. Staff felt confident to approach the management team regarding issues to do with their professional or personal life.

Managers had some understanding of the priorities of the service including implementing COVID risk assessments during the pandemic and having a business continuity plan in place. However, the service did not have systems to review policies and risks on the risk register. As a result, we are not assured that leaders understood the challenges the service faced and could identify actions needed to address them.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

The service's mission statement states they endeavour to provide clients with a warm and compassionate environment, with special attention to privacy, sensitivity and personal dignity; ensuring ultimate client-satisfaction in a safe and homely atmosphere. They state their aim was to make Peek-a-Baby experience one of the most pleasant memories of pregnancy for all their clients.

The provider states they achieved their goals through a culture that supported learning and innovation, teamwork, staff and patient engagement.

The provider laid out its future plans which included expanding services into the community by identifying areas of need and any gaps in services which were not readily available to the community. The provider stated they will work towards contacting the local Clinical Commissioning Groups (CCGs) and obtaining contracts to provide ultrasound services as well as becoming an Any Qualified Provider (AQP).

Staff understood the service's primary focus on customer care and comfort and we found this embedded within the unit.

Culture

Staff felt respected, supported and valued. The service had an open culture where patients, their families and staff could raise concerns without fear.

The service employed a diverse team of staff, who felt valued and informed us they worked well as a team. Staff confirmed they worked in a very close-knit team and we noted they had worked for the service for significant number of years.

Staff reported there was a positive culture within the service. Staff said they worked in a friendly environment. Staff informed us they felt confident to raise concerns with the management team and felt listened to.

Staff recognised the need to be open and transparent with women when something went wrong in line with duty of candour requirements.

Governance

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. However, governance processes were not always effective.

There were clear responsibilities, roles and some systems of accountability to support good governance and management. The service carried out various audits to monitor the quality of care and treatment. These included staff audits and scan audits amongst others.

The service carried out monthly staff meetings which were mostly well attended. Staff discussed operational issues, mandatory training and customer service amongst other issues.

The service had monthly management meetings where senior staff discussed the operations of the business, staffing, audits, regulatory requirements and financial issues. However, minutes of the last three management meetings merely listed the issues/topics discussed. The minutes did not contain sufficient detail to provide a clear understanding of what was discussed. The minutes did not identify staff in attendance.

Policies and procedures were in place for safe and effective running of the service. However, policies did not have review dates. We also noted that scanning protocols did not have an effective or review date. Therefore, we were not assured there were sufficient systems in place to update policies in line with national best practice.

The provider had service level agreements with third party organisations for the delivery of some of its services.

Management of risks, issues and performance

Leaders and teams used systems to manage performance effectively. However, they did not always identify and escalate relevant risks and issues.

The service had a risk register which identified controls in place to mitigate against the impact from the risks. There were six risks on the risk register. These included the risk to reduction in quality of service, loss of credibility, service disruption, additional workload, staff continuity and regulatory criticism by the CQC. However, each risk was not assigned to a named person and did not have a review date. Our review of the last three management meetings showed that risks were not routinely reviewed.

In addition, there was no evidence to indicate controls were effective. For example, “regulatory criticism by CQC” is a risk on the risk register. Mitigating controls include keeping up to date with CQC regulations and updates, monitoring Public Health England (PHE) updates and monitoring British Medical Ultrasound Society (BMUS) updates. However, the provider did not adhere to the PHE guidance “Good infection prevention practice: using ultrasound gel”.

Requires Improvement

Diagnostic imaging

The risk register did not include some of the main risks around infection control and individual risk assessments identified during our inspection.

The service had implemented a contingency plan to mitigate any business continuity risk. The provider had a valid insurance for their service covering both public and employer liability, including professional indemnity insurance for registered professional staff. They had malpractice insurance as well as management liability insurance.

Staff had carried out various risk assessments including health and safety risk assessment. This identified various hazards (including slips and trips, use of scanning equipment, cleaning materials and electrical fire) and mitigating controls were in place. Each risk had a named person responsible for it and date of action.

The service had conducted adequate risk assessments to protect staff, particularly Black and Minority Ethnic staff vulnerable to Covid-19. Safety precautions were implemented for all staff and visitors to the clinic.

The service carried out various audits including report audits, image audits, scan audits and staff audits. These audits included key performance indicators which enabled the provider to monitor the quality of the service.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. However, access to some electronic records were not password protected.

Staff informed us they could access information needed to provide safe and effective care. Paper records were stored securely and readily assessible to all staff. All electronic records on computer systems were password protected. However, access to the ultrasound machine was not password protected. Images stored on an external drive were not encrypted. Although this was stored in a locked cupboard it is best practice to encrypt all removable electronic devices, in order to keep the data secure, in the event of unauthorised access.

Staff had received training on information governance and data protection as part of their mandatory training programme.

Engagement

Leaders and staff actively and openly engaged with patients and staff to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service engaged staff through staff meetings and through operating an open-door service which enabled staff to approach leaders on any issue.

Staff were kept up to date with relevant information during daily staff briefings, appraisal meetings and monthly staff meetings.

The service monitored feedback received from electronic website sources, analysed trends and used findings to implement changes. Notes of a recent staff meeting reviewed showed staff were encouraged to ensure patients understood all issues regarding their scan before they left the clinic.

Requires Improvement

Diagnostic imaging

The service collaborated with charities which supported women after a miscarriage in order to provide emotional support.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

The service had systems to monitor staff training and development. Senior staff informed us they are looking to expand into different areas of diagnostic scanning. The service used a modern scanning machine which captured 4D and HD images. Staff informed us they kept up with the latest scanning technology to produce good quality images.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The provider must ensure that the fire extinguisher is regularly tested/checked. (Reg 15(1d)(e)).

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider must ensure staff control infection risks well. (Reg 12(2)(h)).