Bumpkins York

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	Good
Are services safe?	Good
Are services effective?	Not sufficient evidence to rate
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Bumpkins York is operated by Bumpkins York. The service is a single speciality independent healthcare provider offering 2D, 3D and 4D imaging to self-funding women who use the services.

Bumpkins York is staffed by one person (ultrasound technician) who is also the registered manager and owner of the service.

Bumpkins York is situated in a small ground floor business unit in a rural area. The service provides wheelchair access and has designated car parking at the front of the building. Women who use the service entering the unit are escorted directly into a waiting area which opens into a scanning room, and small staff kitchen area. The central reception has adequate seating and a reception desk. Toilets were provided for women who use the service, along a small corridor near to the front entrance.

The service provided a screening and ultrasound scan service for people aged 18 plus in relation to pregnancy (from seven weeks through to full term), including gender scans, and early bonding experiences. In addition the provider offers heartbeat teddy bears and gender reveal balloons.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 26 June 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 needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Services we rate

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

- The service provided mandatory training in key skills
- The service controlled infection risk well.
- The service had suitable premises and equipment and looked after them well.
- The service provided care and treatment based on national guidance and evidence of its effectiveness. The service made sure staff were competent for their roles.
- Staff cared for women who use the service with compassion. During the inspection we spoke to two women who were using the service. They said, "staff went above and beyond". One said, "staff were very friendly".
- Staff involved people who use the service and those close to them in decisions about their scan.
- People could access the service when they needed it.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results.
- The manager had the right skills and abilities to run a service providing high-quality sustainable service.
- The service had a vision for what it wanted to achieve and workable plans to turn it into action.

We found areas of outstanding practice:

- We saw an example of the service going above and beyond to assist those people who use the service.

Summary of findings

We found areas of practice that require improvement:

- Some policies did not have a creation date or review date.
- The ultrasound practitioner does not receive an appraisal or peer support due to being the only employee.

We found that the /service was meeting all standards of quality and safety it was inspected against.

Ann Ford
Deputy Chief Inspector of Hospitals (North Region)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good 	The service provided souvenir baby scans at this location. We rated this core service as good overall. There were systems to monitor safety, outcomes and experience for women who used the service. Appropriate, nationally referenced guidelines were used in the delivery of the service. Staff were consistently caring, friendly and professional and all individuals we spoke with were positive about the service they received. The service was responsive to make reasonable adjustments for people who use the service. Risk, governance and operational performance was managed. The manager was committed to developing a well-led, highly responsive service. There was a culture of improvement and it was safe, effective, caring, responsive and well-led.

Summary of findings

Contents

Good

Bumpkins York Limited

Services we looked at
Diagnostic imaging;

Summary of this inspection

Background to Bumpkins York

Bumpkins York is operated by Bumpkins York. It is a single speciality independent healthcare provider, which opened in York in 2016. The service primarily serves the North East area of the Country; however women who use the service travel to the unit from all areas of the Country.

The service has had a registered manager in post since 2017. The service is registered for the following regulated activities:

- Diagnostic and screening procedures

We conducted a short-announced inspection of baby souvenir scanning services on 26 June 2019.

Our inspection team

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

Information about Bumpkins York

The service employed one member of staff (owner / registered manager). Opening times at the location were Wednesday to Friday, dependant on demand. The service outsourced equipment maintenance services with a third party provider.

During the inspection we spoke with the only staff member. We spoke with four women and one relative. We also received 10 feedback cards which women had completed prior to our inspection.

This was the service's first inspection since registration with CQC.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection.

Activity – August 2017 to June 2019 (reporting period)

- In the reporting period there were no complaints.

Track record on safety:

- Zero deaths or never events (never events are serious patient safety incidents that should not happen if healthcare 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 because there have been no notifiable incidents (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 women to another health care provider.
- Zero cancelled appointments for a 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?

Good

We rated it as **Good** because:

- The ultrasound technician understood how to protect women from abuse and had completed training on how to recognise and report abuse**.**
- The design, maintenance and use of facilities, premises and equipment kept people safe. Clinical waste was managed well.
- The ultrasound technician completed and updated risk assessment for each women and removed or minimised risks. The ultrasound technician identified and quickly acted upon women at risk of deterioration (if a person become unwell). The staff member had the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care.
- The service kept detailed records of women'. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Are services effective?

Not sufficient evidence to rate

We inspected but did not rate.

- The service provided care and treatment based on national guidance and evidence-based practice. The ultrasound technician protected the rights of women in their care.
- The service monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for women.
- The ultrasound technician gave women practical support and advice to lead healthier lives and supported women to make informed decisions about their scan. They followed national guidance to gain the womens' consent.

Are services caring?

Good

We rated it as **Good** because:

- The ultrasound technician treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- The ultrasound technician provided emotional support to women, families and carers to minimise their distress. They understood the womens personal, cultural and religious needs.

Summary of this inspection

- The ultrasound technician supported and involved women, families and carers to understand and make decisions about their scan.

Are services responsive?

Good

We rated it as **Good** because:

- The service planned and provided care in a way that met the needs of women.
- The service was inclusive and took account of womens individual needs and preferences. Reasonable adjustments were made to help women access services.
- People could access the service when they needed it and received the right care in a timely way.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and improved practice based on lessons learned. The service included women in the investigation of their complaint.

Are services well-led?

Good

We rated it as **Good** because:

- The registered manager had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for women.
- The vision and strategy were focused on sustainability of services.
- The service focused on the needs of womens receiving care and had an open culture with women, and their families.
- The manager identified and escalated relevant risks to medical professionals. They had plans to cope with unexpected events.
- The ultrasound technician actively and openly engaged with women to plan and manage services.
- The service was committed to continually learning and improving services.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Good	Not rated	Good	Good	Good	Good

Good

Diagnostic imaging

Safe	Good
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Good

Are diagnostic imaging services safe?

Good

We rated this service as **good.**

Mandatory training

- The service provided mandatory training in key skills for the one person employed at Bumpkins York.
- The ultrasound technician had undertaken courses in 3D ultrasound; infection prevention & control; paediatric first aid and emergency first aid at work; phlebotomy skills – three credits at level three; personnel, health & safety and data protection.

Safeguarding

- The ultrasound technician had training on how to recognise and report abuse, and they knew how to apply it. They understood how to protect women from abuse and discussion the actions they would take and the agencies they would contact if required.
- < >afeguarding vulnerable adults and children (level 1 and level 2) had been completed by the ultrasound technician.
  A DBS enhanced certificate dated 2nd February 2017 was held by the ultrasound technician.
- In the last twelve months prior to inspection there were no safeguarding referrals by the service.

Cleanliness, infection control and hygiene

- The service controlled infection risk well. The ultrasound technician used equipment and control measures to protect women, themselves and others from infection. They kept equipment and the premises visibly clean.
- Standards of cleanliness and hygiene were maintained. Bumpkins York had infection prevention and control (IPC) policies and procedures in place which provided the ultrasound technician with guidance on appropriate cleaning of the unit and infection control prevention practice.
- Women who used the service stated the facility was cleaned to a good standard.
- We saw there were alcohol hand gels available on entry into the unit and adequate supplies of personal protective equipment such as gloves.
- The ultrasound technician followed bare below the elbow policies. There was a sink in the scanning room for hand washing. Probes were cleaned before and after use.
- The premises were visibly clean, and we saw cleaning schedules which included cleaning the facility twice daily (morning and night). A deep clean by an external cleaner was undertaken every other week.
- The couch in the treatment room used by women was covered with disposable paper which was changed between people who used the service and the couch wiped with an antiseptic wipe before laying out a new disposable paper.
- The service had a clinical waste bin which was collected by an external agency.

Good

Diagnostic imaging

- There were no consumables used by the service.
- The flooring throughout the service location was carpeted (including the scanning room) and because of this presented a challenge with infection control. Additional carpet cleaning took place to mitigate risk.
- The provider did not take bloods or any clinical specimens which reduced any biological cross infection risk.

Environment and equipment

- The design, maintenance and use of facilities, premises and equipment kept people safe. Clinical waste was managed well.
- Women who used the service accessed the premises through the front entrance, situated on the ground floor of a business unit. The entrance was wheelchair accessible and had designated parking which was free of charge. Women who used the service were directed by clear signage to the main entrance which opened into a waiting area.
- The reception had adequate seating and a reception desk. Toilets were along a small corridor near to the front entrance and were available for anyone using the service.
- All additional rooms such as the scanning and storage room were accessed from the central waiting area.
- The scanning room contained seating, the couch and the ultrasound system, together with a large TV for women to view the scan.
- The service had a high performance ultrasound machine and had a system to record any faults or issues.All machine faults were recorded by the ultrasound technician, and servicing was carried out under a service level agreement by the manufacturer.
- We inspected storage areas and found that it required organisation. We were advised the storage area has been organised since the inspection.
- Small electrical items were appropriately tested on an annual basis.

Assessing and responding to patient risk

- The ultrasound technician completed and updated risk assessment for each woman and removed or minimised risks. Women who became unwell during their scan were promptly assisted and referred for medical attention.
- Initial risk identification was through the first enquiry form to the service. Women who used the service were assessed as medically fit by their health professional prior to receiving a scan. All women regardless of medical condition would be seen as long as it was medically permitted.
- Those women who wanted to use the service and were deemed to be unsuitable, for example, individuals with serious life-threatening conditions, such as cancer, or those who were not adults, were not seen by the service.
- The ultrasound technician was first aid trained, and if someone was feeling unwell, the ultrasound technician would attend and call an ambulance if required.
- All scan reports were provided to women immediately following the scan.
- The service reported zero unplanned urgent transfers of a woman to another health care provider and zero cancelled appointments for a non-clinical reason.
- If any anomaly was found on the scan, the women would be advised to see their GP or attend their local hospital.

Staffing

- The ultrasound technician had the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care.
- In the period August 2017 to June 2019, the ultrasound technician was a single post holder. The service did not use bank or agency staff.
- The ultrasound technician had undertaken a disclosure and barring check which we saw was up to date.

Records

- All women who used the services received a copy of their report after their scan.

Good

Diagnostic imaging

- No NHS records were held by the provider and only basic terms and conditions and the initial booking forms were held on the womans record.
- With prior consent from individuals, records could be shared with third party healthcare professionals such as GPs or NHS maternity and gynaecological services.

Incidents

- The service had a process in place to manage patient safety incidents. The ultrasound technician advised she would recognised and report incidents and near misses. We were advised that if anything went wrong, the service would apologised and give the women honest information and suitable support.
- In the last twelve months before the inspection the location did not report any patient deaths or never events (never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious person harm or death but neither need have happened for an incident to be a never event), or serious incidents.
- In the same period there had been zero duty of candour notifications due to there being no reportable incidents (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).

Are diagnostic imaging services effective?

Not sufficient evidence to rate

We inspected but did not rate

Evidence-based care and treatment

- The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of women in their care.
- We saw examples of protocols, and pathways to support safe care and treatment of women who use the service.
- Staff followed policies, procedures and guidance in relation to diagnostic procedures.
- The unit participated in a number of audits. For example, infection control, booking forms and, image quality.

Nutrition and hydration

- There were no formal nutrition services for woman that attended the service.
- The ultrasound technician had access to a selection of refreshments (tea, coffee and water) which they provided to women who used the services..

Patient outcomes

- The service monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for women, for example, improved imagine quality. Images were subject to regular review to drive improvement.
- The ultrasound technician used protocols and standard operating procedures to ensure safe standardised care and treatment for all women who used the services.
- Each person seen at the Bumpkins York had an allocated time slot to ensure sufficient time for each scan. For example a gender scan was allocated 15 minutes with additional time for discussion. This allowed sufficient time to summarise and assess the outcome of each scan.

Competent staff

- The ultrasound technician made every effort to ensure she was competent for the role. Ongoing competence was self-managed by the owner / ultrasound technician as she was the only staff member. We saw a continued professional development (CPD) log which highlighted ongoing training updates.
- There were no peer reviews or appraisals in place for the ultrasound technician.

Seven day services

Good

Diagnostic imaging

- The service was supplied depending on demand and so this meant services at the location were not necessarily open seven days a week.
- The service routinely opened Wednesday to Friday with some appointments on a Saturday.

Multidisciplinary working

- The service linked with midwives, independent services and a local medical clinic. The ultrasound technician knew who to contact, when required.

Health promotion

- The ultrasound technician gave women practical support and advice to lead healthier lives.

Consent and Mental Capacity Act

- The service supported women to make informed decisions about their scan. They followed national guidance to gain consent.
- The ultrasound technician understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. She had received training on mental capacity and was aware of what to do if she had concerns about a women and their ability to consent to the scan. The ultrasound technician was familiar with processes such as best interest decisions.
- We saw that the service obtained written consent from the women who used the service. This was for the procedure and any disclosure of their results to third party healthcare professionals involved with their continuing care.
- We saw consent was captured within the initial booking form.

Are diagnostic imaging services caring?

Good

We rated this service as **good.**

Compassionate care

- The service treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- We observed the ultrasound technician introducing themselves to women who used the service prior to the start of an intervention and provided calm clear guidance.
- The provider sought feedback from women who used the services through surveys and social media comments.
- Feedback from people who use the service, those who are close to them was continually positive about the way staff treat people. People thought that staff went the extra mile and the care they receive exceeded their expectations.
- During the inspection we spoke to two women who were using the service. They said, “staff went above and beyond” and “they were provided with additional scans when image quality was reduced”. One said, “staff were very friendly”.
- Following inspection we spoke with an additional two women who used the services, they provided extremely positive feedback. One person told us ”I would recommend to family and friends”.
- We saw that the ultrasound technician was polite and attentive to the needs of women and provided appointment times in a relaxed, organised manner.
- We learned of the service going above and beyond to help women using the service. The ultrasound technician provided a 3D scanning service on a day when the service would normally be closed. This enabled a women using the service to obtain a scan of their baby promptly to share with a terminally ill relative.

Emotional support

- The ultrasound technician provided emotional support to women, families and carers to minimise their distress. She understood womens personal, cultural and religious needs. People’s emotional and social needs were highly valued and were embedded in the service delivery.
- The ultrasound technician understood the potential impact a womans care or condition had on their

wellbeing and on their relatives, both emotionally and socially. The ultrasound technician ensured they took time to speak to women who used the service making sure that privacy and dignity was maintained.

- The ultrasound technician told us that occasionally scan results were upsetting for women who used the service, particularly early scans which were unable to detect a heartbeat. As a result, the service allotted adequate time between the appointments to ensure privacy for women leaving the premises.
- We found that there was sufficient time before and after scans that so women and families had the service to themselves and where possible did not meet others. If any anomalies were found on the scan, it was sensitively advised that they were to contact the most appropriate medical professional.
- All women we spoke with who used the service gave positive feedback. We received comments such as 'I will definitely use this service again'. Another person told us 'she persevered until I was able to get a high quality scan'.
- We observed the ultrasound technician providing support to women and those close to them..

Understanding and involvement of patients and those close to them

- The ultrasound technician supported and involved women, families and carers to understand their scan.
- All women who used the services we spoke with, understood when and how they would receive their scan. Women told us the process and packages had been explained to them clearly and they felt sufficient time was provided during the scan.
- We were told the service had been clearly explained and women informed of the costs relating to the scans and tests during their initial phone call and subsequent emails. We saw that a price list was present in the waiting area, detailing the various packages on offer.
- The ultrasound technician made sure that women and those close to them, felt able to ask questions about their scan. People's individual preferences and needs were always reflected in how care was delivered.
- The ultrasound technician told us that parents and carers of small children were able to stay in the scanning room during procedures. There were toys provided for children.

Are diagnostic imaging services responsive?

Good

We rated this service 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 service provided gender scans earlier and more frequently than they can be obtained through the National Health Service.

Meeting people's individual needs

- The service was inclusive and took account of womens individual needs and preferences. The ultrasound technician made reasonable adjustments to help women access the service.
- Screening took place through the bookings systems which was managed electronically. Any specific needs were noted at this booking point. Women who used the services were later emailed details about their appointment, the type of scan they were having, plus consent forms and cost information.
- Reasonable adjustments were made so that women with disabilities could access and use service on an equal basis to others.
- There was no provision of information in any language other than English but if required an interpreter could be organised during the booking appointment.
- We saw the provider had installed a large ultrasound screen which was placed at the foot of the bed making viewing images much easier and more comfortable.
- We found that there had been a number of occasions when the provider had offered additional free scans when the baby had been in the wrong position or when the women had not consumed enough fluids. Additional scans were also offered if there was any uncertainty about the gender.

Good

Diagnostic imaging

Access and flow

- Women could access the service when they needed it and received the right care in a timely way.
- Women who used the services could book an appointment at a time to suit them and appointments took place according to demand with staffing organised accordingly.
- The service did not have a waiting list.
- Appointment times were planned and timed to allow sufficient time for the ultrasound technician to record and review scanning reports.
- No planned appointments were cancelled or delayed for a non-clinical reason such as breakdown of equipment.
- All women we spoke with, who used the service were positive about the availability of scans and they told us that they had received appointments in a timely fashion that they were happy with.

Learning from complaints and concerns

- It was easy for women to give feedback and raise concerns about the service they had received.
- The service treated concerns and complaints seriously. The service included women in the investigation of their complaint.
- Women spoke with knew how to make a complaint or raise concerns.
- We saw the provider collated all comments and took steps to rectify any concerns that were raised.
- The service had a complaints policy which was due for review in June 2019. We were advised this policy has been reviewed.
- The service recorded no complaints in the period August 2017 to June 2019.
- All formal complaints would be dealt with by the manager and acknowledged within three days, with a full investigation and written response within 28 days.
- The service told us that learning from complaints would result in changes made to practice if necessary.

Are diagnostic imaging services well-led?

Good

We rated this service as **good.**

Leadership

- The manager had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for women.
- The leadership team consisted of the owner who was also the registered manager and ultrasound technician. There were no other members of staff.

Vision and strategy

- The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of the service.
- During the inspection we reviewed the service business plans. We saw clear objectives which remained applicable. However, these were not signed and dated.

Culture

- The ultrasound technician focused on the needs of women receiving care. The service had an open culture where women, and their families could raise concerns without fear.
- The ultrasound technician spoke passionately about their work, and about the quality of care delivered.
- The service's culture was centred on the needs of women. We saw that some women had travelled from all parts of the country to access the service.
- Feedback from women who used the service was acted on.
- We saw an up to date duty of candour policy.

Governance

- There was a governance framework to support the delivery of the provider's vision of good quality care. The service undertook quality audits, and information from these assisted in driving improvement.

Good

Diagnostic imaging

- We saw that appropriate policies and procedures were in place and due for renewal in June 2019. However, not all policies were signed and dated. Following the inspection, the service provided copies of up to date, signed and dated policies and procedures.
- There were processes in place which showed a sustainable service.
- There was an up to date governance and monitoring policy in place.

Managing risks, issues and performance

- The ultrasound technician identified and escalated relevant risks to the appropriate medical professional. They had plans to cope with unexpected events.
- The service had a risk register for the location. Controls were noted for each risk and a review date was in place.
- There were plans to install CCTV security around the premises in the future.

Managing information

- The service had a form which was provided to women to inform them of the service and cost. We were advised that all information was available on the service website.
- Electronic service user records were kept secure to prevent unauthorised access to data, and the ultrasound technician demonstrated they could be easily accessed when required.
- The service had policies and procedures in place to promote the confidential and secure processing of information held about people who used the service. The was a confidentiality and General Data Protection Regulation (GDPR) policy in place.
- The service was paper light and mainly used an electronic database to create and share service user information.

Engagement

- The ultrasound technician actively and openly engaged with women and local organisations to plan and manage the service. They collaborated with partner organisations to help improve the services for women.
- Attempts were made to gather the views of women who used the service through the service user surveys.
- Women were engaged through the service's website and social media accounts, which promoted its service. The portals enabled people who used the service to compliment or complain about the service and enable the provider to respond quickly.
- We reviewed a full folder of approximately 50 plus feedback forms from women who had used the service. All feedback was positive.

Learning, continuous improvement and innovation

- The registered manager / ultrasound technician was committed to continually learning and improving the service. There was a good understanding of quality improvement methods and the skills to use them.

Outstanding practice and areas for improvement

Outstanding practice

- We learned of the service going above and beyond to help a person using the service. The ultrasound technician provided a 3D/4D scanning service on a day the service would normally be closed. This enable the person using the service to obtain a scan of their baby promptly to share with a terminally ill relative.

Areas for improvement

Action the provider SHOULD take to improve

- Ensure all policies identify the author, date and next review dates.
- Ensure appraisal and peer support is sought from a suitably qualified peer.

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.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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