Hey Baby 4D Mansfield Ltd

Hey Baby 4D Mansfield

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

Summary of findings

Overall summary

This was the first inspection of this service. We rated it as good because:

• The service had enough staff to care for women and keep them safe. Staff had training in key skills, understood how to protect women from abuse, and managed safety well. The service-controlled infection risk well. Staff assessed risks to women, acted on them and kept good care records. The service did not have any safety incidents, although the staff knew how to respond to incidents.

• 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 women, advised them on how to lead healthier lives, 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 women and made it easy for women to give feedback. Women could access the service when they needed it and did not have to wait too long for appointments.

• Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of women receiving care. Staff were clear about their roles and accountabilities. The service engaged well with women and the community to plan and manage services and all staff were committed to improving services continually.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good	• The service had enough staff to care for women and keep them safe. Staff had training in key skills, understood how to protect women from abuse, and managed safety well. The service-controlled infection risk well. Staff assessed risks to women, acted on them and kept good care records. The service did not have any safety incidents, although the staff knew how to respond to incidents. • 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 women, advised them on how to lead healthier lives, 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 women and made it easy for women to give feedback. Women could access the service when they needed it and did not have to wait too long for their appointments. • Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of women receiving care. Staff were clear about their roles and accountabilities. The service engaged well with women and the community to plan and manage services and all staff were committed to improving services.

Summary of findings

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Summary of this inspection

Background to Hey Baby 4D Mansfield

The Hey baby 4D service in Mansfield is operated by Hey Baby 4D Mansfield Limited. The clinic opened in 2019 and provides private non-diagnostic ultrasound services to self-funding women over the age of 18 and more than six weeks pregnant. Private ultrasound scans are separate from NHS standard care pathways. The service offers early pregnancy reassurance scans from six weeks of pregnancy, dating, growth, gender, later reassurance scans and 3D and 4D scans up to 31 weeks of pregnancy.

The clinic specialises in different services such as 2D, 3D, 4D baby scans, early pregnancy scans, gender scans (fetal sexing), growth and well-being scans. The service also provides gender reveal celebrations or new-born photoshoots which are not within the scope of registration. The service had one scan room, a waiting area and a toilet accessible to clients. On the first floor there were storage rooms and a room used as an office and staff room as required. The service was open three days a week, one day in the week and both days at the weekend. The opening times were 10-4 pm Tuesdays and 9-5pm at the weekends. However, the registered manager told us if there was an increased demand for the service, they would make more time available.

The service is registered with CQC to undertake the regulated activity of diagnostic and screening procedures. We have not inspected this service before.

How we carried out this inspection

We carried out an announced comprehensive inspection, looking at all five key questions. Is the service safe, effective, caring, responsive and well led.

During the inspection we observed three baby scans, with the consent of the women using the service.

The inspection team comprised of one CQC inspector and an offsite CQC inspection manager.

We gave the service 24 hours' notice of the inspection because we needed to be sure it would be in operation at the time we planned to visit. We spoke with three members of staff including the registered manager, sonographer and receptionist. We spoke with three women and their partners who had used the service and reviewed feedback on website browser platforms and social media.

We reviewed a range of policies, procedures and other documents relating to the running of the service including consent and scan reports. We also reviewed the appointment system.

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.

Outstanding practice

We found the following outstanding practice:

Summary of this inspection

- The service had an outstanding safeguarding process for women or visitors to discreetly seek immediate help from staff.
- The service were in the process of developing an employee occupational health support system for any health-related concerns that may be identified as a result of working practices.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Diagnostic imaging

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

Are Diagnostic imaging safe?

Good

This was the first inspection of this service. We rated it as good.

Mandatory training

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

All staff received and kept up to date with their mandatory training. During our inspection we reviewed all mandatory training records. They were accurate and fully completed.

The mandatory training was comprehensive and met the needs of women and staff. All staff completed first aid, hand hygiene, health and safety infection control, equality, diversity and inclusion, Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS), basic life support, fire safety, safeguarding adults and lone working.

The registered manager and the receptionist had also completed level three safeguarding children training. Sonographers were not required by the Hey Baby 4D franchise owner to undergo safeguarding children training, however, the registered manager had provided level three training for all three sonographers.

The manager monitored mandatory training and alerted staff when they needed to update it.

Records and electronic records reflected the date each staff member had completed their required training and the manager used this to arrange future training to ensure staff skills and knowledge were kept up to date. Staff told us they were encouraged by the registered manager to identify any training they felt would benefit them in their role and they would be supported to undertake this.

Safeguarding

Staff understood how to protect women from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse.

Good

Diagnostic imaging

The registered manager and staff had in-date Disclosure and Barring Service (DBS) checks which were completed and renewed regularly and in line with guidance.

The registered manager and receptionist received training specific for their role on how to recognise and report abuse. This included safeguarding children level three and safeguarding adults' level three.

These courses were updated in line with Safeguarding Children and Young People: Intercollegiate Document 2019. Sonographers working in the service had completed adult and child safeguarding training level three.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The registered manger knew how to make a safeguarding referral and who to inform if they had concerns.

There was an up to date safeguarding policy which referenced national guidelines and contained contact details for local authority safeguarding teams.

No safeguarding alerts had been required in the previous 12 months.

Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act.

The service reflected good practice by displaying information regarding safeguarding from abuse in the toilets and there was a process for women to discreetly seek immediate help.

The service did not accept women under the age of 18 for any scans.

There was always a chaperone present during scans requiring internal scanning.

Cleanliness, infection control and hygiene

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

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. Staff cleaned equipment after patient contact. Dependent on the scan performed staff used different wipes to clean the equipment and the bed after each patient and before the start of the list. Staff also recorded the batch number of gel on delivery, in order that a batch could be identified if there were any adverse reactions.

The service had an infection control policy in place, which offered guidance to staff on how to clean different areas of the environment, equipment was observed to be clean.

The service performed well for cleanliness. The waiting room and other communal areas were clean and tidy and free from clutter.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. During the inspection we looked at cleaning records. These identified when the areas were cleaned and what specifically had been cleaned.

Good

Diagnostic imaging

The service had a hand hygiene policy in place and completed hand hygiene audits. These reflected the service was 100% compliant. Staff followed infection control principles including the use of personal protective equipment (PPE). We also observed staff replacing their PPE and washing their hands between women. Hand washing facilities were available in the scanning room. During the inspection we observed all staff were bare below the elbow.

There were face masks and hand gel in the waiting areas for women and family members to use.

The service had a good supply of personal protective equipment (PPE) located in the scanning room. Staff used personal protective equipment when face to face with the women, this was also changed between each appointment.

The service had received a safety alert relating to the safe use of ultrasound gel and which advised they were not to be refilled. The service changed their practice in response to this alert by replacing them once they were empty.

The service ensured there was enough time between each appointment to give enough time for the equipment to be cleaned before the next scan took place.

Environment and equipment

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

The service had enough suitable equipment to help them to safely care for women. The service had first aid equipment readily available and all staff were trained in first aid.

The service had suitable premises to meet the needs of the women and their families using the service. This included a spacious waiting room, scan room and toilet facilities on the ground floor of the building. There was also wheelchair access and an accessible fire exit.

The scanning room contained a couch, scanning machine and seating area for family and friends. There were two monitors and two large screens positioned so that the woman and their family could see the scan clearly.

The registered manager held a record of when equipment was due for servicing and made sure this was completed.

Staff carried out daily safety checks of specialist equipment. During the inspection we looked at the documentation for equipment safety checks and found they were up to date. This included the scan machine quality assurance/ guidance procedure, servicing of the scan machine. Portable Appliance Testing (PAT), alarms and fire service certificate and policy and fire extinguishers safety checks.

Staff whose role involved using the equipment received training to ensure they were safe to do so.

The service had risk assessments in place and staff were able to demonstrate their understanding of these during the inspection

The ultrasound scanners were regularly audited by the sonographer. The service ensured that machine checks were completed daily.

Staff disposed of clinical waste safely. The service had a clinical waste contract, clinical waste was collected every four weeks. Clinical waste was kept outside in lockable clinical waste bins.

Good

Diagnostic imaging

Assessing and responding to patient risk

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

Staff responded promptly to any sudden deterioration in a patient's health. Staff told us that if there was a medical emergency then they would call 999 to get the patient transferred to an acute hospital setting. If there was any urgent findings from the scan, then staff explained how they would advise the patient to attend the local ED or the midwife unit to seek assistance.

The service asked women to complete information prior to their appointment. This covered personal information and NHS scan dates.

Staff knew about and dealt with any specific risk issues.

Staff identified potential risks with the women's pregnancies and took appropriate action in response to any concerns. For example, where a heartbeat was not able to be detected or the scan showed a multiple pregnancy.

Where women may be placed at risk of frequent scanning the service's booking system identified this to alert staff, so they were aware. Staff then took appropriate action to ensure women were not placed at risk of harm.

Staff shared key information to keep women safe when handing over their care to others. Staff requested permission to share results from scans with the women GP, or the women midwife team should this be required. Staff also gave the patient a copy of their scan and report to take away so they could also share with the relevant professionals.

We observed and interviewed the sonographer and they demonstrated a good understanding of how to complete scans and how to keep women safe.

Women were asked to bring along their NHS maternity medical record when they came to the clinic. This was to help assure the service that the woman was on an NHS maternity pathway. We saw staff advising women to continue with their NHS scans as part of the maternity pathway.

Staffing

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

The service had enough staff to run the ultrasound service. There were three self-employed sonographers working in the service, who each covered different clinic sessions. There was also a chaperone available who would always be present when there was a scanning list on.

Managers gave all new staff a full induction before they started work. The manager could adjust staffing levels according to the needs of clinic. The service was open three days a week and the manager ensured there was a staff member available each day, to support the service.

Records

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

Good

Diagnostic imaging

Patient notes were comprehensive, and all staff could access them easily. All records and scans were stored electronically.

We reviewed four sets of records. Staff accurately recorded the information. Information included, the woman's estimated due date, observations of the scan, conclusions and gender (if requested). These were printed off and handed to the patient at the end of the scan.

Records were stored securely. All paper records were scanned and shredded at the end of each day.

Medicines

No medicines were used in the ultrasound service.

Incidents

Staff had a good understanding of incidents and how to report them. The registered manager investigated incidents and shared lessons learned with the whole team.

The service had an incident/accident policy in place. Staff we spoke with understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and how to report them.

The service had not had any serious patient safety incidents.

However, the registered manager had a good understanding of what was required and was aware of their responsibilities, including 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 women (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Duty of candour should be discharged if the level of harm to a patient is moderate or above.

Staff met to discuss feedback and look at improvements to patient care. There was evidence that changes had been made as a result of feedback. Staff told us learning took place after incidents and events and were able to give examples of this. One example given was after a wrong gender was given the service reviewed the procedure and amended it to ensure three views were taken and a review of the blood flow in order to reduce the risk of any errors.

Are Diagnostic imaging effective?

Inspected but not rated

We do not rate the effective domain for diagnostic imaging services

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

Good

Diagnostic imaging

Staff worked to as low as reasonably achievable (ALARA) guidelines. ALARA is defined as a fundamental approach to the safe use of diagnostic ultrasound using the lowest output power and the shortest scan time possible. During our inspection, staff were working within these guidelines when undertaking an ultrasound scan.

The service followed British Medical Ultrasound (BMUS) guidelines, staff had a good understanding of this guidance. The service had a terms and conditions form which all women completed before their scan this covered all medical history,

The service had multiple policies in place, these were in date and staff were required to sign to say they had read them.

Processes were in place to ensure there was no discrimination, all staff were trained in equality, diversity and inclusion.

The sonographer had a discussion with the women to advise them where to seek advice and additional support when they had concerns about their pregnancy. We observed the sonographer advising a woman to visit her GP in order to register her pregnancy.

Nutrition and hydration

Women were given written information prior to their scans if they drink extra fluids for the procedure. This information was given to women on booking.

There was bottled water available for women if required.

Pain relief

Staff assessed and monitored women regularly to see if they were in pain.

Staff did not formally monitor pain levels. However, we saw staff asked women if they were comfortable during their scan. If women required pain relief for the scan, then the scan would be suspended, and the patient advised to contact their GP.

Patient outcomes

Staff monitored the effectiveness of care and achieved good outcomes for women.

Outcomes for women were positive, consistent and met expectations, such as national standards. The service monitored outcomes by reviewing the feedback and complaints. The service monitored how many scans they completed and how many resulted in rescans.

From June 2021 to July 2022 the service completed 3054 scans, during this time there were 306 rescans. These were 10% of all scans. The rescans were required due to sub optimal positioning of the baby.

The service reported any anomalies to the local NHS trust via the client report form. Previously there had been a referral pathway to local trusts early pregnancy units but this had been recently withdrawn in the local area. It had offered women emotional support to help minimise anxiety that ensured women could access follow on care without further distress.

The registered manager ensured a percentage of all scans were all peer reviewed by an independent sonographer. This ensured the sonographers were completing scans to a consistent standard. Records of these peer reviewed scans were kept on file.

Good

Diagnostic imaging

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women. The sonographers were experienced and had received training relating to sonography, and had experience working in the NHS and other Hey Baby 4D locations.

The manager supported staff to develop through yearly, constructive appraisals of their work. All staff had received appraisals for the year of 2022 and these records were stored on staff files. Staff wellbeing was added to the appraisal document in order to ensure staff felt fully supported.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. During the inspection we looked at the previous two months of team meetings. These were in a file for staff to access. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

The manager told us that if staff approached them with additional training requirements then this would be facilitated through the service.

Multidisciplinary working

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

During our inspection we saw that the team worked well together and communicated well with each other. They were kind and supportive of all women and their families.

The sonographer worked closely with the chaperone to ensure a well ran service for the women.

There were multidisciplinary meetings that involved all staff. The manager also communicated with other directors of services in order to develop the service for his clients.

Sonographers always advised pregnant ladies to continue with their routine NHS baby scans and share information with their midwife and we observed this during our inspection.

Staff were also able to contact the local safeguarding team should they need to make a referral.

Seven-day services

The service organised clinic lists to accommodate patient access.

The service did not open seven days a week. They were open for appointments on one weekday and both days at the weekend. The service advised they could offer additional days if required and were considering which extra day may benefit the local community.

Health promotion

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

Good

Diagnostic imaging

Prior to Covid-19 the service had relevant information promoting healthy lifestyles and support in patient areas. As a result of the pandemic these were removed. The director had requested a further supply post Covid-19. However, these had not yet arrived.

Staff assessed each women's health at every appointment and signposted women to support for any individual needs to live a healthier lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women consent. They knew how to support women who lacked capacity to make their own decisions.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff could not recall a time when they had a concern about capacity but told us that they would not carry out a scan if they had concerns about a women ability to consent.

Staff gained consent from women for their care and treatment in line with legislation and guidance. Information on the scans was given at the time of booking and was available on the organisation's website. We observed staff explain the scan and its purposed before seeking verbal consent before commencing. Women signed an information form after the scan to confirm they were happy with the procedure. This was stored in the women records.

Are Diagnostic imaging caring?

Good

This was the first inspection of this service. We rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for women. Staff took time to interact with women and those close to them in a respectful and considerate way.

We observed staff treat women well and with kindness. Throughout the scan the sonographer checked that the patient was comfortable and had no concerns.

Staff followed policy to keep patient care and treatment confidential. The clinic room was kept shut for the duration that the patient was in the room.

We observed the staff provide the women with an information pack and explained what was within these packs, which also contained free items which may be relevant to their pregnancy. This pack also contained additional information for charities that may be able to support the women during their pregnancy.

Good

Diagnostic imaging

During the inspection we noted women's feedback of the service; "Very happy with services, lovely team, will definitely recommend". "Absolutely amazing! Every single member of staff makes you feel so special and the sonographer is so patient and makes sure you get the best possible outcome. Amazing". "We have had 2 amazing scans at hey baby, one at 6 weeks and one at 18 weeks both were amazing we were made to feel welcomed and comfortable". "Lovely staff amazing experience"

Staff understood and respected the personal, cultural, social and religious needs of women and how they may relate to care needs.

There was a chaperone in the scanning room with the sonographer when required or requested.

Emotional support

Staff provided emotional support to women, families and carers to minimise their distress.

Staff gave women and those close to them help, emotional support and advice when they needed it. Staff described how they had supported women in the past with bad news and how the women had later thanked staff for how well they had handled the situations. Staff told us they would support the women with accessing additional care from other services if required.

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. We observed that staff were calm and reassuring throughout the scan the sonographer provided reassurance about what was being imaged and displayed on the screen and shared what they observed.

Staff were invested in ensuring the experience of having a scan was special for the women and their families and appeared to share in the excitement of the experience

Understanding and involvement of women and those close to them

Staff supported women, 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. Family and friends (in line with current government guidance on Covid-19) were welcome in the scan room and there were large screens positioned in the room to ensure that everyone in the room could see the scan images.

Staff talked with women, families and carers in a way they could understand, using communication aids where necessary. During the inspection we observed three scans. During these scans both women and partners were able to ask questions, where a clear explanation was given, and time was also given to enable the women and partners to receive information about the scan in a way they could understand. Staff suggested a client go outside for a walk around in order to get her baby moving in order to attempt to get a clearer image. This ensured clients were receiving the best possible images on the day.

Women and their families could give feedback on the service and their treatment and staff supported them to do this.

Women gave positive feedback about the service. From January 2022 to July 2022 there were 28 patient feedback forms completed for Hey baby Mansfield 4D, 100% of women gave positive feedback. We also reviewed feedback on social media platforms.

Good

Diagnostic imaging

Are Diagnostic imaging responsive?

Good

This was the first inspection of this service. 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.

The service operated opening hours to enable women to access the service in the week and at weekends. Staff told us that women could access an appointment when they required one and where necessary additional appointment slots could be made available. The service and the sonographers were passionate about the service being accessible for the local population so ensured that prices were kept competitive.

Facilities and premises were appropriate for the services being delivered. The clinic was housed in a building central to the town with easy access and clear designated waiting areas with good signage. The scan room was also spacious and there was seating for five in the scan room for family members to be comfortable whilst the scan was taking place.

Staff at the service had received chaperone training and equality, diversity, inclusion training, and the staff had a good understanding of how to identify women's individual needs and how to support these. The service provided the women with pictures of their baby and a report for them to take away with them at the end of each appointment.

Meeting people's individual needs

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

Staff made sure women living with mental health problems and learning disabilities received the necessary care to meet all their needs. One example given described how staff had supported a vulnerable woman to complete the informed consent. As she was unable to read the staff were able to read the sections to her and explain them in order that she would be aware of what she was consenting for. This was done in private in the clinic to ensure privacy and confidentiality.

Staff had a good understanding of the women's individual needs, and how to support them, and were able to give examples about how they met the women's individual needs.

The service had requested information leaflets from the provider, in languages spoken by the women and local community, as they were not available, they were investing in sourcing these themselves. In order that they could provide information to reflect the diversity of the local community.

Staff assessed each women's health and every appointment and provided support for any individual needs to live a healthier lifestyle.

Managers made sure staff, and women, loved ones and carers could get help from interpreters or signers when needed. The service could access language line if they needed an interpreter to support the women that used the service.

Good

Diagnostic imaging

Access and flow

People could access the service when they needed it.

Managers worked to keep the number of cancelled appointments to a minimum and ensured that women who did not attend appointments were contacted.

During the inspection we observed women arriving to their appointment on time and were shown to the waiting room by staff on reception.

The women were told straight away if there were any delays and were given a scan photo at the end of the appointment.

The service had an electronic booking system which enabled women to choose an appointment suitable to their needs.

Staff contacted women if they had not arrived for their appointment to ensure there were no concerns. The service did not have a waiting list. Women could book appointment at a time and date of their choosing. The service would try to accommodate additional appointments if these were requested outside of their three-day working week.

Appointment slots varied dependent on the type of scan that was required. This helped to ensure that clinics ran to time and that women were not made to wait for long periods of time. At the time of our inspection we saw that all appointments were running on time.

Learning from complaints and concerns

It was easy for women 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.

Women, relatives and carers knew how to complain or raise concerns. The service had received two complaints in the last 12 months. Both were investigated and resolved by the registered manager at the service.

The service dealt with this appropriately and the women were invited back for further scans free of charge.

The service had a complaints procedure and staff had a good understanding of this. Information about how to raise a concern was clearly displayed in patient areas. Staff could give examples of how they used patient feedback to improve daily practice.

The service received lots of positive compliments and these were displayed online and on social media platforms they were posted on.

Are Diagnostic imaging well-led?

Good

This was the first inspection of this service. We rated it as good.

Good

Diagnostic imaging

Leadership

The registered manager had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced They were visible and approachable in the service for women and staff.

Staff told us that the registered manager was supportive and approachable and supported the staff to develop their skills and knowledge.

The service was led by a managing director who was supported by a receptionist and the part time sonographers.

The leaders demonstrated high levels of experience and appeared to be compassionate and inclusive of all staff. There was a CQC registered manager in post, who was responsible for the daily running of the service, provision of staff and equipment. The manager was fully aware of the Care Quality Commission registration requirements for the service. The service employed a receptionist who was responsible for chaperone provision and all front of house responsibilities.

The manager was fully aware of the scope and limitations of the service, based on the size, numbers and staff.

The manager understood the challenges to quality and sustainability, and identified the actions needed to address them. For example, the manager regularly reviewed booking information and encouraged staff to ensure the women and their families had a welcoming experience.

The manager performed appraisals and was available to offer one to one daily support. The staff we spoke with told us that they felt confident they would be able to raise concerns with their management if required. They told us that the manager was receptive to feedback and continually wanted to improve the service.

Feedback information told us staff treated the women and their families with respect.

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 development of the service locally.

The service displayed the Hey Baby franchise values of being fair, family orientated, fun and friendly. We reviewed the franchise fundamental standards which outlined the different ways the service cared for woman and visitors and their related policies.

The registered manager added to the franchise values that the service they wanted to provide was always “feedback driven”. We were told “this means we listen to the client’s needs, recommendations and feedback to enable us as a provider to continually develop our practice ensuring clients get the service, they desire which exceeds all other private scan experiences”.

To achieve these goals, the service aimed to support and develop their staff by ensuring staff had the knowledge, and equipment to capture and action feedback from women and families.

Culture

Staff felt respected, supported and valued. They were focused on the needs of women receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Good

Diagnostic imaging

During the inspection we observed positive relationships between the staff. The staff team shared their passion of meeting the individual needs of the women. Staff had positive relationships with women and families who used the service, the service had an open relationship with the women and encouraged women to raise any concerns. Staff told us that they felt respected and working there 'felt like a family'. The service ensured all staff had completed equality, diversity and inclusion training to meet the individual needs of the women using the service.

Staff spoke positively about their roles and demonstrated pride and passion. They worked well as a team and supported each other to deliver high quality care.

The website and social media displayed a strong emphasis of care for women. The service had a whistle blowing policy which encouraged staff to raise any concerns confidentially with the manager.

There were clear processes for investigation and learning from concerns, as well as support for staff raising them. Staff told us they enjoyed their work, felt appreciated and valued, and were rewarded.

The manager created a positive working environment by organising events for staff throughout the year and providing a Christmas bonus. The service encouraged women and staff to raise any issues. We saw examples of where concerns had been investigated with a view to ensuring improvements.

Governance

The director operated effective reviewed governance processes, throughout the service. Staff were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service had implemented health and safety, infection control, employment and a whistle blowing policy. Staff did not hold formal governance meetings due to the small size of the service.

However, there were monthly team updates which were shared with staff to update them on the current business arrangements and provide feedback from complaints or incidents. The service had up to date policies for staff to follow. These were written by the managers and reviewed during as necessary. They were all up to date and signed as reviewed by the director.

All staff had access to policies and procedures were clear about their roles and responsibilities and what they were accountable for. All staff signed to say they had read new policies.

We observed team updates which were available electronically.

We reviewed three staff personal files (randomly selected). We found all staff files complied with the Schedule 3 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014. The service also had an in-date recruitment policy and staff induction to ensure all staff adhered to the requirements.

The service followed correct recruitment processes through ensuring staff had an enhanced Disclosure and Barring Service (DBS) check as part of the recruitment process. The files held included curriculum vitae (CV) and DBS. We saw from the team brief that incidents and training compliance rates were reviewed.

The service had an accident reporting book and a complaints record which provided a framework for monitoring any incidents and complaints. We saw evidence of lessons learned and shared in the team brief.

Good

Diagnostic imaging

If there was a more urgent concern it would be shared immediately through the team social media group.

Management of risk, issues and performance

The director managed performance and demonstrated commitment to best practice. They reviewed, identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events

The service had a risk register in place. The risk register contained risks such as; failure of IT systems, fire and patient/ staff injury. Each risk contained controls that were in place to mitigate the director reviewed the risk register at least yearly.

The service had a business continuity plan, after an IT problem during August which affected several Hey Baby 4D locations nationally. The director had strengthened local contingency plans in order to ensure lessons were learned. The plan identified equipment, infrastructure, staffing and a recovery phase in order to ensure business as usual was returned as soon as possible after any incident.

Information Management

The service collected data and analysed it. Staff could find the data they needed, in easily accessible formats, to make decisions and improvements. The information systems were integrated and secure.

Electronic databases were password protected; information could only be accessed by staff. Managers only had access to performance management data such as staff details, audits, training and human resource processes.

The service kept electronic records for all patients any written consent documents were scanned into the system and shredded before the end of the day.

The registered manager was the information governance (IG) lead who supported the service to ensure information was managed appropriately. The IG lead ensured systems and processes were compliant with the General Data Protection Regulation (GDPR) introduced in May 2018. GDPR is a legal framework that sets guidelines for the collection and processing of personal information of individuals within the European Union (EU).

The registered manager was aware of the need to notify the CQC about certain changes, events and incidents that affected the service or the people who used it. Notifications had been submitted appropriately.

Engagement

The director and staff actively and openly engaged with patients and staff, to plan and manage services.

There were high levels of constructive engagement with staff. Staff we spoke with told us they were regularly kept up to date in person, by phone, messaging applications and emails. Staff were kept updated with best practice developments from a regular staff bulletin.

A staff member had raised a concern which related to the possibility of increased risk of repetitive strain injury with repeated 4D scanning. This had prompted the director to look at ways of reducing the risk and considering occupational health care for staff.

Good

Diagnostic imaging

The service encouraged women to provide feedback post-scan, offering a variety of formats and platforms to provide this through to suit individual needs. The manager monitored and responded appropriately to all reviews, complaints, and feedback. The service shared examples of how feedback was used to improve the quality of care and service delivery.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation and celebrated it.

The service was proud of their client centred approach and were not willing to allow changes to the service that could compromise it. The service provided a chaperone who accompanied any woman when required. Feedback from women and families about the service was positive; they stated that they felt safe and reassured throughout visits.

The service have made improvements to reduce the risk of an incorrect gender being given they take three “potty shots” of the babies’ gender from different locations along with a blood flow review to ensure the gender given is correct.

The service offer gender review lighting to make the room light up the baby’s gender to make the day extra special.

The service offer a free rescan should clients be unhappy with their scan images.

The service discussed feedback in team meetings to ensure improvements are made in a timely way.

The director had built a local network with other scanning clinics which enables us to redirect clients if we’re unable to support their needs.

The service were in the process of developing an employee occupational health support system for any health-related concerns that may be identified as a result of working practices.