Mediscan Diagnostic Services Ltd

Mediscan Centre

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	Inadequate
Are services safe?	Inadequate
Are services effective?	Inspected but not rated
Are services well-led?	Inadequate

Summary of findings

Overall summary

Our rating of this location went down. We rated it as inadequate because:

- The service did not always control infection risk well. The infection control policy did not provide clear guidance for staff to follow in how to use equipment and control measures to protect patients. They did not always keep equipment and the premises visibly clean and monitoring processes were not robust.
- The design, maintenance and use of facilities, premises and equipment did not always keep people safe and there was limited evidence that staff had received appropriate training in the use of equipment. The service did not have robust systems in place for the oversight of equipment maintenance and we found equipment that posed a risk to patients' safety.
- There was not a robust process in place for the oversight of staff resuscitation training and the policies in place for staff to follow in respect of deteriorating patients were not fully reflective of the service provided.
- We found that there was limited access to policies and procedures for staff and managers did not always check to make sure staff followed guidance, there were limited evidence of audits undertaken by the provider.
- The service did not always make sure that staff were competent for their roles there was limited evidence of staff competencies and required training compliance was low. Managers did not always appraise staff's work performance or hold supervision meetings with them to provide support and development.
- Leaders did not operate effective and governance processes, throughout the service. Policies and procedures were not reflective of the services provided and so staff at all levels could not be clear about their roles and accountabilities.
- Leaders did not always use systems to manage performance effectively. They did not have effective risk management processes in place to identify and escalate relevant risks and issues or identified actions to reduce their impact.

However

- Staff could describe how to identify and quickly act upon patients at risk of deterioration or those with unexpected findings.
- The service provided care and treatment based on evidence-based practice.
- Staff had regular opportunities to meet, discuss the service and learn.

Following our inspection we took enforcement action which included the use of our urgent enforcement powers under Section 31 of the Health and Social Care Act 2008. We imposed conditions on the provider which prevented them from carrying out any invasive diagnostic procedures and told them that they must make improvements in relation to infection prevention and control, equipment maintenance, medicines management, staff competencies, leadership and governance and risk management systems.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Inadequate 	See the main summary above for our overall summary of the service.

Summary of findings

Contents

Summary of this inspection

Background to Mediscan Centre

Mediscan Centre is operated by Mediscan Diagnostics Services Ltd. The centre, which opened in February 2018, is registered to deliver diagnostic and screening procedures and surgical procedures services and is operated by Mediscan Diagnostics Services Ltd.

The centre primarily serves the communities within the Oldham and Greater Manchester area. There are two ultrasound scanning rooms, a waiting area and toileting facilities for patients.

The centre delivers a range of adult diagnostic ultrasound examinations for NHS and private patients which include but are not limited to musculoskeletal, vascular and transvaginal. The centre has had a registered manager who has been in post since opening in February 2018.

We last inspected the service in October 2018 and rated it as Good overall with good in each domain, there were no breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identified at the last inspection.

How we carried out this inspection

We carried out an unannounced focused inspection of the diagnostic and screening core service on the 6 April 2021, because we received information that gave us concerns about the safety and quality of the services.

We looked at parts of the safe, effective and well led domains. We rated the service because we took enforcement action which included the use of our urgent enforcement powers, where we placed conditions on the locations registration in relation to infection prevention and control, equipment maintenance, medicines management, staff competencies, leadership and governance and risk management systems

We observed care and treatment and the environment where services were provided. We interviewed key members of healthcare assistant, sonographer and the senior management team who were responsible for leadership and oversight of the service. We spoke with seven members of staff in total and observed interactions with three patients.

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 is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

We told the service that it must take action to bring services into line with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 legal requirements:

Summary of this inspection

- The provider must ensure that care and treatment is provided in a safe way for service users. The provider must assess the risks to the health and safety of service users in receiving the care or treatment and do all that is reasonably practicable to mitigate any such risks. (Regulation 12)
- The provider must ensure that systems and processes operate effectively to assess the risk of, and prevent, detect and control the spread of, infections, including those that are health care associated (Regulation 12)
- The provider must ensure that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way. They must ensure that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way. (Regulation 12)
- The provider must ensure that all premises and equipment used by the service provider are clean, suitable for the purpose for which they are being used, properly used, and properly maintained. The provider must in relation to such premises and equipment, maintain records and standards of hygiene appropriate for the purposes for which they are being used. (Regulation 15)
- The provider must ensure that all staff, including agency staff, receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. (Regulation 18)
- The provider must ensure that where staff, including agency staff, are health care professionals or other professionals registered with a health care or social care regulator, records are maintained to provide evidence that they continue to meet the professional standards which are a condition of their ability to practice or a requirement of their role. (Regulation 18)
- The provider must implement effective systems, processes and training for staff to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). (Regulation 17)
- The provider must ensure that all policies and procedures are fit for purpose and reflective of the service provided. The provider must ensure that policies and procedures are monitored effectively and reviewed appropriately. The provider must ensure staff understand and know how to access the provider's policies and procedures. (Regulation 17)
- The provider must maintain securely records that are necessary to be kept in relation to persons employed in the carrying on of the regulated activity and the management of the regulated activity. (Regulation 17)

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Inadequate	Inspected but not rated	Not inspected	Not inspected	Inadequate	Inadequate
Overall	Inadequate	Inspected but not rated	Not inspected	Not inspected	Inadequate	Inadequate

Inadequate

Diagnostic imaging

Safe	Inadequate
Effective	Inspected but not rated
Well-led	Inadequate

Are Diagnostic imaging safe?

Inadequate

Our rating of safe went down. We rated it as inadequate because:

Cleanliness, infection control and hygiene

- **The service did not always control infection risk well. The infection control policy did not provide clear guidance for staff to follow in how to use equipment and control measures to protect patients. They did not always keep equipment and the premises visibly clean and monitoring processes were not robust.**
- The Infection Control and Decontamination with Handwashing policy did not provide clarity about personal protective equipment requirements for all staff in relation to COVID 19. The policy covered the equipment available for sonographer staff, but it was not specific about the requirements and did not include other staff groups which the service employed such as healthcare assistants.
- We observed staff providing ultrasound scans at the clinic wore aprons and masks. We did not see that staff changed personal protective equipment between patients, the Infection Control and Decontamination with Handwashing policy stated that gloves and aprons should be changed after patient contact. During our observations we saw that staff did not wear gloves, the policy did not provide clarity about whether they were required to.
- We observed three patients attended the clinic for an appointment, staff did not carry out temperature checks or ask the COVID-19 screening questions in-line with the Infection Control and Decontamination with Handwashing policy.
- Handwashing facilities in the clinical rooms were not reflective of the handwashing facilities described in the Infection Control and Decontamination with Handwashing policy. They did not have elbow operated taps and wall mounted soap dispensers. Service users will or may be exposed to the risk of harm if your infection prevention and control practices are not guided by infection prevention and control policies and procedures that are fit for purpose and are reflective of national guidance.
- There was limited documented evidence to show that cleaning had taken place. We observed that the only documentation with regards to cleaning at the clinic was in the toilet. Equipment cleaning and the cleaning of surfaces between patients was the responsibility of clinical staff, there was no documented evidence that clinical staff had undertaken the appropriate cleaning of equipment. This meant that service leaders did not have oversight of staff adherence to cleaning procedures or assurance that the appropriate cleaning had taken place.
- Staff were provided with household antibacterial wipes, clinical wipes and cleaning sprays for the cleaning of equipment and surfaces in between patients. Leaders told us that the household wipes were to be used for the cleaning of patient beds and surfaces and the clinical wipes and sprays were for the cleaning of equipment. Staff we spoke with were unclear about which products they should use. There was no clear guidance for staff about which products should be used for which areas and this was not reflected in the Infection Control and Decontamination with Handwashing policy. Service users may or will be exposed to the risk of harm by way of infection, if proper cleaning materials are not used to disinfect equipment and surfaces.

Inadequate

Diagnostic imaging

- We observed that the waiting areas and clinic room were visibly unclean. There was dark dust on the patient couch, floors and surfaces and on the first aid kit. We observed that the ultrasound scanning machine was visibly unclean and had evidence of dried gel on the surface and buttons and there were used tissues in the probe holders. Staff confirmed that they did not complete checklists or documentation to evidence that equipment or scanning rooms had been cleaned.
- We requested immediate assurance that the areas of concern were cleaned, and we received photographic evidence of this on 7 April 2021. However, there was limited assurance about actions in place to prevent similar recurrences in future.
- During our clinic visits on 6 April 2021, we spoke with staff at the location who told us they could access infection control guidance via a web system. However, we observed that all of the staff were unable to demonstrate this to us.
- The Infection Control and Decontamination with Handwashing policy did not fully reflect the monitoring processes in place for the service. It identified that the lead role for the auditing of the clinics sat with the 'clinical manager' and that 'matrons' undertook three monthly peer reviews of the audits. The service did not employ 'matrons' and infection control audits were undertaken by non-clinical staff. The Infection Control Lead for the service was the operations manager who was non-clinical, they told us they undertook the audits of the clinics based in the North. Managers could not evidence how non-clinical staff had received the training required to undertake a clinical audit of infection control. Service users will or may be exposed to the risk of harm if infection prevention and control practices are not guided by infection prevention and control policies and procedures that are fit for purpose and are reflective of national guidance.
- During the inspection, we saw that clinic audits had been completed and discussed in the December 2020 and February 2021 Clinical Governance meetings. We reviewed the audit results discussed and observed that they did not cover the Oldham clinic. Some forms had missing information including the clinic location and the auditor's details. Accordingly, we could not be assured that the audits were being completed regularly for the clinic as there was no documented evidence of this.
- Hand hygiene and clinic visit audits for December 2020 and February 2021 did not cover the clinic location.
- The audit template used to assess infection prevention and control did not provide clear guidance for staff for how to comprehensively assess cleanliness and infection prevention and control risks in clinical areas. We were not assured that managers had the appropriate oversight of infection prevention and control policies, measures and audit and therefore there was a risk to service users.

Environment and equipment

- **The design, maintenance and use of facilities, premises and equipment did not always keep people safe and there was limited evidence that staff had received appropriate training in the use of equipment. The service did not have robust systems in place for the oversight of equipment maintenance and we found equipment that posed a risk to patient safety.**
- The clinic was owned and used by the service, it provided a waiting area with wipeable chairs and one examination room. Hand washing facilities were provided in the examination room; however, it did not meet with the requirements of the facilities set out in the infection prevention and control policy for the service.
- During our inspection of the clinic, we found three pieces of electrical equipment with no evidence of electrical safety testing and one which had exceeded its re-test date. This included the patient examination couch, a heater and a lamp. We found a lamp which had a label indicating it was due to be re-tested in April 2017.
- The manager with responsibility for the oversight of electrical testing, confirmed that electrical equipment should be safety tested annually but advised this had not been done since 2019. The service was unable to provide evidence that electrical equipment had been tested in 2019. Service users may or will be exposed to the risk of harm, if a service does not ensure electrical equipment is tested or have procedures to ensure they are routinely tested.

Diagnostic imaging

- The bottle of ultrasound gel on the machine in the examination room had an expiry date of May 2019. Staff told us that they had decanted the gel from a bottle which was in date. There was a risk that staff could not be assured that the gel they were using was within its expiry date and safe to use.
- The ultrasound machine contained stickers with dates to indicate when it had last been serviced and when it was due to be serviced. Our observation of the machine found that it had recently been serviced and was within its re-test date.
- The service had 27 ultrasound machines in total. There was a maintenance contract in place for medical equipment servicing which was managed via the headquarters.
- The asset register was held and overseen by the company who held the contract. Managers could not provide evidence of an effective system for ensuring their oversight of equipment maintenance and had not maintained accurate records of when all equipment was last checked or due to be checked.
- Eleven of the ultrasound scanning machines had been recently purchased and we were provided with a copy of the five-year warranty for this equipment, however the warranty stated servicing was not included. The manager with responsibility over equipment maintenance stated the company they purchased the equipment from had included servicing in the warranty via a verbal agreement, but there was no documentation to support this.
- Resuscitation equipment was not available in the clinic, they did however have use of a first aid kit. During our checks of the first aid kit we found some items that has expired, these included a cool pack for a cold compress which expired in July 2020 and two packs of Lewis pads that expired in January 2020. Staff told us that there was not a process in place for the checking of items in the first aid kit and advised that they did not use it.
- Sonographer training competency assessments included the use of the ultrasound equipment. The service was able to provide evidence of three completed sonographer staff competencies in total out of the 89 staff members they had on the system, the assessments demonstrated that equipment training had been completed for these staff members. However, if was not clear how many staff had been trained in the use of equipment as the service was unable to provide evidence of staff competencies for the remaining staff.

Assessing and responding to patient risk

- **Staff could describe how to identify and quickly act upon patients at risk of deterioration or those with unexpected findings. However, there was not a robust process in place for the oversight of staff resuscitation training and the policies in place for staff to follow in respect of deteriorating patients were not fully reflective of the service provided.**
- The policy in place for staff to follow with regards to deteriorating patients was not fully reflective of the service and did not specify the processes to follow for staff based in the clinic.
- The senior leadership team told us that staff followed an emergency procedure for patient's health who was deteriorating which included calling 999 for medical emergencies. There was no documented evidence of this in the deteriorating patient and escalation policy.
- Staff were able to describe what to do in the event of a medical emergency and told us they would call 999 and inform head office. Staff were unable to access policies for managing medical emergencies in the clinics we visited.
- Staff received training in basic life support. We saw that training compliance for sonographer staff for adult basic life support was 80%.
- There was not a robust process in place for the monitoring of staff's compliance with mandatory training such as basic life support. Sonographer training compliance was recorded on an electronic system which was overseen by the human resource manager. The leadership team confirmed that mandatory training compliance was not reported and overseen as part of the clinical governance meetings.
- The service performed ultrasound scans for non-urgent NHS patients who were referred to the service mainly from GPs. We were told that the service did not provide scans for pregnant women or children. There was an agreed

inclusion and exclusion criteria which had been agreed with the commissioners of the service. GP's were required to complete a request form which included patient details, clinical symptoms and whether the patient had a disability. The clinical staff had to complete the justification question based on the information provided. The pathway protocol stated that all referrals required triage by a clinical lead.

- There were care pathway protocols in place for staff to follow in the event of unexpected or urgent findings on an ultrasound scan. Staff were aware of the process and explained that they could put a flag on the electronic record which enabled the GP to prioritise the review of the record. Patients requiring urgent referral to the hospital for unexpected findings could have the images shared electronically with the hospital.
- There was a follow up process in place for patients who did not attend their appointments, there were three contacts prior to patients being discharged back to the care of the GP. The follow up process was detailed in the care pathway protocol.

Are Diagnostic imaging effective?

Inspected but not rated

We do not currently rate the effective domain for diagnostic imaging services:

Evidence based care and treatment

- **The service provided care and treatment based on evidence-based practice. However, we found that there was limited access to policies and procedures for staff and managers did not always check to make sure staff followed guidance, there were limited evidence of audits undertaken by the provider.**
- Sonographer staff had 5% of their imaging reports audited for quality in line with the requirements of the Society of Radiographers. There were dedicated senior sonographer staff who carried out a review of the records.
- There were monthly discrepancy meetings which sonographer staff attended, these looked at learning opportunities identified as part of the audits. We reviewed the meeting information from 14 February 2021. We saw that the meeting covered a review of ten case studies, these provided details of the concerns identified and highlighted learning points for staff. The actions covered were to read policies, scan carefully and update knowledge on guidelines. Staff were positive about the process and found these useful.
- Staff stated that they kept up to date with guidance and best practice through their professional body and through the company.
- Our review of policies and procedures saw that they referenced evidence based care and practice and national and professional standards. The service had a quality assurance policy, which detailed the clinical quality committee standard agenda this included a *"review of patient safety alerts, NPSA, MHRA, CAS alerts, NICE guidance, PALS issues and national reports".* The policy also outlined that staff clinical meetings would look at protocols, pathways and performance.
- Whilst we saw evidence that policies and procedures referenced national and professional guidance, we saw that they were not always fully reflective of how the service delivered care and treatment. We found that the ultrasound procedure had exceeded its review date which was November 2020, the policy also referenced 'guidelines for professional ultrasound practice revision 3 2018' Following a review of the national guidelines we saw there was an update in December 2019 which is referenced as 'revision 4'.
- We saw that National Institute of Health and Care Excellence (NICE), Central Alerting System (CAS) alerts and policy updates were standing agenda items on the monthly clinical governance meeting minutes. We looked at the minutes covering December 2020 to February 2021 and saw that there had been "no updates" recorded for these items and so there was limited information recorded about what they had looked at in regard to standards updates.

Inadequate

Diagnostic imaging

- Staff were unable to demonstrate that they had access to policies and procedures for the service. We were told that they were available on a web-based system, but staff could not demonstrate an ability to access these. Staff on induction stated that policies were emailed to them, but when we asked they could not evidence this. There was a risk that staff were unable to access important policies and procedures to ensure that they undertook their role in accordance with the required standards.
- The service did not have a formal standard audit programme for the service. It was stated that their main audits were based on the requirements of the different commissioning groups to whom they provided services and so would be different in different areas. The services core audits were the clinic audit visits, hand hygiene, compliments and complaints and sonographer audits.
- There were annual sonographer audits which were undertaken by the lead sonographer for the company who covered all staff across the service and regions. These audits were an assessment of sonographer staff competence. We were told that staff were invited to the Ashton clinic for the observations. We requested evidence of the annual competency audits which could not be provided.

Competent staff

- **The service did not always make sure that staff were competent for their roles there was limited evidence of staff competencies and required training compliance was low. Managers did not always appraise staff's work performance or hold supervision meetings with them to provide support and development.**
- Managers told us that they did not discuss mandatory training or appraisals compliance in clinical governance meetings. The overall average compliance rate for mandatory training was 68%.
- Staff appraisal information showed that 54 out of 89 members of staff, had not had an appraisal in the last 12 months. Records demonstrated of these there were two members of staff who joined the company in 2017, one who joined in 2016 and three who joined in 2015 who had not had an appraisal recorded.
- We were told by the human resource manager that the process for checking staff had up to date professional registration was part of the appraisal process. As a result, we were not assured that there was a consistent approach across the different locations and satellites; neither were we assured that each location and satellite took the same approach to dealing with supervision, appraisals and mandatory training. Service users may or will be exposed to the risk of harm if the service does not have oversight over mandatory training to ensure it is being completed, or supervision and appraisals to ensure staff are receiving the training and support they need along with ensuring up to date professional registration.
- There was no oversight of training competencies for all staff. On 7 April we requested to see staff competencies for sonographers, physiotherapy and locum nursing staff. The human resource manager was unable to provide evidence of these. The sample of sonographer competency assessments that were provided were dated 2015/2016. There was no evidence of the annual assessments that were referenced in the quality assurance policy and those described by the registered manager.

Are Diagnostic imaging well-led?

Inadequate

Our rating of well-led went down. We rated it as inadequate because:

Governance

Inadequate

Diagnostic imaging

- **Leaders did not operate effective and governance processes, throughout the service. Policies and procedures were not reflective of the services provided and so staff at all levels could not be clear about their roles and accountabilities. However. Staff had regular opportunities to meet, discuss and learn from the service.**
- There were monthly clinical governance meetings held for the service. We reviewed the minutes dated 14 December 2020, 15 January and 18 February 2021 which showed limited documented evidence of discussions of key agenda items.
- The clinical governance meeting minutes for December 2020 and February 2021 noted that hand hygiene and infection prevention control audits were received and discussed each month, however records showed *'no action required'* each month. This did not correspond to the infection prevention control concerns that were found during the inspection at the clinic. As a result, we could not be assured that there was appropriate oversight of the service, as key issues were not be discussed in proper detail at these governance meetings.
- The key performance indicator report monitored local quality requirements for each Clinical Commissioning Group for the ultrasound service. The service did not monitor key performance indicators at 'provider-wide' level. There was limited evidence that these had been discussed and considered as part of the clinical governance meeting minutes we reviewed.
- There was not a robust system in place for the oversight of mandatory training and appraisal compliance. We saw poor compliance with mandatory training and appraisal requirements. We identified that there were three sonographer staff had worked in the organisation for six years and not had one annual appraisal.
- Policies and procedures were not fully reflective of the service provided. We reviewed a range of policies and procedures and found that they had been taken from other organisations but had not been fully adapted to reflect the service and so it was not clear what staff roles and responsibilities were in relation to the procedures. For example, the Infection Control and decontamination with Handwashing policy referenced 'matrons' and 'the trust' and contained a logo from another organisation.
- There was limited assurance that recruitment processes were being followed. There was a recruitment policy in place for the service, which detailed the required recruitment checks. However, the policy did not cover the overseas recruitment programme or the requirements for agency staff and the service was unable to provide evidence of staff files to demonstrate recruitment documents.
- There was not a robust system in place for the monitoring and oversight of equipment maintenance. The service had a contract in place with an external company for the maintenance of clinical equipment. Asset registers for all equipment was held by the external company, the manager with responsibility for equipment had no oversight of the asset register and so was unaware of the servicing was carried out within the required dates. There was no forum where equipment maintenance was discussed with the senior leadership team. We found electrical equipment which had not received safety testing or was outside of its re-test date during our inspection. There was a risk to staff and patients if equipment was not safe to use.
- Ultrasound staff told us they attended quarterly team meetings at the main headquarters where they said they discussed incidents, complaints and changes to working practices. Staff stated that they did not receive minutes following the meetings.
- We requested meeting minutes covering the last three months and were provided with those from February 2021. We saw that they included patient satisfaction information, reporting key performance indicator compliance, personal protective equipment reminders and a discussion about the content of reports. However, it was not clear from the minutes what was discussed in relation to patient satisfaction information and there was no evidence that incidents had been discussed or were a standard agenda item. The information included in the minutes did not provide clarity about the content of the discussions for staff who may not have been present during the meeting and there was no record of which staff members had not attended.

Managing Risks issues and performance

Inadequate

Diagnostic imaging

- **Leaders did not always use systems to manage performance effectively. They did not have effective risk management processes in place to identify and escalate relevant risks and issues or identified actions to reduce their impact.**
- The key performance indicator report monitored local quality requirements for each Clinical Commissioning Group. The service did not monitor key performance indicators at 'provider-wide' level. The key performance indicator report did not provide evidence that managers had oversight at provider level of compliance with staff supervision, and appraisal rates.
- The service had not taken action to address data quality issues in mandatory training, it was acknowledged that the system did not give compliance rates for 'required' mandatory training but provided it across all training some of which was deemed 'not required' for individuals roles. The leadership team could not use the data to identify compliance issues with the training that was identified as 'required' and therefore did not have clear oversight of staff's overall compliance rates.
- The monitoring processes in place were not effective in identifying areas of risk, concern or poor performance that we identified during the inspection. For example, the audits for infection prevention and control had not been effective in identifying non-compliance with the policy and environmental issues that we observed.
- The risk register did not provide detail of key risks, and, or the mitigation and controls established to safely manage organisational risk. Managers told us the risk register was reviewed annually, however there was no evidence to support this.

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.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures	S31 Urgent variation of a condition