Mrs Maria Birch

Sneak-A-Peek Ultrasound

Inspection report

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

Ratings

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

Summary of findings

Overall summary

We have not previously inspected the service. We rated it as requires improvement because:

• Staff did not all have required training in key skills, including safeguarding training.

• The provider did not have a robust recruitment process because two references and other information required under Schedule 3 was not obtained for locum staff.

• The provider and staff did not have an effective audit system in place to monitor and improve the service.

• Staff did not dispose of clinical waste in line with guidance. Staff did not have up to date guidance around the use of ultrasound gels.

• There were no peer reviews or audits of scan images and reports. Sonographers scans and scan documentation should be peer reviewed and audited. Good practice states peer reviews should look at the quality of the report and image and check when a referral was needed, that it had been made to the appropriate people.

• There were no staff meetings or governance meetings to enable discussion and review around risks and trends.

However:

- The service had enough staff to care for women and keep them safe. Staff 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.
- Staff provided good care and treatment. 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 people, took account of women's individual needs, and made it easy for people to give feedback. People told us they could access the service when they needed it, although this was dependent on the availability of the sonographer and did not have to wait too long for their results.
- 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.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic and screening services	Requires Improvement 	We have not previously inspected the service. We rated it as requires improvement because: • Staff did not all have required training in key skills, including safeguarding training. • The provider did not have a robust recruitment process because two references and other information required under Schedule 3 was not obtained for locum staff. • The provider and staff did not have an effective audit system in place to monitor and improve the service. • Staff did not dispose of clinical waste in line with guidance. Staff did not have up to date guidance around the use of ultrasound gels. • There were no peer reviews or audits of scan images and reports. Sonographers scans and scan documentation should be peer reviewed and audited. Good practice states peer reviews should look at the quality of the report and image and check when a referral was needed, that it had been made to the appropriate people. • There were no staff meetings or governance meetings to enable discussion and review around risks and trends. However: • The service had enough staff to care for women and keep them safe. Staff 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. • Staff provided good care and treatment. 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,

Summary of findings

took account of their individual needs, and helped them understand their conditions. They provided emotional support to women, families and carers.

- The service planned care to meet the needs of local people, took account of women's individual needs, and made it easy for people to give feedback. People told us they could access the service when they needed it, although this was dependent on the availability of the sonographer and did not have to wait too long for their results.
- 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.

Summary of findings

Contents

Summary of this inspection

Background to Sneak-A-Peek Ultrasound

Sneek-A-Peek Ultrasound is operated by Mrs Maria Birch. It is a sonographer led service based in Barnstaple, serving those in the local community and beyond.

Sneek-A-Peek Ultrasound provides pregnancy ultrasound services to self-funding women, from six to 40 weeks of pregnancy.

The service was registered to provide services to under 16-year olds but had only provided services to women aged 16 years and above. All ultrasound scans performed at Sneek-A-Peek Ultrasound Limited are in addition to those provided through the NHS as part of a pregnancy care pathway.

The service was registered by CQC in October 2019. The service has not been inspected previously.

Sneek-A-Peek Ultrasound Limited is registered with the CQC to carry out the following regulated activities:

Diagnostic and screening procedures

How we carried out this inspection

We carried out a comprehensive inspection of the service under our regulatory duties. The inspection team comprised of a lead CQC inspector and an offsite CQC inspection manager. We gave the service short notice of the inspection because we needed to be sure it would be in operation at the time we planned to visit.

We undertook this inspection as part of a random selection of services which have had a recent Direct Monitoring Approach (DMA) assessment where no further action was needed to seek assurance about this decision and to identify learning about the DMA process.

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

Areas for improvement

Action the service MUST take to improve:

- The provider must ensure all staff have the training required to provide care in a safe way for service users. The provider must ensure all staff have up to date safeguarding training. Regulation 12 (2)
- The provider must ensure recruitment procedures are established and operated effectively. Regulation 19 (2)
- The provider must establish a programme of audits to assess, monitor and improve the quality and safety of the service provided. Regulation 17 (2)
- The provider must dispose of clinical waste in line with national guidance. Regulation 12 (2)

Action the service SHOULD take to improve:

Summary of this inspection

- The provider should provide current guidance for staff around the processes to follow for safeguarding referrals.
- The provider should have a risk assessment for lack of hand-washing sink in the scan room.
- The provider should follow up to date guidance around the use of ultrasound gels.
- The provider should agree a service level agreement for referring women to the local hospital.
- The provider should consider installing a hand-washing sink in the scan room.

Our findings

Overview of ratings

Our ratings for this location are:

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

Requires Improvement

Diagnostic and screening services

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

Are Diagnostic and screening services safe?

Requires Improvement

This was the first inspection for this service. We rated safe as requires improvement.

Mandatory training

The service did not ensure staff completed mandatory training in key skills.

The provider did not monitor compliance with mandatory training and alert staff when they needed to update their training. As staff had substantive posts with other large employers, they completed their mandatory training with their primary employer. The provider ensured staff completed some of their mandatory training; for example, all staff had completed data security and protection, health, safety and welfare and conflict resolution. However, only one member of staff out of three had completed equality and diversity training. None of Staff had up to date fire safety training. Only one member of staff had resuscitation adults training in date.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff did not all have training on how to recognise and report abuse.

Not all staff received training specific for their role on how to recognise and report abuse. The service did not have clear safeguarding processes and procedures. The safeguarding adults' policy was up to date, having been reviewed in August 2022, but did not clearly guide staff to report concerns to the local authority. However, staff knew who to make safeguarding referrals to and how to raise concerns.

The provider relied on training provided by staff's primary employer but did not provide a service specific update for safeguarding. One member of staff had completed safeguarding adults' level two training, the other two members of staff did not have safeguarding adults training. Two members of staff had completed safeguarding children level two training. A member of staff who was the safeguarding lead did not have up to date training for both safeguarding adults and children.

Requires Improvement

Diagnostic and screening services

Staff were able to clearly articulate signs of different types of abuse, and the types of concerns they would report or escalate to the provider.

The safeguarding children policy also covered child sexual exploitation. Staff had guidance around female genital mutilation.

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 visibly clean and had suitable furnishings which were visibly clean and well-maintained. The scan room, toilet and waiting area were all visibly clean. Staff followed the provider's policies for safety and hygiene in the scan room. Cleaning schedules were updated in line with this policy. Staff cleaned equipment and waiting areas after every customer contact. For example, the couch in the treatment room used by women was wiped down with a clinical disinfectant between patients.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Staff completed a daily cleaning log and undertook cleanliness visibility checks throughout their shifts. Staff documented and rectified any areas of concern as necessary. The provider had introduced more detailed cleaning logs in response to COVID-19 which prompted staff to clean more thoroughly.

Staff followed infection control principles including the use of personal protective equipment (PPE). There were appropriate hand washing facilities in the toilet and sanitising hand gel was available. Staff had their arms bare below their elbows and washed their hands before and after each scan. Personal and protective equipment such as latex-free gloves and antiseptic wipes were readily available for staff to use at the service. The provider had a template for auditing hand hygiene, but there were no records of hand hygiene audits being completed.

The government has updated the guidance around the use of sterile or non-sterile gel for ultrasound. Standard ultrasound gel is not produced as a sterile product, although sterile versions are available. The UK Health Security Agency has produced a 'good infection prevention practice: using ultrasound gel' flowchart to help practitioners decide which type they should be using. As a result of this updated guidance, the use of refillable dispensing bottles is not recommended. Although the provider kept up to date with subscriptions to various associations such as British Medical Ultrasound Society (BMUS) and the National Institute of Clinical Excellence (NICE), they were not aware of this information. Staff used refillable bottles.

In the twelve months before the inspection, there had been no incidences of healthcare acquired infections at the location.

The sonographer followed the manufacturer's and infection prevention and control (IPC) guidance for routine disinfection of equipment. The sonographer wore gloves when carrying out scans in line with IPC compliance.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff did not manage clinical waste well.

Requires Improvement

Diagnostic and screening services

The service had suitable facilities and had enough suitable equipment to meet the needs of women. The clinic's environment was fit for the purpose of service provided. The premises were a converted single storey building and did not have access suitable for people using wheelchairs or with other mobility needs. This was because the steps were directly off the pavement and were steep. The provider referred women to other services if they were unable to accommodate them. The building comprised a ground floor access up some steps through the front entrance, into the waiting area. There was one, separate scan room. The scan room had a modern couch which could be adjusted for comfort. One large screen was on the wall and a couch for people accompanying the woman. The scan room did not have a hand-washing sink, but a sink was available in the toilet next door. The service had storage cupboards for disposable items located in the toilet.

Staff completed regular checks of stock, first aid kit and equipment.

The service did not require a resuscitation trolley. There was a first aid box which was within expiration date. Not all staff had up to date first aid training. Staff told us in case of an emergency they would call 999.

Staff carried out daily safety checks of specialist equipment. The scan equipment was serviced annually and maintained by the company who supplied and installed it. The equipment was covered by a service warranty. The electrical equipment had been safety tested within the last 12 months. This was in line with the provider's safety policy.

Staff did not dispose of clinical waste safely. Staff disposed of clinical waste in domestic waste collections. This included PPE worn by staff, tissue used to wipe the scan gel off the client and probe covers used for trans-vaginal scans. Department of Health and Social Care Health Technical Memorandum (HTM) 07-01 provides the regulatory waste management guidance for NHS England including waste classification, segregation, storage, packaging, transport, treatment and disposal. Blood and body fluids are considered hazardous as they may contain infectious microorganisms and should be dealt with appropriately.

One small corridor linked the waiting area, the toilet and the scan room.

Fire risk assessments had been undertaken and contained guidance for staff on what to do in the event of any emergency. Fire alarms were checked weekly, fire exits were kept clear. The service had two fire extinguishers which were easily accessible.

Staff left the room while women undressed to ensure the privacy and dignity of women. There was a sign on the door to alert people the room was in use and the door could be locked from the inside.

Sonographers could adjust the scanning machine and their chair for their comfort, as well as adjusting the scan couch. The provider also factored breaks into the schedule, so staff could avoid work related musculoskeletal disorders.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and removed or minimised risks. Staff knew what to do and acted quickly when there was an emergency.

Staff knew about and dealt with any specific risk issues. The service provided clear guidance for sonographers to follow when they identified unexpected results during a scan. Staff had a clear referral pathway to follow. The provider had reached agreement with the local hospital to refer women to them if any concerns were identified but did not have a service level agreement which described each persons' responsibilities. A service-level agreement (SLA) is a contract

between a service provider, in this case the hospital and its customers that documents what services the hospital will furnish and defines the service standards the hospital is obligated to meet. The provider asked women to contact them by email if they didn't hear from the hospital. The provider emailed women five working days after the referral to ask how they were.

All scans began with a well-being check. Should any anomalies be found, staff told us they informed the woman in a caring, honest and professional manner. Staff wrote a detailed medical report which clearly explained the scan findings, which was shared with the hospital with the woman's consent. Staff followed the referral pathway agreed with the local NHS Early Pregnancy Assessment Clinic (EPAC).

Staff gave examples of redirecting women who were experiencing pain or bleeding to the EPAC.

Staff told us they had urgently referred four women to NHS services since April 2021 because of potential concerns found. The provider had an 'unexpected findings policy' and staff followed this. Staff completed a report for the woman to give to their maternity provider. These included a description of the scan findings, the reason for referral, who the receiving healthcare professional was and what action they were going to take.

Staff shared key information to keep patients safe when handing over their care to others. Staff responded promptly to any immediate risks to women's health. Staff told us they would phone 999 if they suspected anything which required urgent action.

Staffing

Staff had the right qualifications but no evidence they had correct experience as employment history was not completed. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough staff to keep women safe. The provider was a radiographer trained as a sonographer. The service employed three locum sonographers; all staff worked alone. The provider had a lone-working policy and staff were aware of this. Two locum sonographers were radiographers who had trained as sonographers, and one locum sonographer was a registered nurse with a post-graduate qualification in medical ultrasound. The service did not have any chaperones, although they had a policy in place should women request one. Women were not offered a chaperone as part of their booking process. Staff told us the provider would act as a chaperone if required, although their chaperone training was out of date. Women completed a contact form online with their preferred appointment date and the provider responded by email.

The service did not follow recruitment practices in line with regulation. We reviewed all three personnel files. The service had not obtained satisfactory evidence of previous employment for their locum sonographers because they were self-employed. The service did not have information required under Schedule 3, such as up-to-date photographs of staff, a full employment history, together with a satisfactory written explanation of any gaps in employment and satisfactory information about any physical or mental health conditions which are relevant to the person's ability to carry on, manage or work. All staff had an up-to-date Disclosure and Barring Service check. The provider had evidence of qualifications and professional memberships on file.

The locum sonographers were registered with the Health and Care Professionals Council (HCPC) and had professional indemnity insurance with the service. The nurse sonographer was registered with the Nursing and Midwifery Council.

Requires Improvement

Diagnostic and screening services

The service had no vacancies. Staff turnover and sickness rates were low and stable. The service did not use bank or agency staff.

Records

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

The service had an up-to-date information governance policy, and a data retention policy. The provider was the information governance lead for the service. The service was registered with the Information Commissioner's Office (ICO).

Women's notes were comprehensive, and all staff could access them easily. Pre-scan forms were used to collect the name, address, telephone number, email address and consent of the woman. Information about the woman's GP was also collected, but information was only shared with the GP with the woman's consent.

Staff ensured women's confidential personal information (CPI) was maintained and not accessible to others.

Records were stored securely. All records were kept electronically, and computers were password protected. When a woman was referred to hospital, a copy was sent to the hospital with the woman.

Incident reporting, learning and improvement

Staff recognised and knew how to report incidents and near misses. Managers had protocols in place for investigating incidents and sharing lessons learned with staff. When things went wrong, staff apologised and gave women honest information and suitable support. Managers ensured that actions from safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. The service had an up-to-date incident reporting policy, which detailed all staff responsibilities to report, manage and monitor incidents. The service used an electronic system to report incidents and an incident log was available in the clinic, although there had never been any incidents. If an incident was to occur, the provider was responsible for conducting investigations into all incidents at the service.

Staff understood the duty of candour. In the past year, there were no incidents requiring duty of candour notifications. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff could explain the process they would undertake if they needed to implement the duty of candour because of an incident, which was in line with the requirements.

Staff had opportunities to discuss feedback and look at improvements to patient care. As there were only three locum members of staff at the time of the inspection, information was shared using encrypted communications groups.

Are Diagnostic and screening services effective?

Requires Improvement

Diagnostic and screening services

Inspected but not rated

We do not currently rate effective.

Evidence-based care and treatment

The service did not always provide care and procedures based on national guidance and evidence-based practice. Managers did not always check to make sure staff followed guidance.

The service did not have an effective audit programme that provided assurance about the quality and safety of the service. Staff had created a quarterly record keeping audit schedule which began in June 2022, where the systems used by the service to record their business activity such as bookings, images and reports were monitored. However, there were no effective audits in place. For example, there were no records of infection prevention and control audits and no audits of the records of consent.

Staff explained the provider had plans to begin peer reviews of scan images and reports in October 2022. Actionable reports are required for safe patient management, and audit of the reporting outcomes is strongly advised by the Royal College of Radiologists (RCR) (2018) in the document 'Actionable reporting'. It is good practice for sonographers to peer review each other's scans and reports. Peer reviews are used to monitor the quality of the images and the reports written. This is to ensure any referrals had been done properly.

Most of the policies staff followed were up-to-date. Staff were aware of how to access policies, which were stored electronically in Staff handbook. Local policies and protocols were in line with current legislation and national evidence-based guidance from professional organisations, such as the National Institute for Health and Care Excellence (NICE) and the British Medical Ultrasound Society (BMUS). However, please note comments above under safeguarding. All 12 policies and protocols we looked at had a next renewal date. The infection control policy was updated after the inspection to reflect the use of disposable gel bottles, rather than refilling them.

The service followed the 'As Low As Reasonably Achievable' (ALARA) principles. This was in line with national guidance (Society and College of Radiographers (SCoR) and British Medical Ultrasound Society (BMUS), Guidelines For Professional Ultrasound Practice (December 2018)). This meant sonographers used minimum frequency levels for a minimum amount of time to achieve the best result. Machines were pre-set to the lowest frequency and this was checked during scans.

The service used technology and equipment to enhance the delivery of effective care and treatment to women. The service utilised up-to-date scanning equipment to provide high-quality ultrasound images. They also had one large wall-mounted screen situated in the scan room which enabled women and their families to view their baby more easily.

Women were able to access their scan photos and download them onto their phone/laptop. Women were sent a link and a password to access their scan images. The link was valid for seven days. The link was specific for the woman to ensure patient confidentiality.

Nutrition and hydration

Staff took into account women's individual needs where fluids were necessary for the procedure.

Requires Improvement

Diagnostic and screening services

Due to the nature of the service, food and drink was not routinely offered to women. However, bottles of drinking water were available. To improve the quality of the ultrasound image, women were asked to drink extra fluids on the lead up to their appointment. Women who were having scans were encouraged to attend their appointment with a full bladder. This information was given to women when they contacted the clinic to book their appointment. It was also included in the 'frequently asked questions' on the service's website.

Pain relief

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

Pain relief was not available at the service. Staff checked women were comfortable during their scan and halted scans if women experienced any discomfort.

Patient outcomes

Staff did not monitor the effectiveness of care.

The provider collected some data for their own use on an on-going basis. This included information about the number of ultrasound scans.

At the time of our inspection there were no peer reviews of scans taking place, though there was a policy in place for this. Staff explained this was because the business had started during COVID-19 with the provider working alone, and the provider had also taken maternity leave during this time. However, Staff showed us the policy and plan for staff to begin peer reviewing each other's scans in October 2022, when the provider hoped to return to work part-time following maternity leave. Each sonographer would have a selection of their own scans peer reviewed and would, in turn, peer review other sonographers' scans. Staff had access to a clinical group where they could share concerns and request additional support if they wished. The provider was a member of the British Medical Ultrasound Society (BMUS) and received journals and updates as well as keeping their Continuing Professional Development (CPD) up to date.

The provider ensured there were clear criteria for doing scans and repeat scans. Rescans were done in the most appropriate timescales. This was to ensure women were not persuaded to have multiple scans, which would not have given them any more information than they already had.

Competent staff

The service did not sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were qualified and had the right skills and knowledge to meet the needs of women. Staff accessed their training through their primary employment. Training records confirmed staff had completed some role-specific training. Staff provided copies of their training certificates to the provider annually as part of their appraisal.

The provider gave all new staff a full induction tailored to their role and experience before they started work. All staff underwent an induction programme which included providing information about staff roles and responsibilities, and mandatory and role-specific training. New staff also completed a three-month probation period.

Requires Improvement

Diagnostic and screening services

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 the provider and were supported to develop their skills and knowledge. Staff told us there were opportunities to develop at the service.

Staff had a review meeting after their probation then an annual review after that. However, at the time of our inspection, none of Staff had worked for a year so an appraisal was not due.

Staff were aware of incidents that occurred in other services because the provider subscribed to weekly Medicines and Healthcare products Regulatory Agency (MHRA) safety alerts and BMUS newsletters. Staff information was shared in the clinical communication group.

Multidisciplinary working

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

The team worked well together and communicated effectively for the benefit of the women and their families. The provider had developed a referral process with a local hospital.

We observed positive staff working relationships promoted a relaxed environment and helped put women and their families at ease.

Seven-day services

Sneek-A-Peek Ultrasound Limited was not an acute service and did not offer emergency tests or treatment, although they reminded women to call emergency services if necessary and gave women contact details of other NHS services available to them. This meant services did not need to be delivered seven days a week to be effective.

Services were supplied according to women's demand and the opening times varied each day to meet this demand. Services at the location were typically provided one and a half days a week, including Wednesday evenings, Saturdays and Sundays. This offered flexible service provision for women and their companions to attend around work and family commitments.

Booking for appointments was available seven days a week, 24 hours a day using the provider's online booking system available on their website. Women completed the form and the provider contacted them by email to discuss their needs and complete the booking.

Health promotion

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

The service had relevant information on their website promoting healthy lifestyles, for example, information about acupuncture and exercise in pregnancy. Women were advised to contact their maternity unit immediately if they thought their baby's movements had changed and/or reduced. This was in line with national recommendations (NHS England, Saving Babies' Lives: A care bundle for reducing stillbirth (February 2016)). Information was available in other languages.

Requires Improvement

Diagnostic and screening services

The service provided clear information that the scanning services they provided were not a substitute for the antenatal care pathway provided by the NHS.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

There was a Mental Capacity Act (2005) policy for staff to follow, which clearly outlined the service's expectations and processes. Staff understood the relevant consent and decision-making requirements of legislation and guidance. Staff followed the service's policy relating to individuals who suffered from any condition covered under the mental capacity act (MCA). This detailed how staff should support women and ensure they acted in their best interests.

Staff gained consent from women for their care and treatment in line with legislation and guidance. Before their scan all women received written information to read and sign. This included information about ultrasound scanning and safety information, a pre-scan questionnaire and declaration form which included the terms and conditions, such as scan limitations, referral consent, and use of data.

Staff clearly recorded consent in women's records. Sonographers were responsible for obtaining the informed consent of women and completing ultrasound reports during the woman's appointment.

Are Diagnostic and screening services caring?

Good

This is the first inspection for this service. We rated caring 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. Staff were very passionate about their roles and were committed to providing personalised care.

Staff followed policy to keep women's care and treatment confidential. Staff ensured scans were conducted in a way that protected women's privacy and dignity. Staff kept the door to the scanning room shut during the scan to ensure women's privacy was maintained and women were covered throughout. The scan room door was locked during scans to ensure no-one could walk in.

Requires Improvement

Diagnostic and screening services

Women consistently and emphatically said staff treated them well and with kindness. Staff were very warm, kind and welcoming whey they interacted with women and their companions. Staff took time to interact with women and those close to them in a respectful and considerate way. For example, staff asked the woman's name upon arrival and would support them throughout their appointment.

Feedback from women included, "[Staff name] is so lovely and went over every aspect possible of the stage of pregnancy I was at" and, "Highly recommended."

Staff understood and respected the personal, cultural, social and religious needs of women and how they may relate to care needs. For example, the provider was aware some women would choose their service because they wanted a female sonographer.

Emotional support

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

Staff gave women and those close to them help, emotional support and advice when they needed it. The service held staggered appointment times; women booked at a time to suit them. Women could provide information at the time of booking an appointment, so staff knew if there was a concern. Staff were mindful early scans held a higher risk of complications being identified. The sonographer gave women the option of starting the scan without the other screen in the room being turned on, especially if there was a child present. This meant if any anomalies were identified the sonographer could make their diagnosis and share the information in an informed, compassionate manner. Staff were calm and reassuring throughout the scan. The sonographer provided reassurance about the scan images and clearly explained what they observed.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff supported women who received upsetting news. The sonographer delivered initial feedback to women and ensured they gave women more time and emotional support, for example, in the event of a scan revealing an anomaly or the lack of a heartbeat. Staff offered women information referring them to their next medical steps, or signposted women to the miscarriage trust. As the service did not have a separate entrance for women to use if they were distressed, they had to exit through the waiting room. However, because scans were booked hourly this meant women had time to leave the premises before the next client arrived.

Staff understood the emotional and social impact that a woman's care, treatment or condition had on their wellbeing and on those close to them. Staff told us how they explained to women they were not a diagnostic service and would refer women to their maternity provider. The service's terms and conditions explained how it may be necessary to share information with healthcare providers.

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 procedures. Staff communicated with women and those accompanying them in a way they could understand. Staff adapted the language and terminology they used when performing the scan. They took the time to explain the procedure to ensure women understood. Family

and friends were welcome in the scan room and there was one screen positioned in the scan room to ensure everyone could see the scan images. Staff told us during the COVID-19 pandemic they had restricted women to one visitor accompanying each woman, although these restrictions had been lifted and at the time of our inspection, up to four people could accompany the woman. Children were welcomed in the waiting area and the scan room.

Women and their families could give feedback on the service and their treatment and staff supported them to do this. Women and their partners felt they were fully involved in their care and had been given the opportunity to ask questions throughout their appointment. Staff took time explaining procedures to women before and during ultrasound scans and left adequate time for women and their companions to ask questions.

Staff supported patients to make informed decisions about their care. Staff made sure women were told about the different scans available and the costs associated with them. Staff signposted women to other care providers and reminded women they should attend their NHS appointments.

Women we spoke with were delighted with the service they received. Women told us they felt the service they received was 'excellent' and praised Staff highly. They told us staff were very friendly and kind and this made them feel very comfortable.

Are Diagnostic and screening services responsive?

Good

This was the first inspection for this service. We rated responsive as good.

Service delivery to meet the needs of local people

Women's individual needs and preferences were central to the delivery of tailored services and were delivered in a way to ensure flexibility and choice. The service also worked with others in the wider system and local organisations to plan care.

Staff planned and organised services, so they met the changing needs of people who used the service. People could access services and appointments in a way and at a time that suited them. The service had varied their opening hours depending on the appointments made and operated clinics one and a half days a week including weekends. The service was flexible with the last appointment dependant on the number of bookings.

Managers planned and organised services, so they met the changing needs of the local population. At the time of our inspection, all scans were available.

Clients wishing to book an appointment book a pre-appointment through the website. When clients booked in, they were able to identify if they had any language or accessibility problems. The provider used a well-known language line for translation purposes. The service was not able to accommodate wheelchair users.

Requires Improvement

Diagnostic and screening services

Information about services offered at the location were accessible online. The service offered a range of ultrasound scans for pregnant women; such as early pregnancy scans from six weeks gestation, wellbeing and gender scans and 2D, 3D or 4D scans. The provider engaged with the client to determine the appropriate scan and any information specifically about the scan. This included whether they needed a full bladder and when was the best gestation for their scan. Ultrasound scan prices were detailed during the discussions with the provider.

Facilities and premises were appropriate for the services being delivered. The environment was appropriate for the service being delivered and was customer centred. The scan room was large with ample seating and additional standing room for several guests, and children of all ages were welcome to attend. The scanning room had one large wall-mounted screen which projected the scan images from the ultrasound machine. This enabled women and their families to view their baby scan more easily and from anywhere in the room. This was in line with recommendations (Royal College of Radiologists, Standards for the provision of an ultrasound service (December 2014).

If a woman suffered a miscarriage before their appointment, staff would refund the deposit payment. Women were able to postpone their appointments if they phoned in advance of the appointment.

The provider monitored the waiting times for clinics with clinics running slightly late during our inspection.

Meeting people's individual needs

The service was inclusive and took account of women's individual needs and preferences. Staff made reasonable adjustments to help women access services. They directed women to other services where necessary.

All staff ensured women did not stay longer than they needed to.

All scans started with a wellbeing check. The sonographer always looked at the baby's movements, heartbeat, water, position, kidneys, stomach and placental position if the woman was past 20 weeks in her pregnancy. The service had systems to help care for women in need of additional support or specialist intervention.

The service also specialised in providing antenatal scans for women from 6 to 40 weeks of pregnancy. Gender confirmation and growth scans were also available. Women who mostly wanted a scan for souvenir purposes had a well-being scan as well and could view their baby in 4D as well as 2D. NHS pregnancy scans show a two-dimensional image. A 4D scan enables women to see their baby moving as a 3D image. Women with a history of ectopic or failed pregnancy had a range of scans they could access. The service only provided private pregnancy ultrasound scans. They did not undertake any ultrasound imaging on behalf of the NHS or other private providers.

Women who wanted to find out the gender of their baby outside of their appointment, such as at a gender reveal party with their family and friends, were given a sealed envelope with a pre-loaded confetti cannon telling them whether they were expecting a boy or a girl. The sonographer could turn the screen off while looking for the baby's gender.

Access and flow

Women could access the service when they needed it. They received the right care and their results promptly.

Requires Improvement

Diagnostic and screening services

All women self-referred to the service. Women booked their scan appointments with the provider after completing a contact form on the provider's website. Women who did not need to be referred were sent an email which contained a link giving access to their scans at the end of their appointment.

The service had a fetal abnormality policy which detailed the process to follow if these were identified.

Learning from complaints and concerns

It was easy for women to give feedback and raise concerns about care received. The service had a policy in place which detailed how concerns and complaints were to be taken seriously, investigated and lessons learned shared with all staff. The policy explained how women should be included in the investigation of their complaint.

Women, relatives and carers knew how to complain or raise concerns. The service had an up-to- date complaints policy, which outlined procedures for accepting, investigating, recording and responding to local, informal, and formal complaints about the service. The policy confirmed that all complaints should be acknowledged within three working days and resolved within 28 working days. In the past year, there had been no complaints. The complaints policy stated how all complaints would be investigated and closed in a timely manner in line with the policy.

Staff understood the policy on complaints and knew how to handle them. Women could make complaints in person, by phone or email. The provider attempted to deal with concerns at the time to resolve women's concerns.

The provider had not considered how they would refer anyone who wished to make a complaint about the provider.

Sneek-A-Peek Ultrasound Limited's induction programme included a course on customer care and dealing with complaints which all staff had completed. All staff knew who to contact if they received a complaint.

Are Diagnostic and screening services well-led?

Requires Improvement

This is the first inspection for this service. We rated well-led as requires improvement.

Leadership

Leaders 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.

The provider led the service. The provider was supported by a family member and had regular meetings with them to discuss the service's performance, limitations and the challenges it faced.

Staff informed us that the provider and staff were very friendly, approachable, and effective in their roles. Staff felt confident to discuss any concerns they had with them; and were able to approach the provider directly, should the need arise.

Requires Improvement

Diagnostic and screening services

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services. Leaders and staff understood and knew how to apply them and monitor progress.

The mission of Sneak-A-Peek Ultrasound was to provide a place where pregnant women felt safe, valued and acknowledged.

The provider had a plan to grow the business and a strategy how to achieve this. The provider's mission was to, "Provide a place where pregnant women feel safe and acknowledged."

The service had a clear vision and values which were focused on providing a first-rate service. Staff told us the values included growing a reputation to be technically good and competent and exceeding people's expectations of care.

Staff told us the ethos for the service was to provide the highest possible standards of service and care every time. They were passionate about treating women with empathy and understanding and led staff to make everyone's experience the best it could be. Feedback from women overwhelmingly praised staff for the friendly and supportive environment that surrounded them. Everyone we spoke with confirmed this and said they would highly recommend the service.

Culture

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

Staff we met were friendly, welcoming and confident. Staff told us they felt supported, respected, and valued by their manager. They enjoyed coming to work and were proud to work for the service. Staff were aware of the whistleblowing policy and could raise any concerns.

Only one of three staff had completed equality and diversity training. Staff were encouraged to raise concerns openly and without fear of recrimination.

Governance

Leaders did not always operate effective governance processes and was not managing performance against regulations. Staff at all levels were clear about their roles and accountabilities and but did not have regular opportunities to meet, discuss and learn from the performance of the service.

The provider had an information governance policy, which staff were aware of. Staff told us they were kept informed of everything by regular phone calls and emails. However, there were no staff meetings or any formal governance meetings where quality, risk and trends could be discussed and reviewed. There were no audits to improve the service.

Requires Improvement

Diagnostic and screening services

We found a clear line of communication between the provider and staff, and to also escalate and cascade information up and down lines of management and staff relating to complaints and support. However, there was no communication about governance, such as audits. Staff were clear about their roles and understood what they were accountable for and to whom. Staff could describe the governance processes for incidents and complaints and how they were investigated.

Staff were able to access the provider's policies electronically.

Management of risk, issues and performance

Leaders and teams did not use systems to manage performance effectively. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service had an online risk register**.** The risks to the service included rising energy and consumables costs, staff shortages and unplanned absence and equipment failure. Controls to minimise these risks were in place.

The provider did not have an effective audit programme to provide assurance of the quality and safety of the service. Local audits, such as clinical and compliance audits were not undertaken regularly to monitor performance and there was no oversight of new national guidance.

The provider had completed risk assessments for identified risks such as COVID-19, IT failure and staff shortages. Environmental risk assessments such as for Legionella were also in place. The risk assessments identified who or what was at risk, the risk rating, and additional control measures needed. Most of the risks were graded low and had adequate controls in place to minimise each risk. Staff were aware of the risk assessments because they had access to the online system where they were stored. All risk assessments were reviewed annually or sooner if indicated.

The service had a clinic contingency plan with identified actions to be taken in the event of an incident that would impact the service. For example, extended power loss, short notice staff sickness and equipment failure. The contingency plan included contact details of relevant individuals or services for staff to contact.

When staff worked alone a mobile number was set up to automatically contact the provider if an alarm was activated. Any staff working alone also had a panic alarm button they could use to call for assistance from the provider or staff, who lived in the near vicinity.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service was up-to-date with information governance and had data retention policies. These stipulated the requirements for managing patients' personal information in line with current data protection laws. The service was registered with the Information Commissioner's Office (ICO), which is in line with 'The Data Protection (Charges and Information) Regulations' (2018). The ICO is the UK's independent authority set up to uphold information rights.

Requires Improvement

Diagnostic and screening services

The provider's GDPR policy stated all personal data such as scan images and reports older than 18 months should be removed from all Sneek-A-Peek systems. The sonographer confirmed this was done. This information was clearly detailed in the terms and conditions of the service.

We saw that appropriate and accurate information was effectively processed, challenged and acted upon. Key performance, audit, and patient feedback data was frequently collated and reviewed to improve service delivery.

Engagement

Leaders and staff actively and openly engaged with women, staff and local organisations to plan and manage services.

The provider had developed a relationship with the local hospital and EPAC to refer women.

Women and their families were asked to provide feedback when they visited. The service also used social media and internet reviews to obtain feedback from women and their families. Feedback included, "Out of all the scans I've ever had (and that's a lot) today was so lovely and a day I won't forget. You made it an amazing experience" and, "Absolutely amazing experience, will be a day I remember forever."

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Staff did not have all the training required to provide care in a safe way for service users. Staff did not have up to date safeguarding training. Staff did not dispose of clinical waste in line with national guidance.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The provider did not ensure recruitment procedures were established and operated effectively.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have a programme of audits to assess, monitor and improve the quality and safety of the service provided.