Wythenshawe Cardiac MRI Centre

Quality Report

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Date of inspection visit: 14 November 2018
Date of publication: 26/04/2019

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Wythenshawe Cardiac MRI Centre is operated by Allied Medical Limited. The service provides magnetic resonance imaging diagnostic scans and computed tomography scans on an outpatient basis. Facilities include two magnetic resonance imaging scanning rooms, and scanner control room, a computed tomography scan room with control room, patient preparation areas, patient changing rooms with toilet facilities, storage and equipment room and administration offices.

The service provides diagnostic imaging to adults. We inspected the service under our independent single speciality diagnostic imaging framework, using our comprehensive inspection methodology. We carried out a short notice announced inspection on 14 November 2018.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

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

We found good practice in relation to diagnostic imaging:

- The service managed patient safety incidents well. Staff knew what constituted an incident and could demonstrate how to use the electronic reporting system. We saw evidence that the centre was staffed with enough staff, who had the appropriate skills, experience and training to keep patients safe and to meet their needs. Patients completed a patient assessment form to identify any patient risks and these were reviewed and checked by staff before the magnetic resonance imaging diagnostics scan or computed tomography scan took place. Pre- assessment areas were clean, maintained and comfortable. Staff followed the corporate policy for waste management processes. Waste was appropriately labelled and segregated. However, we saw a medicine cupboard was left open with keys in it and left unattended.
- The service used evidence based practice and followed a range of recognised guidance, protocols and regulation. The service participated in local and corporate audits to evidence the effectiveness of using evidence based practice. Staff were skilled and competent in their roles and kept up to date with their professional practice. Staff understood their responsibilities regarding patient consent and the Mental Capacity Act 2005.
- Staff treated patients with dignity and respect. They were kind and compassionate when caring for patients. We saw that staff worked especially hard to make the patient experience as pleasant as possible. They recognised that patients were anxious and responded by reassuring them and keeping them informed.
- The centre had planned their service to meet the needs of service users and external organisations they worked closely with. The centre met the needs of patients using the service including patients with learning disabilities or with claustrophobia. Facilities were appropriate, and patient areas ensured privacy and dignity. The service offered a seven-day service to ensure patients could access appointments at a time that suited them. However, staff did not always inform patients or relatives of delays or when the clinic was running late. The service had no outstanding complaints at the time of inspection.
- The leadership was visible and approachable, staff felt comfortable to raise concerns with managers. The service vision was aligned to the vision and values of the provider and host hospital. The service had appropriate governance structures. Senior managers used performance data to identify, mitigate and learn from incidents. However, the service did not have a formal system in place to monitor local risks. We raised this with the manager who acknowledged our concerns and said that this would be raised at a corporate level.

Summary of findings

Ellen Armistead

Deputy Chief Inspector of Hospitals (North)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good 	Diagnostics was the only activity the service provided. We rated this service as good because it was safe, caring, responsive and well-led. We do not rate effective.

Summary of findings

Contents

Good

Wythenshawe Cardiac MRI Centre

Services we looked at: Diagnostic Imaging.

Summary of this inspection

Background to Wythenshawe Cardiac MRI Centre

The Wythenshawe Cardiac MRI Centre went into partnership with Alliance Medical Limited in 2008. It now offers a seven-day service between the hours of 8am and 8pm. The service offers general magnetic resonance imaging scans at the weekend in line with the current medical cover. The service reported 3,750 cardiac magnetic resonance imaging scans to date.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, second CQC inspector and a specialist advisor with expertise in diagnostic imaging. The inspection team was overseen by Nicholas Smith, Head of Hospital Inspection.

Information about Wythenshawe Cardiac MRI Centre

The Wythenshawe Cardiac MRI Centre is a magnetic resonance diagnostic imaging service which undertakes both magnetic resonance imaging diagnostic and computed tomography scans on patients to diagnose disease, disorder and injury. The service has two fixed magnetic resonance imaging scanners and one fixed computed tomography scanner. The centre is located within Wythenshawe Hospital site.

The premises are managed by the host hospital, however the magnetic resonance imaging scanners, computed tomography scanner and equipment belong to Alliance Medical Limited.

During the inspection, we visited both magnetic resonance imaging scanning and control rooms and the computed tomography control room, patient preparation cubicles, patient changing rooms, toilet facilities, administration office and the patient waiting area. We spoke with 10 members of staff including five radiographers, two doctors and three administrators. We spoke with four patients. During our inspection, we reviewed five electronic records.

We did not carry out any special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection.

Activity (August 2017 to July 2018)

- The service undertook 3,750 scans during the year

The service employed 15 radiographers, the registered manager, eight administrative staff and two clinical assistants.

The service reported;

- Zero Never events
- No serious injuries
- No incidences of healthcare acquired Methicillin-resistant Staphylococcus aureus (MRSA).
- No incidences of healthcare acquired Methicillin-sensitive staphylococcus aureus (MSSA).
- No incidences of healthcare acquired Clostridium difficile (codify).
- No incidences of healthcare acquired Escherichia coli (E-Coli).
- No complaints currently opened.

Services accredited by a national body:

- The Royal College of Radiologists and College of Radiographers 'Imaging Services Accreditation Scheme (ISAS).

Services provided at the service under service level agreement:

Summary of this inspection

- Use and maintenance of premises
- Use of hospital facilities
- Grounds maintenance

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated it as **Good** because:

- The service provided mandatory and safeguarding training to all staff to ensure staff had the right knowledge to keep patients free from harm. The service provided us with evidence whilst on inspection that 93% of staff had completed their mandatory training.
- The service provided us with evidence that the centre was sufficiently staffed to keep people safe.
- We saw there were appropriate systems to identify patient risks, these were supported by safety processes.
- Equipment was clean, well maintained and serviced appropriately in line with manufactures recommendations.
- All staff we observed complied to infection prevention and control practices.
- Records were up to date and complete and they were securely kept safe.
- Staff reported incidents through the electronic reporting system. They were investigated and learning was implemented.
- Medicines were managed in line with best practice.

However

- We found although staff were knowledgeable of what constituted a safeguarding concern and reported them to the local safeguarding lead, they did not always report the safeguarding incident on the incident reporting system as specified in their policy. Therefore, the service manager did not always have oversight of what had been reported. This meant there was no assurance that all safeguards had been appropriately reported and checked by the registered manager. This was raised with the registered manager who had put actions in place to address this before the end of the onsite visit.

Are services effective?

We did not rate effective

- The service provided care and treatment based on national guidance. The effectiveness of these pathways was monitored through local and corporate audits.
- The service ensured staff were competent in their roles by providing induction programmes, appraisals and supervision.

Summary of this inspection

- There was a strong focus on ensuring newly qualified staff were supported through the competency based frameworks and shadowing senior staff so they were confident in scanning.
- Staff worked together as a team for the benefit of patients. Consultants and radiographers supported each other to provide care.
- Consent was taken at pre-assessment and then checked at the face to face assessment with the radiographer.

Are services caring?

Good

We rated caring as 'Good' because:

- Staff cared for patients with compassion, treating them with dignity and respect.
- Staff frequently talked to patients whilst in the scanner to reassure patients when they were anxious.
- Clinicians involved patients and those close to them in decisions about their care and treatment.
- All patients and those close to them told us they had discussed the procedure during the consultation with the doctor and in the pre- assessment cubicle.
- Patients, families and carers gave positive feedback about their care. We saw that staff introduced themselves and communicated well with patients to ensure they fully understood the treatment they were to receive.

Are services responsive?

Good

We rated responsive as 'Good' because:

- The service was planned with the needs of service users and the needs of the host hospital.
- Facilities and the environment were suitable for the needs of the patient.
- We did not see any patients who were distressed but staff we spoke with discussed the steps they took if a patient was claustrophobic or anxious.
- Patients had access to the service at times that suited them. For example, appointments were available during the evening and at weekends.
- The service worked with patients and clinicians to accommodate appointments at short notice.
- The service had three complaints between May and November 2018, which were all acted upon and changes to practice were shared with patients and staff.

However

Summary of this inspection

- The service did not always keep patients and relatives informed when there were delays.

Are services well-led?

Good

We rated well-led as good because:

- The vision and values were aligned to both Alliance Medical Limited and the host hospital.
- The service had supportive, competent managers who promoted a learning culture.
- Staff understood and were invested in the vision and values of the organisation. They engaged with the manager in shaping the service to meet the needs of patients.
- Corporate governance structures were in place to provide scrutiny of performance data, audit outcomes, incidents and complaints.
- We saw that staff kept personal data secure via access only systems to prevent unauthorised access.
- The service engaged with staff, stakeholders and partners to develop the service.

However

- The service did not have a local risk register showing how risks were managed mitigated and monitored.
- We found that all non-clinical risk assessments were overdue for review.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Good	N/A	Good	Good	Good	Good

Good

Diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are diagnostic imaging services safe?

Good

We rated it as **good.**

Mandatory training

- The service had a corporate mandatory training policy. The registered manager was responsible for ensuring staff had undertaken training based on their roles and responsibilities.
- Mandatory training was mainly e-learning but some was face to face. The training covered 16 modules including; basic life support, intermediate life support, safeguarding children and vulnerable adults, moving and positioning people, infection prevention and control, equality and diversity and manual handling.
- Compliance with mandatory training was good; whilst on site we saw that 93% of staff had completed the training. The service reported that the data protection module had previously been included in the information governance module but had recently changed and had only become available. It was intended that all staff would be compliant by the end of November 2018.

Safeguarding

- The service followed the corporate and host hospital's safeguarding policy and liaised with the hospital safeguarding team for any concerns or advice.
- Safeguarding vulnerable adults was included in the service mandatory training programme. Whilst on site we saw evidence that 93% of staff had received safeguarding training level two.
- The staff demonstrated knowledge of safeguarding and told us how they would report incidents.
- Staff had access to a level three and level four trained staff member at Alliance Medical Limited, who were available for advice by telephone or email.
- The centre reported identifying one safeguarding concern between June and November 2018.
- Staff reported safeguarding to the local safeguarding lead based at the host hospital and to the named lead for Alliance Medical Limited. However, staff submitting safeguarding concerns did not always follow Alliance Medical Limited policy and did not report safeguards on the incident reporting system. This meant that the service manager was not always aware of reported safeguarding incidents. This was addressed at the time of our inspection as we were not assured the service manager had oversight of safeguards being reported by staff.
- The manager confirmed processes had been put in place to improve the safeguarding referral process. We were told all safeguarding concerns would be raised as an incident report through the service electronic reporting system. This would ensure the service manager was informed of all concerns and the incident would be sent to the corporate quality team. Lessons learned and a summary of the incident was shared in the quality newsletter.
- We saw posters being placed on walls during the inspection visit to reinforce the safeguarding policy.

The manager developed written guidance prompting staff to raise a clinical incident for any safeguarding concerns. This included a flow chart indicating the route to referring a safeguard. This was disseminated to staff through email and verbal discussions during our inspection.

Cleanliness, infection control and hygiene

- We reviewed the infection prevention and control policy which was due for renewal in July 2018. We were informed that the policy was under review and the current policy had been extended until December 2018.
- Information relating to the management of patients with a communicable disease was embedded in the service infection prevention and control policy.
- Staff we spoke with were familiar with the safe process to ensure correct procedures were followed to prevent cross contamination. We heard of examples of managing patients with methicillin-resistant staphylococcus aureus or other bacterial infections that needed to be isolated.
- Staff told us patients who had been identified with any infection control risk were allocated an appointment at the end of the day. This meant the risk of cross infection to other patients was reduced and the area could be deep cleaned afterwards with the appropriate cleaning materials. Areas requiring deep cleaning were not used again until the following day.
- The service annual infection prevention and control audit identified no concerns with the management of infectious patients.
- Comprehensive monthly audits of infection prevention and control were completed. These assessed environmental cleanliness, hand hygiene and insertion of medical devices. The audit identified compliance of 98% in hand hygiene and insertion of peripheral vascular devices with areas of improvement required in staff following bare below elbows guidance.
- Minutes from the infection prevention and control subcommittee meeting showed the organisation considered actions from audits and discussed their 2019 to 2020 action plan. We saw there had been no issues escalated from the Wythenshawe Cardiac MRI Centre.
- The centre appeared visibly clean and tidy and free from clutter. Preparation areas, control rooms and scanning areas had an environmental cleaning schedule. This identified items that needed to be cleaned and the cleaning material to be used. We observed staff cleaning the preparation areas, including examination couches, after each patient consultation using antibacterial wipes. Staff signed the cleaning schedule after each session.
- All clinical areas had soap dispensers, hot and cold running water and paper towel dispensers. Preparation areas had an antibacterial rub dispenser which were also located at intervals on the corridors and in the patient waiting area. We observed all dispensers were clean and full of the relevant product. There was also hand hygiene guidance located at each sink with diagrams for effective hand hygiene.
- There were dispensers for aprons and gloves in small, medium and large sizes located in all clinical areas. This meant staff could easily access the appropriate personal protective equipment as required. We observed staff wearing gloves and aprons when carrying out treatment, such as inserting or removing cannulas. These were disposed of in clinical or non-clinical waste bins as necessary.
- During the inspection we saw all staff complied with infection prevention and control practices, they appropriately washed their hands between direct contact and care with patients and were all bare below the elbow.
- The service provided us with evidence that they had reported no healthcare related infections between May and November 2018.

Environment and equipment

- We observed a resuscitation trolley located in the central assessment area. The trolley was checked daily by a designated person and a log book was signed after each check. Checks were made on equipment

and consumables on the trolley to ensure they were fit for use. All items were intact and in date. Staff signed the log book after each check and there were yellow tags dated to indicate that these had been checked.

- All items of equipment requiring servicing had a maintenance schedule which was kept with each item. We observed weighing scales serviced in April 2018 and calibrated fit for purpose in September 2018.
- Magnetic resonance imaging (areas were kept locked to prevent unauthorised access. They could only be accessed by a key code.
- We saw all areas had the appropriate signage on doors to advise staff and patients they were entering a radioactive area. For example, doors had signs about the risks of the magnetic resonance imaging scanners and information indicating safe and unsafe equipment that could be taken into the area.
- We saw there were signs on each mobile piece of equipment, such as transfer chairs, indicating whether they were safe to enter the scanning areas.
- The scanning equipment was well maintained. Equipment was serviced and maintained in line with manufacturers guidance on a regular basis and we saw that records evidencing this were kept.
- Staff at the centre were responsible for maintaining the equipment in the clinical area they were working in. They were also responsible for emptying clinical waste.
- General cleaning of the floors and emptying of general waste was carried out by the housekeeping team based in the trust.
- All sharp implements, clinical and offensive waste were discarded in the appropriate containers and stored in locked cupboards located away from the clinical areas. These were secured by keypads which meant they were not accessible to anyone without the appropriate codes.
- The service had a spillage kit which was used to clean bodily fluids such as blood and urine. This was in date and there were clear directions for how to use the kit. Staff were familiar with the process of cleaning spillages and formed part of the infection prevention and control mandatory training.
- The building was maintained by the host hospital who had responsibility for maintenance and management of the building. Staff informed us that any environmental issues concerning the building were reported to the host hospital and dealt with quickly.
- The preparation area was located along a short corridor. This was a secure area accessed only by staff holding swipe cards. This meant all consultations and any confidential activity was carried out away from the patient waiting area. There were two patient changing rooms with lockers to secure personal items. This meant patients could change in private.
- There were labels on each of the curtains indicating when they were last replaced. We observed both sets of curtains were due to be replaced in April 2019. Staff told us these were monitored daily as part of the cleaning schedule and replaced sooner when required. We saw cleaning records that confirmed this.
- An external organisation conducted a range of system checks to ensure routine equipment performance measurements were accurate. Results formulated an annual diagnostic x-ray equipment performance and radiation safety report.

Assessing and responding to patient risk

- We observed signage located across all clinical and non-clinical areas with information of emergency assistance. The contact number for the emergency resuscitation team based in the main hospital were clearly displayed in the centre. The emergency resuscitation team based in the host hospital would attend in the event of an emergency. Transfer of a patient to the accident and emergency department would require an ambulance.
- There were clear pathways and processes to assess patients who were clinically unwell or if a scan revealed something requiring urgent medical intervention. For example, cardiac perfusions were only carried out in the presence of a medic, so that the patient could be constantly monitored.
- There were systems in place to care for patients who suddenly felt unwell during the scan. All staff were aware of the process and we saw that equipment was outside the room ready for use.

Good

Diagnostic imaging

- Radiographers had access to the radiation protection advisor and the medical physics expert via email or telephone for advice in relation to radiation.
- The centre was clearly signed in terms of radiation and magnetic risk. Waiting areas included posters alerting patients to tell staff if they were pregnant.
- The service displayed The Society and College of Radiographers "have you paused and checked?" posters in the magnetic resonance imaging and computed tomography control room to remind staff to follow the process. The "have you paused and checked?" process is a step by step safety check to ensure the right patient and all checks had been completed. We observed this practice whilst on inspection.
- Emergency pull cords were available in changing rooms, toilets and pre- assessment areas. Staff could communicate with patients via the intercom whilst they were in the scanner to ensure they were well. Patients were also given a handheld alarm which was audible in the control room and used to alert staff if they felt unwell or wanted the scan to stop.
- All patients were asked to complete a risk assessment in the form of a safety check questionnaire to determine if the patient was fit for the planned scan. The questionnaire asked patients for information on any risks that might be detrimental to their treatment. For example, if they had any medical devices such as pacemakers, they required specialist staff to turn off the device.
- The radiographer conducted an additional comprehensive screen to ensure the patient was safe to enter the scanner. Other checks such as pregnancy and medical conditions were also addressed. During this assessment we heard staff go through safety precautions and made sure patients understood them.
- Patients were further checked when entering the scanning area. This meant there were robust safety checks at various stages of the patient's assessment.
- The service had systems to monitor the safety of staff working in the scanning departmentin line with the Ionising Radiation Regulations 1999 (IRR99) updated IRR17, local rules for the operation of all equipment were in place. There was a designated officer and radiation protection supervisors who were responsible for carrying out checks on exposure to radiation where applicable.
- Diagnostic reference levels, the use and performance of equipment were monitored and recorded. All staff were required to follow these rules and signed the log to confirm these had been acknowledged. The documents we reviewed had been updated in September 2018 and all but three staff had signed to indicate they had read them.
- The service had risk assessments to support the safety of patients and staff. We observed three risk assessments in manual handling, slips, trips and falls. Assessments were completed at the time of assessment and electronically stored.

Radiographer staffing

- We found there were sufficient radiographers to maintain patient safety. The service manager followed Alliance's procedure 'staffing requirements in support of a safe scanning pathway.' Hours required to deliver the service were measured against the number of staff available.
- The service always had two radiographers on duty at any time for the period of 8am to 8pm. At the time of our inspection there were 16 radiographers employed, 13 of these were full time and three-part time. We were told the corporate provider was flexible and extra staffing could be requested where necessary. When a vacancy became available, the service advertised internally through the corporate provider network for one week then the post went to advert nationally.
- The service used agency and bank staff to cover maternity cover. At the time of inspection, the service reported 36 hours a week was covered by an agency radiographer between May and October 2018 and 24 hours a month were currently covered by two bank radiographers.

Medical staffing

- The service did not employ any medical staff, however visiting consultants were rostered to do sessions at the centre.

Good

Diagnostic imaging

- All cardiac perfusion magnetic resonance imaging scans were conducted with a doctor present.

Records

- There was an electronic patient record system at the centre. Initially referrals were received by fax, email or letter. These were then scanned into the electronic patient record so that information was readily available.
- We looked at five patient records and saw that all patient information and risk assessments had been fully completed.
- Patients completed a magnetic resonance imaging safety consent checklist form which recorded the patients' consent, this was then verbally checked by the radiographer. The document was also scanned onto the electronic system and kept with the patients' electronic records.
- The radiology information system and picture archiving and communication system was a secure system that could only be accessed by password. Each radiographer had their own password.
- Staff completing the scan updated the electronic records and entered the radiation dose alongside images. This was then submitted for reporting to the referring provider.

Medicines

- All medicines were kept in cupboards and were locked. However, we observed staff had left keys in the lock and left this area unattended.
- Staff had access to emergency drugs, these were stored appropriately on the emergency trolley. We saw that adrenaline, atropine, amiodarone and sodium bicarbonate were intact and in date. The log book was completed appropriately to reflect this.
- We checked disposable devices such as needles, syringes and dressings stored in lockable cupboards. We observed one box of surgical tape that had recently expired, dated September 2018. This was disposed of at the time of our inspection. All other items we checked were in date and fit for use.
- Patients requiring intravenous contrast medium were asked to complete contrast screening, consent and record form. The questionnaire identified patient allergens, those who have respiratory and renal function medication and those who may have contraindications to contrast medicines.
- All medicines and contrasts were supplied by the host hospital. All intravenous contrast for magnetic resonance imaging was delivered by a cardiologist, during all procedures the batch lot number and expiry dates were checked and recorded in the patients record.

Incidents

- All staff we spoke with were clear on the process for reporting incidents. Incident's relating to patient care were reported locally using the incident reporting system. Staff accessed the reporting system on the intranet.
- All incident reports were reviewed and investigated by the service manager and a copy was sent to the corporate quality team at the time of submitting the incident. We saw that action plans were put in place where required.
- The service reported 38 incidents between October 2017 and October 2018. We reviewed three incidents relating to patient safety. Documentation of the investigation showed the duty of candour was exercised and actions to ensure patient safety were recorded. The service manager kept comprehensive records of all incidents on the service computer which was accessible only by staff.
- The quality and risk team produced a corporate newsletter each month identifying key learning points from incidents, complaints and safeguarding reports. We reviewed May, October and November 2018 newsletters which summarised the issue and lessons learned. Staff found this helpful in identifying where things went wrong and where things could be improved. The service submitted incidents for inclusion in the quality newsletter.
- All incidents relating to estates and facilities of the building such as; broken windows or electrical faults for example, were reported using the acute hospital services incident reporting system. We heard an

example of a broken window that posed a potential risk reported by the service staff. Staff told us incidents were everyone's responsibility and would be reported regardless of where they were identified.

Safety Thermometer (or equivalent)

- The service collected data on the performance relating to scanning.This was collected at corporate level and reported monthly in a performance dashboard.
- The service reported no patient harm incidents in the period May to November 2018.

Are diagnostic imaging services effective?

We did not rate effective

Evidence-based care and treatment

- Guidance from the National Institute of Health and Care Excellence and Royal Colleges was disseminated to appropriate specialities and divisions. For example, we saw staff had read and signed metformin guidance, which was used for patients with abnormal renal functions.
- We found radiographers followed evidence based protocols for scanning of individual areas or parts of the body
- Managers updated staff when new guidelines were introduced, staff were expected to sign to confirm understanding and application. We saw this was followed by staff when the service introduced the 2017 radiation hazard awareness policy, this was signed by 22 members of staff.
- We saw a range of standard operating procedures for staff to follow. For example, the management of monitoring of radiation doses received by Alliance Medical Limited radiation workers was in place.

Nutrition and hydration

- Drinks machines, water fountains and snacks were available in the adjacent café area located in the host hospital.

Pain relief

- Staff tried to make patients as comfortable as possible during their time in the unit.
- Pain relief was not administered by the service.

Patient outcomes

- The service had a comprehensive audit programme, this included local, regional, modality specific and corporate audits. These were aligned to evidence based practice and national guidance where appropriate.
- The service regularly reviewed the effectiveness of care and treatment through local audits. For example, after an audit the service recognised patients with a heartbeat of 45 beats per minute undergoing a diagnostic scan had a better image. As a recommendation of this audit, patients were now given beta blockers if it was deemed safe.
- The service participated in the national dosimetry reporting process to ensure the service administered dose quantities in line with Schedule 4 of the Ionising Radiations Regulations 1999. The July to September 2018 reports showed that the service administered radiation in line with the regulation.

Competent staff

- Staff in the centre were appropriately trained to ensure they had the right skills and knowledge to deliver magnetic resonance imaging and computed tomography scans in line with Ionising Radiation (Medical Exposure) Regulations.
- Staff told us all new staff to the centre were given a tour of the premises on their first day. There was a checklist that staff completed before starting any activity in the centre. Orientation took place for bank staff as well, even if the staff member had worked at the department previously.
- Training needs were identified through observations, supervision, appraisals and discussions at team meetings. For example, radiographers scanning performance was monitored through audits and supervisory observations. Any concerns were discussed in a supportive manner to help radiographers to perform to the best to their ability.
- New staff undertook an induction with Alliance Medical Limited and one with the host hospital. This

was deemed best practice because of the close working relationship the centre and the hospital had. We spoke to one new member of staff who told us they had received effective support since joining. As well as training provided by the clinic, they could also access training at the host hospital.

- Staff we spoke with said they had an open discussion with the manager during their appraisal and identified any training needs they had. Appraisal rates were at 65% at the time of inspection. We raised the compliance rate with the registered manager who subsequently completed all appraisal. As of the 22 November 2018, all staff have had an appraisal.
- All training records of staff operating imaging equipment were kept electronically but the managers provided staff with training folders that held competency frameworks for sign off in them.
- We reviewed competency frameworks which included; contrast media pressure injector, radiographer led computed tomography coronary artery angiogram and practical safety. All 19 competency frameworks had clear documentation and evidence of observations and actions taken if any.
- Staff undertook competencies and assessments with the gradual reduction in supervision as they demonstrated they were able perform magnetic resonance imaging and computed tomography procedures in line with the legislation set out under Ionising Radiation (Medical Exposure) Regulations.

Multidisciplinary working

- The team at the centre worked well with their colleagues at the host hospital. This provided a continuous pathway for patients.
- We saw good interactions between radiographers and medical staff, during all magnetic resonance imaging procedures they talked to each other to ensure the patient received the best possible treatment.
- The service had developed joint clinical pathways with cardiac consultants in the acute hospital services. Pathways such as the significant pathology pathway supported staff in decision making and informed staff on appropriate referral pathways for review of assessments.

Seven-day services

- The service offered a seven-day service, opening Monday to Sunday between 8am to 8pm.
- The service offered appointments at weekends and during the evening to meet the needs of patients.

Health promotion

- Information leaflets in the waiting room were available for patients to read. Leaflets detailed information about the scan and what to expect during the procedure.
- We observed literature about a range of cardiac and other health related conditions such as diabetes and chest conditions in leaflet format. There was also a notice board with posters on health promotion activities and infection prevention messages.

Consent and Mental Capacity Act

- Staff had a good understanding of the rationale for gaining consent and ensuring patients had the capacity to consent. Patients were escorted to the preparation area where a comprehensive assessment was taken, this included checking they understood what they were consenting to.
- Due to the nature of the service, patients who lacked capacity were not seen at the centre.
- The patient completed and signed a declaration to state they understood the type of procedure they were attending for. There was also a section asking the patient if they consented to their images being used for training purposes. We observed verbal consent throughout the assessment such as staff requesting to take the patient's blood pressure or to insert a needle.

Are diagnostic imaging services caring?

Good

We rated it as **good.**

Compassionate care

- Staff demonstrated a kind and caring attitude to patients. We observed staff being polite and friendly.

Good

Diagnostic imaging

- Reception staff were often the first to speak with a patient and we saw evidence of staff being courteous.
- Staff introduced themselves and wore name badges saying 'Hello My Name Is' campaign. We saw staff explain their role and went on to fully describe what would happen next.
- There were dignity curtains around the preparation area which separated the patient from the general corridor. This meant patient's dignity was further protected and we observed curtains were kept closed throughout consultations.
- Patient satisfaction survey results showed that over 80% of patients would recommend the service to friends and family.

Emotional support

- Staff supported patients through their scans, ensuring they were well informed and knew what to expect.
- We observed radiographers providing ongoing reassurance throughout the scan, they updated the patient on how long they had been in the scanner and how long was left.

Understanding and involvement of patients and those close to them

- All patients we spoke with said they felt informed about the procedure and involved in decision making prior to being referred.
- The details of the scan, the precautions and what would happen was fully explained to patients and their relatives during appointments prior to the procedure. They also confirmed they had received written information detailing all the information they needed.

Are diagnostic imaging services responsive?

Good

We rated it as **good.**

Service delivery to meet the needs of local people

- The service was planned and designed to meet the needs of the patients requiring the service. We saw the service had expanded over the 10 years in response to the demand for a more comprehensive service. For example, opening times had been extended and more equipment had been purchased.
- The service provided evening appointments to accommodate the needs of patients who were unable to attend during the day.
- To meet the demand of patients across the city, the service utilised mobile scanning units. This meant patients could access the service in other areas.
- The service worked to complete all scans within six weeks of receiving the referral. We saw that staff date stamped referral letters to ensure they did not breach the six-week key performance indicator.
- Images from scans were uploaded onto a shared electronic system so they could be reviewed by the consultant radiologist and doctors. Routine reports were sent to the referrer.
- When performing cardiac scans, radiographers had access to a consultant radiologist on site for clinical advice and decision making. During out of hours, the service had access to the hospital cardiologist. They were easily accessible by telephone or pager and could be contacted 24 hours a day. All images were accessible using the picture archiving and communication system.

Meeting people's individual needs

- Patients were booked in at the reception area where reception staff carried out initial personal identity checks. Staff were informed of the patient's arrival and they were greeted in the waiting area.
- Hearing loops were available for patients with hearing difficulties.
- There was a large notice board in the patient waiting area with information in more than 50 languages on local interpreting services. There was a sentence in each of the languages with a contact number for various services. Staff told us they used professional

interpreters rather than relying on family members to interpret messages. This was to ensure information given to the patient was clear and mitigated the risk of any misunderstanding.

- Patients were given the option of a chaperone to join them at their appointments. Patients were asked prior to their appointment, by letter if they required a chaperone. There were signs clearly explaining the chaperone process in the patient waiting area and the patient changing area. Patients could request a chaperone to be present at any stage of their assessment and there was adequate staffing for patients to request specific gender of practitioner if required.
- The centre met the needs of patients who required wheelchair access. Access to the building and the clinical area was at street level which meant patients could enter the building without any issues. There was a lift suitable for wheelchairs, so that patients could visit the onsite café.
- The seating area was clean and comfortable with individual chairs around the central area. There was seating for approximately 14 people. The waiting area was also used for patients attending the mobile unit located outside the building. However, there was no overcrowding and we observed no more than nine patients in the waiting area at any one time.
- There were two offices at the rear of the reception which staff told us could be used for confidential conversations.
- The service provided emergency cardiac scans for the local trust rapid access chest pain clinics. Patients were reviewed by a specialist cardiologist at the clinic and arrangements were made to access the service for an immediate scan. This meant patients had access to immediate diagnostic tests to support clinical decision making.
- There was a system in place for patients who were anxious; staff individually assessed patients with additional needs so that they could make reasonable adjustments for them.

Access at the right time

- Patients received access to the service and test results in a timely way. The service managed this by performing all examinations in order of clinical priority.
- The clinic offered a seven-day service so that patients could access care and treatment at a time that suited them. For example, we saw that the service offered patients a cancelation service, where patients were given the option to join a list to be contacted in the event of a cancelled appointment.
- Referrals to the service were received by fax, letter or email, these were passed to the service administration team to set up an electronic patient record. This was date stamped with the received and six-week breach date to ensure appointments were made within this time.
- All referrals were initially triaged by a consultant radiologist. Risks and contraindications to having the tests were considered. The benefits were measured against the risks for each patient, consultant expertise and an awareness of the patient's condition. Therapeutic guidelines such as blood results, medical history and patient's mental health were also considered. Once the patient was deemed suitable for the scan, a contact letter was sent offering them an appointment.
- Appointments and reminders for computed tomography scans were sent out via the short messaging service, for those patients who opted in to the method of communication.
- We were told the average length of the initial appointment was one hour to complete a comprehensive assessment. Patients with more complex needs; for example, those identified by the consultant during triage as requiring further assessment, were allocated longer.
- However, patients and relatives were not kept informed of any delays. We noted that the service was running 45 minutes late and two relatives and one patient told us they had been waiting for over an hour and had not been informed of any delays.

Learning from complaints and concerns

- The service had a formal complaints procedure which guided patients through several steps from raising a

complaint to escalating it further if dissatisfied with the response. Complaints leaflets 'how to complain' was available in the waiting area. Information on how to make a complaint, raise a concern or give feedback regarding the service was all detailed in the leaflet.

- The service had a clear complaints process and a complaint handling procedure and policy which staff followed.
- Staff reported all complaints as incidents on the service electronic reporting system to ensure the service manager and head office had sight of them. This meant any lessons learned from complaints were picked up at a local level during team meetings and corporately through the monthly newsletter.
- The service aimed to respond to all complaints within 20 working days. At the time of our inspection the service was within this target. They had received three complaints during the period May and November 2018 and currently had no complaints opened.
- We reviewed two complaints from patients that had followed the formal complaint process. The service manager reviewed the complaints and discussed these with the relevant staff and patients involved.
- We saw the service made improvements from information they had received from complaints. For example, the centre had changed the way they contacted MRI patients regarding appointments to prevent the wrong information being sent out via the short messaging service.

Are diagnostic imaging services well-led?

Good

We rated it as **good**

Leadership

- The centre was led by the service manager who was an experienced senior radiographer. The service manager had the right skills and abilities to run the service providing high-quality sustainable care. Leadership across the service was positive, visible and proactive; this included the office manager and clinical team.
- We saw the registered manager was well supported and empowered by Alliance Medical Limited to develop and make changes to the service if it was necessary and within their scope of practice.
- All staff we spoke with told us the managers were visible and approachable, they encouraged an open-door policy that promoted a close working relationship.

Vision and strategy

- The service vision was aligned to both Alliance Medical Limited strategy and the local plans of the host hospital. Staff we spoke with told us of the service values; collaboration, excellence, efficiency and learning.
- Staff explained how they implemented the corporate vision and values in practice and how they used them towards delivering person centred patient care.
- The service manager told us the team worked towards an informal local vision which was to develop the service and their strategy to become a centre of excellence in teaching.
- We were told that whilst the service was a corporate provider, more than 90% of service users were referrals from the NHS. The service planned long term partnerships with NHS providers and liaised with the trust to develop services that meet the needs of the community.

Culture

- The culture in the centre was open and transparent. Staff we spoke with said they felt valued and enjoyed working at the centre.
- We saw there was good communication from the corporate team, staff felt informed about by various issues that occurred across other sites. This information was well communicated in newsletters, team meetings and emails.
- The centre was staffed seven days a week, staff supported each other to cover the rota across weekends and late evenings. All staff we spoke with said they were well supported and felt they were valued by the organisation.

- Staff felt they could raise concerns if they needed to and these would be addressed appropriately.
- We observed staff working together, sharing information and knowledge.Staff told us they could approach any of their colleagues for professional advice and they were not made to feel inadequate or less knowledgeable. Newer members of staff told us they had a range of people they could speak with for support. Staff in senior roles said they would always support staff where they could.

Governance

- The service reported up to the corporate integrated governance and risk board to provide assurance that there were appropriate governance and risk processes to ensure patient safety.
- Integrated corporate governance and risk board meetings were undertaken every three months and minutes were recorded from these meetings. Minutes showed discussions regarding incidents, complaints, policies, performance and updates from sub committees with actions allocated to individuals with appropriate timescales.
- There was a local governance process in place, this involved the registered manager attending weekly trust directorate meetings to discuss local performance such as waiting times.
- The overall performance of the centre was overseen at a corporate level. The service had a close relationship with the host hospital, which allowed for some cross over in governance processes such as incident reporting, safeguarding and complaints.

Managing risks, issues and performance

- The centre's performance was monitored on a local and corporate level, reports were produced which enabled overall comparisons and benchmarking against other services. The service monitored a range of performance indicators such as turnaround times, 'patient engagement scores, incidents, complaints and mandatory training levels.
- The service had safety systems to prevent disruption to services in the event of power failures. There was a backup generator system that supported the scanning machine. This meant the service could continue scanning on this machine in the event of a fault with the main power to the hospital.
- The service had a lone working policy which stipulated the contractual agreements of the host hospital that prevented staff performing scans alone. We were told this was strictly adhered to and assured that staff were supported in lone working procedures.
- All incident reports were reviewed by the committee as well as the corporate quality team. Actions from each incident relevant to the service were disseminated to the service managers and plans put in place to help mitigate future risks.
- However, although there was a system in place to ensure the service manager was aware of risks, it was dependent on what staff reported on the incident reporting system and did not proactively identify risk. Where risks had been identified, they were addressed locally by the manager in the first instance and a report containing risks, incidents and service performance which was sent to the clinical governance committee each month.
- However, we found that the service did not hold its own risk register, which included their high-level risks for the centre. This meant there was no evidence that risks were mitigated, monitored and reviewed regularly.
- Additionally, there was no system in place that monitored individual non- clinical risk assessments locally. Whilst on inspection we found they were all overdue for review. We raised this with the registered manager who acknowledged our concerns and informed us they would be renewed.

Managing information

- Staff had unique profiles to access both the Alliance and host hospital's computer systems.
- There were adequate numbers of computers in the centre for administration staff, which supported their daily functions.
- The electronic patient records could only be accessed by authorised individuals, this prevented unauthorised staff accessing personal data.

Good

Diagnostic imaging

- Images from scans could be reviewed remotely by doctors so that interpretation was timely.
- The service had three software licences for reviewing images. This meant that images could be reported quicker.

Engagement

- Patient satisfaction survey results showed that patients were satisfied with the facilities and care they received.
- The service held a staff meeting each month where service performance and areas of improvement were discussed. We reviewed minutes from the May, September and October 2018 meetings which detailed discussions about compliments, staffing policy sign off, lessons learned from incidents, safeguarding and publication of the months 'Risky Business' newsletter.
- The service manager met with the service leads if there were issues but no formal meetings were in place. This was a small service, so all staff attended the monthly staff meetings.
- The service met with commissioners to address contract and service reviews. Feedback was given to all stakeholders about how the service was performing in line with the key performance indicators.

Learning, continuous improvement and innovation

- All staff we spoke with could provide examples of improvements that the service had implemented or were looking at implementing based on patient feedback, incidents and staff suggestions. For example, the centre was looking at becoming a training hub.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure the service manager has sight of all safeguard referrals.
- The provider should ensure that patients and their relatives are informed of waiting time delays.
- The provider should ensure that there is a local risk register in place which contains all local risks alongside details of mitigation and accountability.
- The provider should ensure all non-clinical risk assessments are up to date and reviewed in a timely way.

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