Mediscan Diagnostic Services Ltd

Mediscan Diagnostic Services Limited

Inspection report

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

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Overall summary

Our rating of this location stayed the same. We rated it as inadequate because:

- The service did not always provide mandatory training in key skills to all staff or make sure everyone completed it.
- The service did not recognise and respond appropriately to abuse or discriminatory practice. There was insufficient attention to safeguarding children and adults. Staff did not always have the correct level of safeguarding training.
- The service did not recognise and report incidents. Managers did not manage patient safety well and share lessons learnt with the whole team.
- The service did not clinically triage each patient referral.
- The service did not store records safely or securely.
- The service did not manage patient safety incidents well. Staff did not recognise and report incidents. Managers did not investigate incidents and did not share lessons with the team.
- Leaders did not have the skills and abilities to run the service and did not understand and manage the priorities and issues the service faced. Policies and procedures were not reflective of the services provided.
- The service did not always have an open culture and staff did not always feel respected, supported, and valued.
- There were poor governance processes throughout the service and with partner organisations, and so staff at all levels could not be clear about their roles and accountabilities. There was a lack of robust processes to ensure safe, high quality care was delivered.
- There were poor risk management processes in place which did not allow for identification and escalation of relevant risks and issues or identify actions to reduce their impact.

However:

- Staff member onsite said they felt respected, supported, and valued.
- Portable Appliance Testing (PAT) of electrical equipment had been completed and was in date.
- The Infection Control Prevention policy had been updated.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic and screening services	Inadequate 	

Summary of findings

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Summary of this inspection

Background to Mediscan Diagnostic Services Limited

Mediscan Diagnostic Services Limited is operated by Mediscan Diagnostics Services Ltd. The location has been registered to deliver diagnostic and screening procedure services since June 2013. The location, which is also the provider's head office, is the call and administrative and managerial centre from which the provider's national diagnostic imaging services are managed. The provider delivers a range of services including ultrasound scanning, endoscopy procedures including sigmoidoscopy, colonoscopy and gastroscopy, some audiology services and physiotherapy which are regulated by CQC. The location does not host any clinics on site, the clinics are provided in GP surgeries, private clinic buildings, hospitals, and a mobile endoscopy unit. Mediscan Diagnostics services ran between 99 and 130 satellite locations from this location. We last inspected the service in April 2021 and rated it as Inadequate. In the last report, the service breached regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were:

- Regulation 12: Safe care and treatment
- Regulation 15: Premises and equipment
- Regulation 17: Good governance
- Regulation 18: Staffing

How we carried out this inspection

We carried out an unannounced focused inspection of the diagnostic and screening core service on the 10 to 11 June 2021. During our inspection we visited the main location and one other satellite location based in Oldham, because we received information that gave us concerns about the safety and quality of the services. We looked at parts of the safe, and well led domains. We rated the service because we took enforcement action which included the use of our urgent enforcement powers, where we placed conditions on the locations registration in relation to infection prevention and control, equipment maintenance, medicines management, staff competencies, leadership and governance and risk management systems. We interviewed key members of staff including a healthcare assistant, sonographer, and the senior management team who were responsible for leadership and oversight of the service. We spoke with 7 members of staff in total.

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

Areas for improvement

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

Action the service MUST take to improve:

- The service must ensure that all staff are compliant with mandatory training. (Regulation 12)
- The service must ensure that persons providing care or treatment to service users have the qualifications, competence, skills, and experience to do so safely. (Regulation 12)

Summary of this inspection

- The provider must ensure that systems and processes operate effectively to assess the risk of, and prevent, detect, and control the spread of, infections, including those that are health care associated. (Regulation 12)
- The provider must ensure that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way. They must ensure that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way. (Regulation 12)
- The provider must ensure that all premises and equipment used by the service provider are clean, suitable for the purpose for which they are being used, properly used, and properly maintained. The provider must in relation to such premises and equipment, maintain records and standards of hygiene appropriate for the purposes for which they are being used. (Regulation 15)
- The service must have robust systems and processes established and operated effectively to prevent abuse of service users. (Regulation 13).
- The service must have systems and processes to effectively investigate, immediately upon becoming aware of, any allegation or evidence of such abuse. (Regulation 13).
- The service must ensure that staff are aware how to raise concerns if not resolved by a line manager e.g., by using the whistleblowing policy. (Regulation 13)
- The service must ensure that incidents are properly reported and investigated, and that learning is embedded to prevent similar incidents occurring in the future. (Regulation 12)
- The service must ensure that all staff and volunteers receive appropriate safeguarding adults and children training, at the correct level, and that this training meets intercollegiate guidance. (Regulation 13)
- The service must have up to date processes to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. (Regulation 17)
- The service must ensure that records are maintained securely. (Regulation 17)
- The service should provide appropriate support, training, professional development, supervision, and appraisal for staff as is necessary to enable them to carry out duties they are employed to perform. (Regulation 18)
- The service must appropriately recruit staff and keep good recruitment records, so it is assured that there are sufficiently suitably qualified, competent and experienced staff on duty to meet the needs of patients. (Regulation 18)
- The provider must ensure that where staff, including agency staff, are health care professionals or other professionals registered with a health care or social care regulator, records are maintained to provide evidence that they continue to meet the professional standards which are a condition of their ability to practise or a requirement of their role. (Regulation 18)

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic and screening services	Inadequate	Not inspected	Not inspected	Not inspected	Inadequate	Inadequate
Overall	Inadequate	Not inspected	Not inspected	Not inspected	Inadequate	Inadequate

Inadequate

Diagnostic and screening services

Safe	Inadequate
Well-led	Inadequate

Are Diagnostic and screening services safe?

Inadequate

Our rating of safe stayed the same. We rated it as inadequate.

Mandatory training

The service did not always provide mandatory training in key skills to all staff or make sure everyone completed it. Not all staff completed all modules relevant to their role.

Managers did not monitor mandatory training and did not always alert staff when they needed to update their training.

Staff told us they completed online training on the electronic training system. We requested mandatory training compliance data, but no evidence was provided.

During the inspection, we did not see up to date mandatory records for all staff. Nine staff files were reviewed and none of them showed staff were up to date with mandatory training.

Staff told us that the team of eight infection prevention and control (IPC) staff comprised of a lead nurse and seven members of the marketing team who received four to five hours basic IPC training. Patients may be exposed to harm if staff do not have the necessary experience, competencies, and training to manage IPC and have oversight over IPC across the locations and satellites around the country.

Safeguarding

Staff did not recognise or respond appropriately to abuse or discriminatory practice. There was insufficient attention to safeguarding children and adults. Staff did not always have the correct level of safeguarding training.

Staff had not all received training specific for their role on how to recognise and report abuse.

Inspectors reviewed nine staff files across the Mediscan provider for both locations. Five files showed staff had received no safeguarding training. The other four files showed staff were not up to date as per national safeguarding training guidance.

The registered manager told us that clinical staff were trained to Level 3 safeguarding adults and children's training. However, staff files we reviewed showed two staff members who were required to have level 3 safeguarding training, only had level 1 training which was out of date. One clinical staff member had cared for patients for over three months before they received any safeguarding training.

Clinical staff knowledge of safeguarding 'red flags' was not clear. When we spoke to staff, they were not familiar with terms such as FGM (Female Genital Mutilation) or CSE (Child Sexual Exploitation). If staff had received safeguarding training, they should be aware of such terminology, how they are used, and what to do if they had suspicions or concerns relating to patients. Staff said they did not have regular safeguarding supervision.

Staff were not aware of what to report as a safeguarding referral and who to inform if they had concerns.

Staff told us that a safeguarding referral should be made for patients "that had a low pulse" and when we asked them to expand on this, they further stated "taking care of the patient". One staff member told us safeguarding was something related to fire safety. Another staff member thought it meant looking after someone's child while the parent had a scan.

No safeguarding referrals had been made or received from Mediscan Diagnostic Services Limited since 2019. This did not give us assurance that staff could recognise potential safeguarding situations.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff did not use equipment and control measures to protect patients, themselves, and others from infection. They did not keep equipment and the premises visibly clean.

The infection prevention policy and control (IPC) policy had been improved since the last inspection however, we could not be assured it was being put into practice and neither were we assured there were measures in place to ensure it was being adhered to.

All areas were not cleaned effectively or well-maintained.

Cleaning records were not up-to-date and did not demonstrate that all areas were cleaned regularly.

Daily cleaning logs contained gaps. There was no assurance that rooms had been thoroughly cleaned. Cleaning logs were confusing and unclear, and therefore there was a risk that staff could not ascertain which areas were clean and which were not. This was a risk to patients because there was an increased risk of infection.

We spoke with staff at the location who told us they had training on infection control. However, the service could not provide evidence of infection control training for staff. Staff were unable to demonstrate how to access infection control guidance via a web system as they did not have suitable access.

IPC audits were completed by an external company. We could not be assured that these were regularly completed as up to date audits were not provided. The registered manager told us that the cleaning company was CQC registered, but the CQC does not register cleaning companies.

The IPC audit was signed off as completed on post inspection action plan. The registered manager told us the IPC team had been to all satellite clinics. However, the spread sheet supplied to us showed IPC audits had been carried out at only 17 out of 99 (17%) satellite clinics.

IPC audit forms were very basic and lacked detail, there was no robust process for measuring improvements through audit.

The IPC policy did not state how frequently patient curtains should be changed. Staff did not always clean equipment after patient use and did not use labels to show when equipment was last cleaned.

Inspectors saw an ultrasound machine that was not hygienically clean and saw also that used disposable gloves were left in the probe holders.

Assessing and responding to patient risk

Staff did not clinically triage each patient referral. Standard practise would be that any referral made for ultrasound Imaging would be triaged by a registered clinician to ensure the scan had been appropriately prioritised.

There was no evidence of a formal written down process to ensure referrals were triaged by a clinician. Senior managers told us that they completed triage of referrals, however there was no written evidence of this. There would also be a significant number of referrals for the satellite services as there are no localised management teams in other areas. This puts patients at risk of harm because their referral may not be correctly prioritised.

Records

Records were not stored securely.

At this location we found a private and confidential letter that contained patient details on a desk in the office. This meant that this posed a risk to a breach of patient confidentiality.

Incidents

The service did not manage patient safety incidents well. Staff did not recognise and report incidents and near misses. Managers did not investigate incidents and did not share lessons learned with the whole team and the wider service.

Staff did not always report incidents and incidence reporting rates were very poor. Managers did not share learning with their staff after incidents.

We were told by the operations manager there had been no serious incidents in the last two years. We saw two incident forms about ultrasound scanner machines. Neither of the forms had an incident number on which would identify the incident. There was no assurance that other incident or serious incidents had not occurred.

One incident report related to the data on the scanning machine from 12 October 2020 to 19 October 2020 indicating it was corrupted. There was no evidence that this was followed up. This posed a potential risk to patients who received scans during that period as their scans might have been inaccurate.

There was no evidence that incidents were followed up and investigated. We were not assured that any learning was shared following investigation. This poses a risk of harm to patients if incidents are not investigated properly, so that issues identified can be fed back to staff to prevent them recurring.

Are Diagnostic and screening services well-led?

Inadequate

Diagnostic and screening services

Inadequate

Our rating of well-led stayed the same. We rated it as inadequate.

Leadership

Leaders did not have the skills and abilities to run the service. They did not understand and manage the priorities and issues the service faced. They were not visible or approachable in the service for staff. They did not support staff to develop their skills and take on more senior roles.

The leadership team consisted of the chief executive to whom three managers reported to. These managers all had multiple roles. We found that they did not always have the skills and ability to perform all elements within their role. For example, one manager had recently inherited the complaints' role because of other staff leaving. However, the manager was unable to describe key elements of the providers complaints policy.

The leadership team did not always understand and manage the priorities and issues the service faced. At our last inspection in April 2021, we highlighted issues with the endoscopy service. However, staff were unable to explain to us and evidence what improvements had been made to that service, to address the issues we had raised.

We asked for evidence of all leader's competencies and skills, but this was not provided.

When we spoke with staff it was clear that there was no succession or development plan in place to support senior staff in securing development of their skills or to take on more senior roles.

When we asked the chief executive about allegations that had been raised by the clinical commissioning group (CCG), but they denied awareness. However, the CCG had written to the chief executive in recent weeks before our inspection. We were not assured about the transparency of leaders.

Two appraisals of staff members was undertaken by the chief executive on 10 May 2021.The staff record indicates there had been two complaints received on 12 August 2020 about rudeness and alleged negligence related to a staff member. There was no evidence of any action taken following these complaints and allegations or that this was discussed during the appraisal.

Culture

Staff did not always feel respected, supported, and valued. The service did not always have an open culture where patients, their families and staff could raise concerns without fear.

We were not satisfied that staff were respected, supported, and valued. For example, several allegations of bullying and harassment had been made; when we asked the leaders, they told us they were not aware.

The service had a whistleblowing policy, and this included a section on a freedom to speak up guardian. Staff told us they would report concerns to their managers but did not know how else they could raise a concern. Staff told us they felt "whistleblowing was a consequence of not doing their job correctly". We could not be assured that staff understood whistleblowing was about disclosing wrongdoing without consequences.

Inadequate

Diagnostic and screening services

After the inspection we received a significant number of whistleblowing concerns in relation to bullying and harassment.

The provider had no system or process in place to support staff being respected, supported, and valued. There were no 'thank you' or other staff recognition awards.

The equality and diversity of staff and volunteers was not always respected. None of the nine staff files contained information about their protected characteristics.

Governance

Leaders did not operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were not clear about their roles and accountabilities and they did not have regular opportunities to meet, discuss and learn from the performance of the service.

At the last inspection we said that leaders did not operate effective governance processes; at this inspection, we saw the position had stayed the same. Senior staff told us the service held monthly clinical governance meetings. We asked for minutes of the meetings and only two months were available. We reviewed the minutes dated April 2021 and May 2021The meeting minutes were sparse and lacked detail. We were not confident that actions marked as complete in the meeting minutes were sufficiently evidenced. For example: the clinical governance meeting minutes for May 2021 noted that hand hygiene audits and staff observations of hand hygiene were completed. However, there was no evidence in the minutes to show how many staff had been observed or what the compliance rates for hand hygiene were.

Leaders told us that they had an agreement with the local university for students to attend to gain competencies in ultrasound scanning. There was no evidence of a service level agreement, contracts, checks, or references, the chief executive told us it was an informal arrangement. This meant there were potential risks to patients due to the lack of checks.

There was limited assurance that recruitment processes were being followed. There was a recruitment policy in place for the service, which detailed the required recruitment checks. However, the policy did not cover the overseas recruitment programme or the requirements for agency staff. Our review of the staff files showed there was an inconsistent approach to the information held which was not reflective of the requirements set out in the recruitment policy. For example, we reviewed nine staff files and we found as follows; two staff members did not have current DBS (Disclosure and Barring Service) certificates on their file and one of them had police cautions, but there was no evidence before or after employing that staff member that risk assessments had been carried out to determine what (if any) measures should be in place considering the cautions. Another staff member's malpractice insurance had expired and another staff file United Kingdom (UK) residency permit had expired on 13 August 2019.

There was not a robust induction process for staff, for example, the chief executive told us that he inducted new staff by them shadowing him for a week or two. There was no written down process, or 'sign off' process to indicate when staff were deemed competent. We could not be assured that the any process and competency checks were being followed.

We found policies and procedures were not fully reflective of the service provided. For instance, we found the medication policy referred to a lead pharmacist, but the service did not employ a lead pharmacist.

There was no oversight of training competencies for all staff. On 10 June we requested to see staff competencies for the sonographers, IPC team and health care assistants (HCAs) Senior leaders did not provide evidence of these.

Whilst staff with a leadership role met monthly, it is clear from our review of the monthly minutes this did not provide an opportunity to discuss and learn from the performance of the service. There was no evidence of multidisciplinary team meetings when things went wrong. We could not be assured that learning was shared. The Royal College of Radiologists guidance states that clinicians should undertake learning from discrepancy meetings (LDM) to improve their own practise and quality of scans. The LDM allows clinical staff to discuss, reflect on the quality of scans and protect patients from potential harm. The service was not following this guidance. There was no evidence that clinical staff were undertaking reflective practise. Therefore, we could not be assured that the service protected patients from harm.

Managers could not demonstrate oversight of the complaints policy. Managers were unclear about targets in place to respond to complaints; they told us complaints need to be responded to within 20 days, but the policy stated 25 days. Complaints feedback to senior colleagues contained details on themes and trends, but not whether targets were met.

There was not a robust system in place for the monitoring and oversight of equipment maintenance.

All the staff contracts we saw had a clause in their contract that if there were any losses caused by staff negligence, conduct, recklessness, or any damages paid out on their behalf that the company had a right to deduct their pay.

We heard a staff member referred to by the chief executive another senior manager as 'doctor'. When we met that staff member, they had a badge on with their name and the title of doctor. This badge was provided by the service. We also saw four IPC audit forms with the title of 'Dr' written on them, even though the service did not employ doctors. Patient complaints we saw referred to 'the Doctor'. It is a criminal offense under the Medical Act 1983 for persons to use the title of doctor, when they are not in fact a doctor. We were not assured that the leaders had oversight to prevent this from happening.

On the 10 June we asked the leadership team about the action plan and any improvements made in practice. They only referred to the IPC and appraisal processes. We were not assured that they had oversight of the issues that we found at last inspection such as effective processes for monitoring mandatory training and safe use of equipment.

Managing risk issues and performance

Leaders and teams did not always use systems to manage performance effectively. They did not have effective risk management processes in place to identify and escalate relevant risks and issues or identified actions to reduce their impact.

The key performance indicator report monitored local quality requirements for each Clinical Commissioning Group. The service did not monitor key performance indicators at 'provider-wide' level. Staff told us that they had created a new KPI (Key Performance Indicators) dashboard that monitored quarterly evidence; however, we requested this, but they did not provide any evidence.

The monitoring processes in place were not effective in identifying areas of risk, concern, or poor performance that we identified during the inspection. For example, the audits for infection prevention and control had not been effective in identifying non-compliance with the policy and environmental issues that we observed.

Inadequate

Diagnostic and screening services

At the last inspection in April 2021, we had significant concerns about risk management. When we carried out this inspection in June 2021 senior management did not provide any evidence to demonstrate any changes or improvements for risk management. There was no evidence of a risk register, and they could not provide detail of key risks, and, or the mitigation and controls established to safely manage organisational risk. Managers told us the risk register was reviewed annually, we requested this, but no evidence was provided.