Baby Ultrasound Clinic Limited

Baby Ultrasound Clinic Limited

Inspection report

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Date of inspection visit: 07 June 2022 and 25 June 2022
Date of publication: 01/09/2022

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

Summary of findings

Overall summary

This was a focused, unannounced inspection in response to specific areas of concern, we did not rate this service as we only inspected key lines of enquiry within the safe and well-led domains. The service had not been inspected or rated previously.

- Not all staff providing care or treatment to service users had the qualifications, competence, skills and experience to do so safely as staff had not received all relevant training. The service did not keep comprehensive mandatory training records and ensure all staff had completed the relevant training.
- The service did not ensure that staff had the appropriate safeguarding training at all levels. We could not be assured that staff would be able to identify safeguarding concerns and report them appropriately.
- The service did not always ensure the safety of their premises and equipment within it.
- The service did not have effective systems to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity.
- Records relating to the care and treatment of each person using the service were not always fit for purpose in particular relating to consent.
- Staff did not always recognise and report incidents and near misses.
- The service did not maintain secure records in relation to persons employed in the carrying on of the regulated activities regarding their competency and suitability to perform their roles.
- The manager did not always understand and manage the priorities and issues the service faced.
- The provider did not have plans in place to cope with unexpected events.
- Leaders did not operate effective governance processes throughout the service. They did not use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues nor take action to reduce their impact.
- The service did not ensure appropriate COVID screening was completed for women and visitors.

However:

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

Following our onsite inspection, we served the provider with a Warning Notice under Section 29 of the Health and Social Care Act 2008. The warning notice told the service that they needed to make significant improvements in their governance processes to ensure the quality and safety of services provided.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic and screening services	Inspected but not rated	This was a focused, unannounced inspection in response to specific areas of concern, we did not rate this service as we only inspected key lines of enquiry within the safe and well-led domains. The service had not been inspected or rated previously. • Not all staff providing care or treatment to service users had the qualifications, competence, skills and experience to do so safely as staff had not received all relevant training. The service did not keep comprehensive mandatory training records and ensure all staff had completed the relevant training. • The service did not ensure that staff had the appropriate safeguarding training at all levels. We could not be assured that staff would be able to identify safeguarding concerns and report them appropriately. • The service did not always ensure the safety of their premises and equipment within it. • The service did not have effective systems to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. • Records relating to the care and treatment of each person using the service were not always fit for purpose in particular relating to consent. • Staff did not always recognise and report incidents and near misses. • The service did not maintain secure records in relation to persons employed in the carrying on of the regulated activities regarding their competency and suitability to perform their roles. • The manager did not always understand and manage the priorities and issues the service faced. • The provider did not have plans in place to cope with unexpected events.

Summary of findings

- Leaders did not operate effective governance processes throughout the service. They did not use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues nor take action to reduce their impact.
- The service did not ensure appropriate COVID screening was completed for women and visitors.

However:

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

Summary of findings

Contents

Summary of this inspection

Background to Baby Ultrasound Clinic Limited

Baby Ultrasound Clinic is privately operated by Baby Ultrasound Clinic Limited. They offer diagnostic scans from 7 weeks to term. They provide pregnancy confirmation scans and gender scans from 16 weeks. They provide 2d/3d/4d baby scans, with an option of HD live, to women over the age of 18 years.

The service registered with the Care Quality Commission in 2015 and has had the same registered manager in place since then. The service registered location is in Bolton and at the time of the inspection they had an additional five satellite clinics in Blackpool, Stockport, Chester, Macclesfield and Huddersfield.

The location is registered to provide the following regulated activities, diagnostic and screening procedures.

The service was last inspected in January 2019 and was rated requires improvement overall, with safe and well led being rated as requires improvement.

How we carried out this inspection

We inspected this service using our focused methodology. We carried out an unannounced visit to the registered location in Bolton on 7 June 2022 and the satellite clinic in Blackpool on 25 June 2022 in line with when the regulated activity was being delivered.

This was an unannounced inspection as a response to concerns raised, the inspection team was made up of two CQC inspectors and an inspection manager offsite. Overall oversight of the inspection was provided by the head of hospital inspection.

We reviewed 19 patient records from across the six satellite clinics and five staff records.

During our visit we spoke with five members of staff including the clinic manager, sonographer and two receptionists. We observed four ultrasound scan procedures with consent. We reviewed 19 patient records from across the six satellite clinics and five staff records. We reviewed a range of policies, procedures and other documents relating to the running of the service including audits, consent, referral, and scan reports.

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

Areas for improvement

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

Action the service MUST take to improve:

Summary of this inspection

- The service must ensure that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. In particular relation to all staff having the relevant accreditations and qualifications and that training meets the requirements including training in Basic Life Support in line with the service' Deteriorating Patient Policy. Regulation 12(2)(c)
- The service must ensure the safety of their premises and equipment within it. They must have processes in place to ensure that all items subject to the Control of Substances Hazardous to Health (COSHH) are stored securely. Regulation 12(2)(d)
- The service must ensure that they assess the risk of, prevent, detect and control the spread of infections. In particular around appropriate cleaning of scanning beds and cushions; the safe use of ultrasound gel and the management and safe disposal of clinical waste. Regulation 12 (2)(h)
- The service must ensure that they have, and implement, robust procedures and processes that make sure that people are protected. Safeguarding must have the right level of scrutiny and oversight, with overall responsibility held at board level or equivalent. The Registered Manager must have the relevant level of training for Safeguarding Vulnerable Adults and Safeguarding Children and Young Adults. Regulation 13(1)
- The service must ensure all staff have the relevant training for Safeguarding Vulnerable Adults and Safeguarding Children and Young Adults, including at induction and updated at appropriate intervals. Regulation 13(2)
- The service must have effective systems to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. In particular, they must ensure that there is a scheme of delegation in place when the Registered Manager is unavailable. They must also ensure they have robust processes in place for the reporting, management of and learning from incidents. Regulation 17(2)(a)
- The service must ensure that records relating to the care and treatment of each person using the service must be kept and be fit for purpose. Women's records should also be stored safely. Regulation 17(2)(c)
- The service must maintain secure records in relation to persons employed in the carrying on of the regulated activities regarding their competency and suitability to perform their roles. Regulation 17(1)(2)

Action the service SHOULD take to improve:

- The service should ensure appropriate COVID screening is completed for women and visitors.
- The service should ensure that staff attend team meetings and when unable to that the record of the meeting is shared.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic and screening services	Inspected but not rated	Not inspected	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated
Overall	Inspected but not rated	Not inspected	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated

Inspected but not rated

Diagnostic and screening services

Safe	Inspected but not rated
Well-led	Inspected but not rated

Are Diagnostic and screening services safe?

Inspected but not rated

We have not rated safe as we did not inspect all the elements.

Mandatory training

The service provided some mandatory training in key skills to all staff. However, they did not ensure staff completed it consistently. The service did not keep complete records of mandatory training.

The service did not always ensure staff received mandatory training. Records were not complete and did not demonstrate staff compliance. The registered manager did not have immediate access to staff training data. The registered manager told us that training records were held at her home address. The registered manager told us that mandatory training rates were 100% compliant. However, evidence provided did not support this. For example, in relation to fire safety and confidentiality. Relevant staff received training in hand hygiene and challenging behaviour. However, not all staff had completed this training. Staff did not have Basic Life Support (BLS) training, this was listed in the Deteriorating Patient Policy as a requirement but was not adhered to.

The mandatory training was designed to meet the needs of services users and staff. The registered manager was in the process of arranging additional courses in Conflict Resolution, Duty of Candour and Chaperone training.

Safeguarding

Not all staff understood how to protect women from abuse. Staff had received training on how to recognise and report abuse. However, it was unclear whether this was appropriate and sufficient for their roles.

The Registered manager reported that all staff received Level 3 Safeguarding Children and Young Adults Training and Level 3 Safeguarding Vulnerable Adults. We did not see evidence of this training being completed. All staff had training in Safeguarding Children and Safeguarding Vulnerable Adults. However, the records provided did not clearly indicate whether this training was completed to an appropriate level.

The registered manager was the designated safeguarding lead. The registered manager reported to have completed Level 4 Safeguarding Children and Young Adults, we saw evidence of Level 3 but not Level 4.

Staff demonstrated some understanding on how to identify adults and children at risk of, or suffering, significant harm. Staff reported they covered female genital mutilation (FGM) in their safeguarding training. Staff understood their responsibilities and how to escalate concerns if they identified a woman who had undergone FGM.

The Bolton location displayed posters and guidance around safeguarding and abuse. The Blackpool site had guidance on reporting children safeguarding concerns in the staff shared areas.

The service had a safeguarding policy in place which outlined the responsibilities of the safeguarding lead and how to make referrals to the local authority. Staff were not required to make referrals directly. Where concerns were identified the policy required them to raise this with the registered manager. Staff demonstrated an understanding of this process.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. The provider kept equipment and the premises visibly clean.

Clinical areas at both Bolton and Blackpool were clean and had suitable furnishings and were well-maintained. The waiting area furniture had suitable material allowing easy cleaning. The service had adequate supplies of appropriate cleaning materials.

Cleaning records at both sites were up-to-date and demonstrated all areas were cleaned regularly. We observed staff regularly cleaning during the inspection. We saw one example of a cleaning audit being completed for the Bolton site. The provider had only recently moved into new premises at the Blackpool site and had not completed a cleaning audit at the time we inspected.

Staff didn't always follow infection control principles including the use of personal protective equipment (PPE). The policy stated staff should be wearing mask, gloves and aprons. Staff were not wearing aprons.

Visitors were not always asked to sanitise their hands and wear a mask when attending scans in line with the service's policy. Not all environmental risk assessments included the PPE requirements. Staff reported the PPE requirements had changed however this was not reflected in the relevant policy documents and environmental risk assessments. We observed no COVID-19 screening questions or temperature checks being completed. PPE was not stocked on site. We received conflicting information regarding the delivery and storage of PPE to the Bolton and Blackpool sites. The registered manager told us staff carried PPE with them when moving between clinics.

Staff did not always adhere to the Code of Practice on the prevention and control of infections under section 21 of the Health and Social Care Act 2008. We found that they were refilling a small bottle of ultrasound gel from a larger bottle stored in the scanning suite. At Bolton the larger bottle had the expiry date noted. The smaller bottles had different expiry dates that had been handwritten. We found the same at the Blackpool clinic. However, the smaller bottles did not have the expiry date recorded. This meant the provider could not be assured ultrasound gel was being stored and used safely in accordance with best practice.

The service had an infection, prevention, and control (IPC) policy in place which staff did not always adhere to. The registered manager was the dedicated IPC lead for the service. The service had not reported any incident of healthcare acquired infection in the past 12 months.

At Blackpool the pillow on the scanning bed was not fit for purpose. In this instance the provider had wrapped two domestic pillows in plastic and secured this with tape. This was an IPC risk as could not be cleaned adequately.

Staff reported they cleaned the scanning suite at the start and end of every working day. At Blackpool we observed staff cleaning the scanning bed, probe and seats between scans. We observed staff washing their hands between scans. We were unable to observe scans at the Bolton site as women did not provide their consent.

Inspected but not rated

Diagnostic and screening services

Environment and equipment

The service did not have suitable facilities at all the locations to meet the needs of women and their families. They were not always used safely in accordance with best practice and regulations.

At Bolton the service was located on the ground floor and was accessible for people in wheelchairs or babies in prams. There was a reception area where women and their families were greeted, a waiting area with multiple single seats, a scanning suite, staff kitchen, a toilet, and a storeroom. The area behind the reception areas was cluttered with various items stored underneath the reception desk. Women and their families viewed the images in the reception area.

At Blackpool the service was located on the ground floor but did not have disabled access. There was a reception area where women and their families were greeted, a waiting area with multiple single seats, a scanning suite and a toilet. There was a staff kitchen upstairs which was shared with the other businesses in the building.

The ultrasound machine was appropriately maintained and cleaned at Blackpool and Bolton. The service records for the ultrasound machine highlighted that appropriate maintenance and servicing was in place.

There were appropriate facilities in both scanning rooms.

Staff did not always dispose of clinical waste safely. The registered manager told us clinical waste was stored in a clinical waste bin in the scanning room. We saw no clinical wasted bins available onsite. Post the inspection the manager informed us that there is no clinical waste unless a woman's water breaks in which case clinical waste collection was arranged by an external company.

Items which were the subject to the Control of Substances Hazardous to Health (COSHH) regulations, for example cleaning solution, were stored on the top of a cupboard in the staff kitchen at Bolton. The toilet is located through the staff kitchen. This practice is not in accordance with COSHH regulations and presents a risk to people accessing the premises.

The service had environmental risk assessments in place which detailed hazards, actions being completed to mitigate the risk and further actions. However, the risk assessments were not consistent across the satellite clinics and did not demonstrate all the risks. For example, not all risk assessments detailed COVID-19.

Fire risk assessments had been completed for all the satellite clinics.

Assessing and responding to patient risk

Staff were not recording risk assessments for women. Staff identified and acted upon women at risk of deterioration. Staff did not always routinely explain the importance of attending all NHS scans and appointments to women.

Staff told us about the process for assessing risk with each new woman. This was done as part of a telephone conversation. We saw no evidence of the conversation being recorded and was not available in women's records. However, the provider told us that the information was stored in the booking system and would be reviewed monthly by management but no evidence was provided.

The service had an exclusion criterion which was documented. Most staff demonstrated an understanding of the criteria. Proof of ID was requested at the time of the appointment to confirm identity and age. We saw this being requested onsite. No women under the age of 18 years old could be scanned.

Inspected but not rated

Diagnostic and screening services

Staff told us scans were not intended to be diagnostic and did not replace routine hospital scans however the service website clearly stated that the scans were intended to be diagnostic but not replace hospital scans. We found that staff did not always routinely explain the importance of attending all NHS scans and appointments to women although, the terms and conditions outlined in the service's consent form recommended service users to continue to attend their NHS appointments. No more than three scan per pregnancy would be performed.

Staff were able to articulate how they would respond promptly to any sudden deterioration in a woman's health whilst on the premises. Staff explained they would make the woman safe, and call emergency services. The service had a first aid kit available in the reception area. Staff were trained in first aid awareness.

Staff explained the process for any incidental findings or where scans detected any anomaly requiring urgent attention. Staff told us they provided service users with a report, explaining that an onward referral would be made to the early pregnancy unit (EPU) or to the emergency department (ED). Staff then told us they would contact the registered manager who would arrange the appointment with EPU and then contact the service user to explain that the appointment has been arranged. The provider showed us one example when they had directed a woman to NHS maternity services.

Women who attended the clinic were encouraged to bring their pregnancy notes with them. Staff informed us that women were asked to consent to staff contacting their GP in urgent situations.

The registered manager would review images when a second opinion was required and this would be done remotely. We were told the registered manager might ask another sonographer to review images if they were unavailable. They told us this would be done within the hour following the image being shared but no documented evidence was provided. Staff assured us they kept women fully informed when a second opinion was required.

Staffing

The service had enough sonographers and support staff, however they did not always have the right qualifications, skills, and experience to keep women safe from avoidable harm and to provide the right care and treatment. The manager regularly reviewed and adjusted staffing levels.

The service had enough staff to keep women safe. There were two full time sonographers and there was one vacancy for a full-time sonographer which the registered manager was providing cover for. There were also four full time reception staff.

Staff files were not always complete to demonstrate staff competencies. The website stated the scanning team were fully qualified sonographers working within the NHS, either registered with the Nursing Midwifery Council (NMC) or the Health Professionals Council (HPC). The records we saw indicated this was not the case. However, the provider amended their website to reflect this.

The provider did not assess the competency of staff. Staff reported they had not had an appraisal in the last year. However, the provider shared records which indicated appraisals had been completed in the previous six months. The appraisal records we saw were not comprehensive. We were not assured that staff were aware of the contents as they had not signed these, and staff had reported they had not had any appraisals. This meant that the registered manager could not be assured of staff's competency.

Staff training in key areas had not been completed by all staff.

Inspected but not rated

Diagnostic and screening services

The registered manager adjusted the opening hours to accommodate for the vacancies.

Sickness rates for staff were low. Concerns were raised by staff that if someone was unwell, they would not have enough staff to meet the demands.

Records

Staff did not keep detailed records of women' care and treatment. Records were not comprehensive and were not always stored in an accessible way for staff.

Women's notes were stored electronically but were not comprehensive. For example, we reviewed 19 women's records. None of the records included anything other than name, basic contact details and GP details. It would be reasonable to expect the inclusion of relevant medical history and an individual risk assessment.

On inspection we reviewed 10 printed consent forms and we found that five of these were missing the second page which is where service users would sign and consent to the terms and conditions of the service being provided. The registered manager was not aware of this and this had not been reported by staff. This meant that the consent had not been formally documented.

At Blackpool, the appointment list for the day detailing women's names and the scan they had requested was visible to anyone accessing the scanning room. In the scanning room there was a drawer unit which had six previous appointment lists with women's details, these could be easily accessed and were not stored securely.

All computers in the locations were password protected.

Women were asked to bring in their green notes (relevant medical records). However, if they did not, staff were not routinely requesting relevant medical information. Staff told us women would volunteer any relevant history. They also told us they would not ask any further questions if the information was not volunteered. This meant staff could not be assured they were in possession of all relevant medical information.

Medicines

The service did not store or administer any medicines to service users.

Incidents

The service had an incident policy. The service could not demonstrate that they understood incidents and near misses. Staff were aware who to raise incidents to and the manager would investigate these.

The service had an adverse incident reporting policy which advised staff what incidents were and how to report them. The policy was created March 2022 and would be reviewed in March 2023.

The service had not had any incidents or never events over the last 12 months.

Staff did not demonstrate an understanding of the Duty of Candour and could not explain what this would entail. The Duty of Candour is about people's right to openness and transparency from their care provider. It applies to every health and social care provider regulated by the Care Quality Commission (CQC).

Inspected but not rated

Diagnostic and screening services

The duty of candour is covered in Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. It requires registered providers and registered managers (known as 'registered persons') to act in an open and transparent way with people receiving care or treatment from them. The regulation also defines 'notifiable safety incidents' and specifies how registered persons must apply the duty of candour if these incidents occur.

Training was being arranged by the registered manager for staff in this regard.

We were not assured staff knew what represented a reportable incident. For example, staff were able to explain what they would do in response to an incident which caused harm to a woman. However, they were unable to provide other examples that would be considered reportable.

Are Diagnostic and screening services well-led?

Inspected but not rated

We have not rated well-led as we did not inspect all the elements.

Leadership

Leaders did not always understand and manage the priorities and issues the service faced. Leaders did not have all the skills and abilities to run the service. They were visible and approachable in the service for staff.

The registered manager had been in place since the service was first registered with the CQC.

The registered manager had day-to-day responsibility for all of the satellite clinics. The registered manager reported visiting all of the clinics that were open each day and providing sonographer cover when required as they had a vacancy. Staff confirmed that she was present at all clinics at some time. Staff confirmed that all queries, issues, or incidents would be raised with the registered manager.

The registered manager demonstrated knowledge of the service. However, there was conflicting information provided to service users about the service and leadership. For example, staff and the registered manager explained scans were non-diagnostic. However, the service's website indicated they were undertaking diagnostic scans and providing reports.

Staff told us they were supported to develop both professionally and personally by the registered manager. Staff reported the registered manager had taught her a new technique using the ultrasound scanner to obtain better images.

Staff we spoke with felt the registered manager was visible, open to discussing their concerns and to suggested changes/adaptation to improve the service.

Staff felt supported after receiving complaints. For example, one member of staff explained how training was provided to improve her skills following a complaint.

Vision and Strategy

The service did not have a vision for what it wanted to achieve or a strategy to turn it into action.

The service did not have a vision or strategy for the service.

Inspected but not rated

Diagnostic and screening services

Culture

Staff felt respected, supported and valued.

Staff told us they felt respected, supported, and valued. Staff told us it was a "fantastic place to work". One staff member told us they enjoyed working for the service due to how they were valued by their manager.

All the staff we spoke with told us the registered manager was approachable and supportive. For example, one member of staff told us they were able to raise suggestions and innovative ideas to help the service.

Governance

Leaders did not operate effective governance processes, throughout the service. Staff were not all clear on their roles and accountabilities.

We received conflicting information about the frequency of team meetings. For example, staff reported three monthly team meetings. However, we were provided with copies of monthly meeting minutes. We reviewed five monthly team meeting minutes. We were not assured the content adequately reflected the discussions taking place. The health and safety policy stated health and safety should be discussed at all meetings, this was not reflected in the minutes. We found not all staff attended team meetings, we did not see evidence of how these discussions would be shared with staff.

The service had an exclusion criterion and Proof of ID was required to confirm identity and age. Following an audit, the results showed that not all staff demonstrated understanding of the new criteria.

Staff and the registered manager reported they would not scan a woman more than three times during her pregnancy term. This was articulated on the website and staff confirmed their understanding of this.

The registered manager was the designated lead for reporting and escalation. For example, the safeguarding lead, incident management and escalating referrals. The registered manager would manage the referrals to the early pregnancy unit (EPU) and manage safeguarding referrals. The service did not have a process in place to provide cover when the registered manager was not available. This meant in cases of emergency, we were not assured this would be addressed appropriately or in a timely way.

The service had a comprehensive set of policies. However, these were not always adhered to and were not specific to the service. The deteriorating patient policy stated all staff should be trained in basic life support (BLS). However, the registered manager had reported this was not necessary. Policies were reviewed every two years by an external company. In the interim changes were reviewed and managed by the registered manager. The policies had no version control. This meant we could not be assured that the policies were reviewed and updated in line with any changes. The service did not have a system in place to ensure staff had accessed and understood the policies. The policies were stored centrally with the registered manager. Policies were sent via email individually to staff. They were not stored centrally and not readily accessible to staff. This meant staff could not refer back to this in case of emergencies.

Incidents were reported to the registered manager to investigate. At the time of the inspection there were no reported incidents and we were therefore unable to review any investigations. On inspection we reviewed 10 consent forms for women and five of these had a significant page missing. We reported this to the registered manager. This should have been picked up through internal quality processes. The incident log did not have this recorded when we received it. There was no record of staff reporting significant incidents to the registered manager.

Inspected but not rated

Diagnostic and screening services

All audits were being completed by the registered manager. The audit plan detailed what audits would be undertaken and at what intervals. However, the re-scan audit and image quality audit were not captured within this plan. The registered manager completed re-scan audits which did not document how often the audit should be undertaken.

Every three months quality image audits were undertaken by the registered manager. We saw evidence of these audits being completed. The policies did not document how often these should be undertaken and did not define what the quality of the images should be. The registered manager reported the majority of their complaints were about the quality of images. We saw evidence of two complaints about image quality in the complaints log. However, the audits did not suggest there were any concerns. We are not assured that the service had oversight of the quality of the service.

Management of risk, issues and performance

Leaders did not manage performance effectively. They did not always identify and escalate relevant risks and issues. They had no plans to cope with unexpected events.

The service did not have an effective system in place to manage absences. Staff expressed concerns about what would happen if staff were off sick. The registered manager reported that she managed the service based on demands. However, they confirmed their response would be to cancel the clinic for the day.

The provider reported there was a continuity plan in place if the registered manager was unavailable. However, staff were unable to communicate what would happen in these situations and this was not documented.,

The service had a risk log but it did not appropriately capture all the risks identified at our inspection. Risks identified were all owned by the registered manager, mitigating actions were identified and contingency plans. However, the risks were generic and were not specific to each satellite clinic. There was no date for next review on the log. The registered manager described the three biggest risks for the service as she saw them. However, these were not reflected in the risk log.

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 • The service did not ensure that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. Regulation 12(2)(c) • The service did not ensure the safety of their premises and equipment within it. Regulation 12(2)(d) • The service did not ensure that they assessed the risk of, prevent, detect and control the spread of infections. Regulation 12 (2)(h)

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment • The service did not ensure that they had, and implemented, robust procedures and processes that made sure that people were protected. Regulation 13(1) • The service did not ensure that all staff had the relevant training for Safeguarding Vulnerable Adults and Safeguarding Children and Young Adults, including at induction and updated at appropriate intervals. Regulation 13(2)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The service did not have effective systems to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. Regulation 17(2)(a) • The service did not ensure that records relating to the care and treatment of each person using the service were kept, stored securely and fit for purpose. Regulation 17(2)(c) • The service did not maintain secure records in relation to persons employed in the carrying on of the regulated activities regarding their competency and suitability to perform their roles. Regulation 17(1)(2)