Bromsgrove Private Clinic

Quality Report

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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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

Bromsgrove Private Clinic is operated by Elite Health Services Limited. The service had one registered location. The service provides ultrasound scans, X-rays and MRI (Magnetic Resonance Imaging) diagnostic facilities for adults and children. We inspected diagnostic imaging services at this location.

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.

We inspected this service using our comprehensive inspection methodology. We carried out a short notice announced inspection on 11 December 2018 and an unannounced inspection on 13 December 2018. This was the first inspection since registration. Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

The service provided was diagnostic and screening procedures and treatment of disease, disorder or injury.

Services we rate

We previously did not have the authority to rate this service as legislation had not applied to all types of independent services, which meant that some providers had been inspected, but not rated. The Department of Health had amended the performance assessment regulations to enable CQC rate almost all independent healthcare providers. We rated this service as inadequate overall.

We found areas of practice that the service needed to improve:

- The service had no incident reporting system in place. Clinical incidents were not always recorded correctly.
- The service did not always have reliable systems in place to protect patients and staff from the risks of radiation exposure. At the time of the inspection, radiation protection signs could not be illuminated which meant people could not easily identify if an x-ray procedure was in progress. This was rectified after the inspection.
- Routine quality assurance and servicing was not in place at the time of inspection to ensure that the x-ray and MRI equipment was safe for use. We were provided with risk assessments of the equipment which had been updated following the inspection. Clinical staff received training following our inspection to enable them undertake quality assurance.
- The service did not have radiation risk assessments available at the time of the inspection and this did not comply with IRR regulation 2017. They updated and provided risk assessments following the inspection.
- The service did not have enough emergency equipment to keep patients safe in the event of an emergency. We raised this with senior staff who ordered more equipment to keep both children and adults safe.
- Hand hygiene audits were not undertaken to measure staff compliance with the World Health Organisation's (WHO) 'Five Moments for Hand Hygiene.'
- Staff had the appropriate qualifications for their role within the service; however, we could not be assured that the radiographers had up-to-date competencies for their role.
- At the time of inspection, there was lack of robust governance process in place to provide oversight around risk assessments, equipment quality assurance and diagnostic reference levels (DRLs) as required under IR(ME)R. Following inspection, the service commenced analysis and monitoring of DRLs and equipment quality assurance and subsequently provided evidence of this.

Summary of findings

- The governance system in relation to the management of risk did not operate effectively to ensure that leaders have clear oversight of the risk of harm to patients and their relatives.

However, we found the following areas of good practice:

- There was a programme of mandatory training in key safety areas, which all staff completed, and systems for checking staff competencies.
- Staff understood what to do if a safeguarding issue was identified.
- Records seen were up-to-date, complete and kept protected from unauthorised access.
- Staff demonstrated a kind and caring approach to their patients, supported their emotional needs and provided reassurance.
- Appointments were scheduled to meet the needs and demands of the patients who required their services.
- The service had systems in place to acquire feedback from patients to enable them to continually improve the service being provided.
- All of the patient feedback we received reflected a good standard of kind, compassionate and understanding care.

Following this inspection, we sent a letter raising our concerns. In response to our letter, the provider decided to pause all regulated activity until 8 January 2019. The provider took actions to address the concerns we raised in the letter.

We told the provider that it must take some actions to comply with the regulations and that it should make other improvements. We also issued the provider with two requirement notices that affected diagnostic and screening procedures and treatment of disease, disorder or injury. Details are at the end of the report.

Amanda Stanford
Deputy Chief Inspector of Hospitals (Central)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	**Requires improvement** 	The service provided magnetic resonance scans (MRI), x-rays and ultrasound scanning services, which are classified under the diagnostic imaging core service, were the core services provided at this service. We rated this service as requires improvement overall because the service did not always comply with IR(ME)R 17 and IRR 17 regulations. The service had no incident reporting system in place. Staff did not have sufficient competencies to enable them carry out their role at the time of the inspection. The service did not have sufficient adult and paediatric emergency equipment required to keep patients safe in the event of an emergency. However, feedback from patients was positive. Appointments were scheduled to meet the needs and demands of the patients who required their services.

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Summary of this inspection

Background to Bromsgrove Private Clinic

Bromsgrove Private Clinic is operated by Elite Health Services Limited. The service opened in 2016. It is a private clinic in Bromsgrove, Worcestershire. The clinic primarily serves the communities of Worcestershire. It also accepts private patient referrals from outside this area.

The clinic has had a registered manager in post since 2016. The clinic also offers knee clinics such as sports injury services, treatment of knee and shoulder disorders, specialist physiotherapy and sports medicine. We did not inspect these services as they are registered separately.

The Bromsgrove Private Clinic is a magnetic resonance diagnostic, x-ray and ultrasound imaging service which undertakes scans on patients to diagnose disease, disorder and injury. The service has a fixed upright scanner and is in Bromsgrove. The unit is operational Mondays 2pm to 8pm and Wednesdays and Thursdays from 9am to 5pm. No clinical emergency patients are scanned within the service. The service cares for adults and patients under the age of 16.

Our inspection team

The inspection team was comprised of a CQC lead inspector and a specialist advisor with expertise in radiological services. The inspection team was overseen by Julie Fraser, Inspection Manager, and Bernadette Hanney, Head of Hospital inspection.

Information about Bromsgrove Private Clinic

The location was registered to provide the following regulated activities:

- Diagnostic and screening procedures.
- Treatment of disease, disorder or injury

During the inspection, we visited the registered location in Bromsgrove. We spoke with four staff including, administration staff, the registered manager, radiographer and the clinic manager. We reviewed two patient records and spoke with one patient.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection.

The service was registered with the CQC in 2016 and this was the first inspection since registration.

Activity (from November 2017 to November 2018):

- The service undertook 434 magnetic resonance imaging (MRI) scans.
- 199 x-rays
- 27 ultrasounds.

Track record on safety

- There were no never events.
- There were no serious incidents.
- There were no incidences of healthcare acquired Methicillin-resistant Staphylococcus aureus (MRSA).
- There were no incidences of healthcare acquired Methicillin-sensitive staphylococcus aureus (MSSA).
- There were no incidences of healthcare acquired Clostridium difficile.
- There were no incidences of healthcare acquired Escherichia coli.
- The service had received four complaints from November 2017 to November 2018.

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?

Requires improvement 

We rated safe as **Requires improvement** because:

- The service did not have radiation risk assessments at the time of the inspection and this did not comply with IRR regulation 2017. They updated and provided risk assessments following the inspection.
- The service did not have sufficient resuscitation equipment required to keep patients safe in the event of an emergency.
- The service did not have a Radiation Protection Supervisor (RPS) at the time of our inspection and this was not in line with IRR 2017 requirements.
- The service recorded radiation doses, however they did not use this information to analyse the doses given to patients. This meant that there was no evidence of optimisation of patient doses within the service which was not in line with IR(ME)R regulation.
- Lead aprons had not been quality checked since 2016 to ensure they were fit for purpose and not damaged. This meant that all lead gowns had not been tested for wear and tear, and that there was a risk that they did not offer the protection required when working with ionising radiation.
- There was no incident reporting system in place. This meant incidents were not always investigated and learning from incidents was not always shared.
- Environmental cleaning and infection prevention and control audits were not carried out. We were not therefore assured the service monitored their systems and used results to improve patient safety.

However, we also found the following areas of good practice:

- There was good compliance with mandatory training across the service.
- Patients' individual care records were generally written and managed in a way that kept people safe. Records seen were accurate, complete, legible, and up-to-date.
- Patients personal data and information were kept secure and only staff had access to that information.

Are services effective?

We currently do not rate effective, we found:

- Radiographers did not have up-to-date competencies to enable them effectively to carry out their role.

Summary of this inspection

- X-ray doses were not robustly recorded and analysed in order to carry out dose audits from which DRLs are derived.
- The service used out of date employers' procedures. This meant that best practice relating to more recent evidence was not being adopted.
- The service did not have any formal arrangement in place to ensure they were informed of any performance problems or other concerns leading to action being taken against a staff member.

However, we also found the following areas of good practice:

- All staff files reviewed contained evidence of disclosure and barring service checks.
- Staff understood their responsibilities under the Mental Capacity Act (2005) and processes were in place to ensure treatment only took place when a patient was assessed as able to give consent.
- Staff worked collaboratively as part of a multi-professional team to meet patients' needs.

Are services caring?

Good

We rated caring as **Good** because:

- Patients received information in a way which they understood and felt involved in their care. Patients were always given the opportunity to ask staff questions, and patients felt comfortable doing so.
- There were systems in place for the service to receive feedback from patients on a regular basis. Feedback received from patients was positive.
- Staff provided patients and those close to them with emotional support; all staff were sympathetic to anxious or distressed patients.
- Patients received information in a way which they understood and felt involved in their care. Patients were always given the opportunity to ask staff questions.

Are services responsive?

Good

We rated responsive as **Good** because:

- The service ensured there were appointments available to meet the needs of the patients.
- Patients had timely access to all scans.
- There was a system in place for supporting patients living with dementia or learning disability.

Summary of this inspection

- There was no waiting list and appointment times were planned in advance to match the availability of staff with patient preferences.
- Interpretation services were available for patients whose first language was not English.
- All facilities were fully wheelchair accessible and provision was in place for language support.
- Information on how to raise a concern or a complaint was available. Complaints and concerns were responded to in line with the service's complaints policy.

Are services well-led?

Inadequate

We rated well-led as **Inadequate** because:

- The provider had not established suitable and effective policies and procedures to fulfil the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)
- Leaders did not ensure the service remained complaint with radiation protection and did not have a clear oversight of the risk of harm to people who used the service.
- There was not an effective governance framework in place. The governance system did not ensure that regulations such as the IR(ME)R employers' procedures were up-to-date. We were not assured that there was a robust system of review for procedures and radiology protocols.
- Robust arrangement for identifying, recording and managing risks were not in place. For example, risk assessments seen whilst on inspection, did not comply with IRR regulation 2017 and there was no incident reporting system in place. Following the inspection, the service provided an updated copy of the risk assessments.
- There was no robust governance process in place to provide oversight around risk assessments, equipment quality assurance and diagnostic reference levels (DRLs) as required under IRR and IR(ME)R.
- Findings from audits were not widely shared within the service. For example, staff we spoke with could not tell us if image peer review audits were carried out. We could not be assured that learning from audits were identified, taken forward and implemented.

However, we also found the following areas of good practice:

- The service had a risk register in place to identify and manage risks to the service.

Summary of this inspection

- Staff we spoke with found the manager to be approachable, supportive, and effective in their roles. They all spoke positively about the management of the service.
- All staff we spoke with told us they felt respected and valued.
- Staff we spoke with told us they felt proud to work for the service and they enjoyed the work they did within the clinic.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Requires improvement

Diagnostic imaging

Safe	Requires improvement
Effective	
Caring	Good
Responsive	Good
Well-led	Inadequate

Are diagnostic imaging services safe?

Requires improvement

We previously did not have the authority to rate this service. We rated safe as **requires improvement.**

Mandatory training

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- The service had a mandatory and statutory training requirement which all salaried and bank staff had to show evidence of completing. The mandatory training compliance for all salaried staff was 100%. Staff conducted annual training in the following mandatory topics:
  - Basic Life Support (BLS)
  - Customer care and complaints certification
  - Data security awareness
  - Safeguarding vulnerable adults
  - Safeguarding children
  - Fire safety
  - Health and safety
  - Information governance awareness
  - Infection prevention and control
- The service had processes in place to monitor staff compliance with mandatory training. Staff were required to complete all mandatory training each year.
- Mandatory training was a mixture of face-to-face and online training. Staff had protected time to complete training.
- Staff had received basic life support training. Training certificates provided following our inspection showed that the basic life support training included paediatric modifications. Staff said the training included paediatric modifications because staff came into contact with children and young people from the age of 12 years.

Safeguarding

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff were trained to recognise adults at risk and demonstrated they understood their responsibilities to safeguard both vulnerable children and adults.
- The service had a designated lead for both children and adults safeguarding, who was available during working hours to provide support to staff. The lead for safeguarding was the nominated individual who was trained to level three.
- The service performed ultrasound scans, x-rays and MRI scans for patients from the age of 12 years old. Staff were trained to level two in children's safeguarding, and the escalation system ensured there was a seamless process to inform the relevant agencies. From review of staff files, we saw that all staff had received safeguarding children's training, appropriate to their role. We also found that the registered manager and consultant radiologists had

completed safeguarding children's level three training. This met the intercollegiate guidance 'Safeguarding Children and Young People: roles and Competencies for Healthcare Staff' (March 2014).

- Staff we spoke with had not made any safeguarding referrals; however, they were able to confidently tell us how they would identify a safeguarding issue and what action they would take. This included informing the safeguarding lead for the service.
- The service had a safeguarding children policy in place for staff to follow which was last reviewed in August 2018. The policy also contained detailed information about specific risks for staff to be aware of when providing care and treatment to children, or if providing care and treatment whilst children were present.
- Child sexual exploitation (CSE) training was not part of all staff safeguarding training and was not included in the services safeguarding children and young people policy. Staff did tell us if they were concerned about any patients they would refer to the local safeguarding team.

Cleanliness, infection control and hygiene

- The service did not always control infection risk well. For example, there was no evidence of cleaning schedules or hand hygiene audits. However, most of the clinical environments that we visited during our inspection were found to be visibly clean and tidy. Staff used paper towels to cover the examination couch during a scanning procedure.
- All areas had no evidence of a cleaning schedules which were signed when staff had completed the cleaning duties. Hand hygiene audits were not undertaken to measure compliance with the World Health Organisation's (WHO) '5 Moments for Hand Hygiene.' These guidelines are for all staff working in healthcare environments and define the key moments when staff should be performing hand hygiene to reduce risk of cross contamination between patients.
- Throughout the clinic all staff were observed to be 'arms bare below the elbow'.
- Bromsgrove Private Clinic had infection prevention and control (IPC) policies and procedures in place which provided staff with guidance on appropriate IPC practice in for example, communicable diseases.
- A nominated infection prevention and control lead was in post who was responsible for standards of hygiene and cleanliness. This individual updated the clinic's infection control policies annually and we saw these were up-to-date.
- From November 2017 to November 2018 there were no incidents of health care acquired infection in the clinic.
- The environment met the standards of the Department of Health (DH) Health Building Notes (HBN) 00-09 and 00-10 in relation to infection control practices and building management. The clinical environment was well maintained and there was no damage to flooring or walls that could present a risk of the build-up of bacteria.
- Staff adhered to the standards of the DH Health Technical Memorandum 07-01 in relation to safe standards of waste disposal, including clinical and hazardous waste. For example, the service employed contracted cleaners who segregated waste in secure and colour-coded bags.
- Waste was handled and disposed of in a way that kept people safe. Staff used the correct system to handle and sort different types of waste and these were labelled appropriately.

Environment and equipment

- There were not always reliable systems in place to protect patients and staff from the risks of radiation exposure. For example, no radiation protection warning signs were displayed outside of the x-ray room where diagnostic imaging took place at the time of our inspection. We raised this with the registered manager who addressed it by the time of our unannounced inspection. However, the sign could not be illuminated, which meant it was not possible for people outside of the room to immediately identify if a radiation imaging procedure was underway. We escalated this to staff who said this will be rectified. We have since been informed that the sign illuminates.

Requires improvement

Diagnostic imaging

- The service had an upright magnetic resonance imaging (MRI) scanner, an x-ray equipment and an ultrasound machine. All equipment was in working order and functioned fully. Routine quality assurance was not in place to ensure that the equipment was functioning safely. We raised this with the registered manager both verbally and in writing following our inspection. In response to our letter, the registered manager said the clinic radiographer had received training to undertake quality control on the 6 January 2019 and will now audit for alignment, output, uniformity and image quality. Following the inspection and the radiographers subsequent training, the quality assurance of the equipment was undertaken weekly and monthly in line with manufacturer guidelines. The service provided evidence that this had been undertaken. The X-ray machine had been reviewed by an engineer in August 2018 and the MRI scanner in December 2018. We were told maintenance visits would continue in 2019.
- The layout of the unit was compatible with health and building notification (HBN06) guidance. Access was good, parking was free with a secure entry point to the clinic. A reception area, outside of the scanning area, was available providing magazines, refreshments and toilet facilities for patients and relatives. A scanning observation area allowed visibility of all patients during scanning.
- The waiting room for the service was clean and airy, with adequate seating available.
- The clinic was accessible to patients in a wheelchair or with limited mobility.
- The service did not have sufficient resuscitation equipment required to keep patients safe. A defibrillator and pocket mask was available as resuscitation equipment. An emergency medicine which could be used for anaphylaxis (a severe and potentially life threatening allergic reaction) was stored in the MRI room. There was no emergency equipment for children. We were not assured that the service had enough emergency equipment to keep patients safe in the event of an emergency. We escalated this to the registered manager who ordered an oxygen cylinder and said arrangements would be made to ensure availability of emergency equipment. Following our inspection, we wrote to the provider detailing our concerns, they took actions to ensure both paediatric and adult emergency equipment were available. Evidence provided showed they had purchased paediatric pocket masks and basic paediatric and adult equipment required in the event of an emergency.
- The service was fully compliant with the Control of Substances Hazardous to Health Regulations (COSHH) (2002). This included the safe storage, use and disposal of controlled chemicals.
- MRI intravenous giving sets were single use and CE marked (this demonstrates legal conformity to European standards).
- A service level agreement was in place with a local company for the day to day maintenance of equipment. Failures in equipment and medical devices were reported through the technical support team. Staff told us there were usually no problems or delays in getting repairs completed. All equipment conformed to the relevant safety standards and was regularly serviced. All electrical equipment was service tested.
- Patient weigh scales were available in the unit and we saw where they had been appropriately service tested. Staff told us, in the event the weigh scales developed a fault or were unfit for use, the fault would be reported.
- As recommended in HBN06-13.64 the room was equipped with an oxygen monitor to ensure that any helium gas leaking (quench) is not moving into the examination room, thus displacing the oxygen and compromising patient safety.
- There was a system in place to ensure that repairs to equipment were carried out if machines and other equipment broke down and that repairs were completed quickly so that patients did not experience delays to treatment. Servicing and maintenance of premises and equipment was carried out using a planned preventative maintenance programme. During our inspection we checked the service dates for all equipment, all equipment was within their service date.
- Bromsgrove Private Clinic did not complete environmental cleaning audits. There was no evidence the service undertook audits of staff adherence to

personal protective equipment procedures, infection prevention and control procedures, or in relation to the completion of patient records. We were not therefore assured the service monitored their systems and used results to improve patient safety.

- We found an ultrasound gel with expiration date July 2017. We raised this with staff who discarded it and said systems would be put in place to ensure safe use of consumables.

Assessing and responding to patient risk

- The service had a risk assessment policy in place which had been reviewed in February 2018. The policy required staff to undertake regular risk assessments to keep staff and patients safe from hazards. Staff assessed patient risk and developed risk management plans in line with national guidance. For example, we saw evidence of a magnetic resonance imaging patient safety questionnaire. Radiographers performed safety questionnaires to ensure anybody entering these areas were kept safe from the high magnetic field.
- We saw no evidence of radiation risk assessment during our inspection. This did not comply with IRR regulation 2017. We raised this during our inspection and sent a letter detailing our concerns to the provider following our inspection. In response this letter, the service provided us with a radiation risk assessment which had been issued on the 27 December 2018. They said this was available to all staff, equipment operators and maintenance persons and would be reviewed annually.
- The service provided evidence following the inspection that they recorded exposure factors routinely. However, they did not analyse them up until the time of inspection. This meant that we were not assured that patients had always received the correct radiation dose. Following the inspection, the service purchased a dose area product (DAP) meter and are routinely recording patient doses. These were being sent to the radiation protection service weekly for analysis to establish up to date DRLs. All referral forms included patient identification, contact details, clinical history and examination requested, question if a patient was either pregnant or breastfeeding, and details of the referring clinician/practitioner. We looked at a referral form and found it contained vital safety information including if a patient had a pace maker, has had a valve replacement, any metal implants or medication patches on their skin. Staff completed an MRI safety checklist to ensure scans were carried out safely.
- The service did not have a Radiation Protection Supervisor (RPS) at the time of our inspection and this was not in line with IRR 17 requirements. The purpose of the RPS role was to ensure that staff followed local rules. The local rules summarise the key working instructions intended to restrict exposure in radiation areas. We raised this with the registered manager at the time of our inspection. We also detailed this in a letter on the 21 December 2018 informing the provider that we were concerned about the seamless running of the unit in the absence of a trained RPS. In response to our concern, the registered manager sent evidence of certificates which showed the RPS had attended training on the 6 January 2019.
- The x-ray room had lead aprons which had not been checked since 2016 to ensure they were fit for purpose and not damaged. Lead aprons are protective equipment for staff and visitors from radiation. This meant that all lead gowns had not been tested for a number of years for wear and tear, and that there was a risk that they did not offer the protection required when working with ionising radiation. We raised this with the registered manager at the time of our inspection. Following our inspection, the registered manager provided evidence which showed the lead aprons had now been checked and fit for use.
- There were pathways and processes for staff to assess people using services in radiology departments who are clinically unwell and need hospital admission.
- The service had a process in place for the management of patients who suddenly became unwell during their procedure. In the event of a cardiac arrest, staff called 999 for an ambulance. Staff were trained in basic life support and would put their training into use until the ambulance arrived. Since the service started, staff reported no incidents of having to call for an ambulance.
- All staff had up-to-date training in first aid and cardiopulmonary resuscitation (CPR). A patient

deterioration and escalation policy was in place, which instructed staff to arrange transfer of patients to an emergency NHS facility in the event of a complication.

- The service was aware of the British Medical Ultrasound Society and Society of Radiographers 'paused and checked' checklist which is recommended to be completed prior to an ultrasound scan. We saw pause and check posters within the department.
- Staff ensured that the 'requesting' of an MRI was only made by staff in accordance with local referral guidelines. All referrals were made using dedicated MRI referral forms. All referrals were either received from GPs or patient self-referrals for private scans.

Staffing

- The service had five staff in post, two of which worked part-time. Staff in the clinic consisted of one part-time equivalent radiographer. Two receptionists provided administrative and customer care support Monday to Friday.
- The registered manager and owner was an orthopaedic surgeon who led surgical clinics and provided overall leadership within diagnostic clinics.
- All staff we spoke with felt that staffing was managed appropriately.
- Staff told us they could contact a radiologist for advice at any time. They gave examples of contacting a radiologist to discuss contrast imaging in a patient.
- The service used locum staff, bank staff or agency staff. In the event of a staff member going off sick, the service did not have any problems with arranging sickness and annual leave cover.
- The clinic manager maintained the rota for safe staffing, including for recruitment, disciplinaries and lone working. Staff we spoke with demonstrated good knowledge of the lone working policy.

Records

- Patients' individual care records were generally well managed and written legibly. Records seen were accurate, complete, legible, and up-to-date.
- Patients completed a MRI safety consent checklist form which recorded the patients' consent and answers to the safety screening questions. This was later scanned onto the electronic system and kept with the patients' electronic records.
- Patients personal data and information were kept secure and only staff had access to that information. Staff received training on information governance and records management as part of their mandatory training programme.
- We reviewed four patient care records during this inspection and saw records were accurate, complete, legible and up-to-date.
- The service had a system in place to ensure initial consultation notes were available at the time of consultation. All reports were reviewed and annotated. Any action taken was recorded and dated by the clinician.
- Self-referring patients who did not give consent for their details to be forwarded to their GP were given a summary of the consultation directly to pass to their GP.
- All records on the computer were protected by passwords and backed up every night. A summary of the patient's health record was sent to the patient's GP within a locally agreed timescale, within two-four weeks.
- Staff stored patient records in numerical order in the records room which was locked at night. When necessary, older records were stored off site at a secure storage facility with arrangements in place to protect the records from use by unauthorised persons, damage or loss.
- Staff used confidential waste bins for all paper with patient details. This was securely disposed of by secure shredding service.

Medicines

- Emergency medicines were available in the event of an anaphylactic reaction.
- Patient group directions (PGDs) were used for administration of contrast media. PGDs allow some registered health professionals (such as

radiographers) to give specified medicines to a predetermined group of patients without them seeing a doctor. We saw, in staff training files, where staff had been assessed as competent.

- The service provided evidence following the inspection that they recorded radiation doses routinely. However, they did not analyse them before the time of inspection. This meant that we were not assured that patients always received the correct radiation dose. Doses of ionising radiation should be recorded and audited on a regular basis to ensure that patients are only exposed to radiation doses as low as reasonably possible. At the unannounced inspection this was seen to have been implemented. The service had purchased a dose area product (DAP) meter and are routinely recording patient doses. These were being sent to the radiation protection service weekly for analysis to establish up to date DRLs.

Incidents

- The service did not always manage patient safety incidents well. There was an incident reporting policy and procedure in place which had been reviewed in October 2018 to guide staff in the process of reporting incidents. Staff understood their responsibilities to raise concerns. However, there was no system in place to record safety incidents, concerns and near misses.
- From November 2017 to November 2018, no incidents had been reported. The service had no incident reporting system in place. We saw an example of a clinical incident relating to images which had been recorded as a complaint and had been dealt with appropriately. We were not assured that all incidents had been identified and opportunities to improve practice or learnt lessons could have been missed. We raised this with staff who agreed this was a clinical incident and not a complaint. Following our inspection, the registered manager told us clinical incident folder had been created and all incidents would be recorded.
- There were no never events reported for the service from November 2017 to November 2018. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation, which was introduced in November 2014. This regulation requires the organisation to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds. The duty of candour regulation only applies to incidents where severe or moderate harm to a patient has occurred.
- Staff we spoke with had an understanding of the duty of candour process and the need for being open and honest with patients when errors occur. A member of staff gave an example of when duty of candour had been applied.

Safety Thermometer (or equivalent)

- The service did not complete the safety thermometer as this was not applicable to the service they provided their patients.

Are diagnostic imaging services effective?

We do not rate effective for diagnostic services because we do not have sufficient evidence to rate.

Evidence-based care and treatment

- Services, care and treatment were not always delivered in line with and against the National Institute for Health and Care Excellence (NICE) requirements.
- Diagnostic reference levels (DRLs) were in place. However, at the time of inspection, we saw no evidence of DRL dose audits. DRLs are typical doses for examinations commonly performed in radiology departments. They are set at a level so that roughly 75% of examinations will be lower than the relevant DRL. They are not designed to be directly compared to individual doses. However, they can be used as a signpost to indicate to staff when equipment is not operating correctly or when the technique is poor.

Upon review of additional evidence provided by the registered manager following our inspection, we sent a letter to the provider stating that we still had concerns around audit of dose and governance around DRLs. In response to our letter, the registered manager said they had added the dose audit to the annual radiographer clinical auditing. This will help optimise doses. The radiographer has now been trained in the use of exposure charts and doses to derive DRLs. The clinic has also purchased a DAP meter and are sending weekly doses for analysis by the radiation protection service.

- Employers' procedures were out of date. The provider still used and referred to out of date IR(ME)R regulation 2000 although a new regulation was introduced in February 2018. This meant that best practice relating to more recent evidence was not being adopted. Following our inspection, we raised this concern with the registered manager who updated the employers' procedures and said this would be reviewed. Following our letter sent to the provider on the 21 December 2018 highlighting lack of an up-to-date employers' procedure as a concern, the employer updated these and sent us evidence of employers' procedures which were now in line with IR(ME)R regulation.
- The service used 'Pause and Check' and we saw posters displayed within clinical areas. The Society and College of Radiographers produced this resource to reduce the number of radiation incidents occurring within radiology departments.
- All staff we spoke with were aware of how to access policies, which were stored electronically on an internal computer drive at the Bromsgrove Private Clinic. This meant that staff working at this clinic, had instant access to local policies.

Nutrition and hydration

- The clinic provided scanning service, which meant there was limited need for a formal catering provision or nutrition monitoring. However, snacks and drinks were available.
- Patients had access to drinks whilst awaiting their scan. During our inspection we observed staff offering drinks before and after the patient was scanned.

Pain relief

- Patients were asked by staff if they were comfortable during their scans and x-rays, however, no formal pain level monitoring was undertaken as these procedures are pain free.

Patient outcomes

- Managers monitored the effectiveness of care and treatment and used the findings to improve them**.** However, the service did not benchmark practice against similar services and did not have structured processes in place to identify if the outcomes of procedures were in line with national performance.
- The quality of images was peer reviewed locally. Any deficiencies in images were highlighted to the member of staff for their learning. We saw evidence of peer review for 28 MRI scans and 18 x-rays. The service also carried out an audit of double reporting in 2018. Results showed no significant disparity between the first and the second opinion.
- There had been no instances of unplanned or emergency patient transfers to other facilities or hospitals from November 2017 to November 2018.

Competent staff

- The service did not always make sure staff were competent for their roles. For example, staff had the appropriate qualifications for their role within the service; however, we could not be assured that the radiographers had up-to-date competencies for their role. We found staff did not always have the right competencies and skills to undertake MRI scans, x-rays and ultrasounds and had not attended appropriate training to meet their learning needs.
- No training records were provided to show competencies required for radiographers to operate the MRI scanner and x-ray unit. We requested for evidence of competencies for radiographers to use the equipment and were provided with certificates of radiography qualifications. The lack of MRI competencies for radiographers meant we could not be assured that radiographers were competent to use the equipment and checked that patients were

suitable for their procedures. Following our inspection, we sent a letter to the provider highlighting our concerns. In response to our letter, the registered manager sent us the following action plan for 2019;

- The radiographer will attend a training day to update on risk assessment skills and to manage patients with additional risks.
- The radiographer had completed work with the radiologist to fully document all the examination protocols in use at the site.
- The service will maintain training and other records with reference to local equipment, IR(ME)R procedures, referral guidelines and examination protocols.
- Induction of new staff will be carried out appropriately with competency signoffs before they can use the x-ray room.

- Although the provider sent us an action plan and evidence of staff competencies and skills, these were not in a standard format or structured competency document; They were in the form of an email. There was no robust process for assessing a radiographer's competence. Local induction for all staff did not always ensure their competency to perform their required role within their specified local area. Local induction for clinical staff was not supported by a comprehensive competency assessment toolkit which covered key areas applicable across all roles including equipment, and clinical competency skills relevant to their job role and experience. For example, staff said the service used agency staff who had local induction for one day. We saw no evidence that local induction had been completed as no induction checklists had been completed.
- All radiographers were registered with the Health and Care Professionals Council.
- At the time of our inspection, staff did not have the opportunity to attend relevant courses to enhance the professional development.
- The service did not have any formal arrangement in place to ensure they were informed of any performance problems or other concerns leading to action being taken against a staff member, or likewise informing other providers if they themselves had concerns about staff members.
- Appraisals were completed on an annual basis and once completed, were stored in staff files. Information provided by the service showed 100% of staff had received an appraisal.
- Radiographer and radiologist qualifications were recorded in their employment files, along with evidence of their professional registration, professional indemnity insurance and professional revalidation.
- All staff files we reviewed contained evidence of disclosure and barring service (DBS) checks. This included the date of the check and whether the check had identified any past criminal history. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.
- As part of our inspection, we also reviewed the personnel files for the radiographer, bank radiographers, radiologists, receptionist and clinic manager. We found they all contained evidence of a recruitment and selection interview, employment history, their employment contract, training records and satisfactory references.

Multidisciplinary working

- The clinic operated independently and was not part of a specialist care or treatment network.
- Staff of different disciplines worked together as a team to benefit patients. For example, during our inspection of Bromsgrove Private Clinic, we observed positive examples of the radiographer and the clinic manager working well together. Their professional working relationship promoted a relaxed environment for patients and helped to put the patients at ease.
- Staff told us if they identified any findings, which required escalation to another health provider, staff would immediately communicate with the patient's GP via telephone. The scan report would also be sent to the referring GP immediately after the patient's appointment.

Requires improvement

Diagnostic imaging

Seven-day services

- As the service was not an acute service, it did not operate seven days a week. Clinics at Bromsgrove Private Clinic were held Monday to Friday from 8am to 5pm.
- Appointments were flexible to meet the needs of patients, they were available at short notice.

Health promotion

- Information leaflets were provided for patients on what the scan would entail and what was expected of them.

Consent and Mental Capacity Act

- Staff demonstrated a good understanding of the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Mental Capacity Act awareness training was a mandatory training requirement for all staff. At the time of this inspection all staff had completed this training. They were aware of what to do if they had concerns about a patient and their ability to consent to the scan. They were familiar with processes such as best interest decisions.
- All staff were aware of the importance for gaining consent from patients before conducting any procedures.
- The service used a MRI safety consent form to record the patients' consent which also contained their answers to safety screening.
- We spoke with a patient who said they fully understood the consent process and felt clinicians had always been very open with them in discussing the likely outcomes of treatment.
- Staff were aware of 'Gillick' competencies for patients under the age of 18. To be Gillick competent, a young person (aged 16 or 17) can consent to their own treatments if they are believed to have enough intelligence, competence and understanding to fully appreciate what is involved in their procedure.

Are diagnostic imaging services caring?

Good

We previously did not have the authority to rate this service. We rated caring as **good.**

Compassionate care

- Staff cared for patients with compassion. All staff we spoke with were very passionate about their roles and were dedicated to making sure patients received patient-centred care. We observed staff treating and assisting patients in a compassionate manner.
- A dignity and respect policy with next review date in August 2019 was in place and staff adhered to this in practice, such as by using curtains when patients were changing.
- Staff told us they treated patients with privacy, dignity and respect during their procedures. They locked the doors to the scanning room to prevent anybody entering unnecessarily.
- Staff demonstrated a kind and caring attitude to patients. This was evident from the interactions we witnessed on inspection and the feedback provided by patients.
- The service gathered patient feedback on a regular basis through an online service. All feedback was published on the provider's website. Feedback received was positive.
- We observed staff introducing themselves to patients and explaining their role during our inspection. This was in line with the recommendations in the National Institute for Health and Care Excellence (NICE) quality standards for patient experiences in healthcare.
- During our inspection of Bromsgrove Private Clinic, we spoke with one patient about various aspects of their care. Without exception, feedback was positive about the kindness and care they received from staff. The patient described staff as "very helpful, polite and personable".

Emotional support

- Staff provided emotional support to patients to minimise their distress. They were aware that patients attending the service were often feeling nervous and

anxious so provided additional reassurance and support to these patients. The clinic receptionist acted as chaperone if required during an ultrasound scan to ensure patients received emotional support.

- Staff understood the impact that a patient's care, treatment, or condition had on their wellbeing, both emotionally and socially.
- The service offered an open upright MRI scanner which was less intimidating for children who could see their parents and be at ease throughout the scanning process.
- We looked at two patient feedbacks left online on Bromsgrove Private Clinic website which related to MRI scans. The first feedback stated 'I believe that more people like myself should be aware that it is now possible to have an MRI scan without being encased in a cylinder for the duration of the scan. This can cause claustrophobia and panic attacks even at the thought of having the scan'. Another patient feedback read 'this is an excellent service and is a wonderful help for anybody travelling any distance'.
- Staff had a good awareness of patients with complex needs and those patients who may require additional support during their visit to the clinic.

Understanding and involvement of patients and those close to them

- Staff involved patients and those close to them in decisions about their care and treatment. They communicated with patients so that they understood the reason for attending the clinic. All patients were welcomed into the clinic and reassured about the procedure.
- The patient we spoke with felt they had been encouraged to make their own decisions. They felt well informed about their care and treatment.
- Staff recognised when patients and those close to them needed additional support to help them understand and be involved in their care and treatment and enabled them to access this. This included for example, access to interpreting and translation services.
- Patients and those close to them could find further information or ask questions about their scan.

Feedback from a patient also confirmed that they were informed about how they would receive the scan results. A wide range of MRI specific leaflets were also available to patients.

Are diagnostic imaging services responsive?

Good

We previously did not have the authority to rate this service. We rated it as **good.**

Service delivery to meet the needs of local people

- The service planned and provided services in a way that met the needs of patients. Facilities were appropriate to their needs.
- The service offered an open upright MRI scanner to patients over the traditional closed MRI tunnel system. This helped to keep the patients calm and delivered a stress-free experience which significantly decreased the chances of claustrophobic related symptoms in patients.
- The environment was appropriate and patient centred. There was comfortable /sufficient seating, toilets and a drinks machine. A disabled toilet with access for wheel chair and ambulance attendance was available.
- Bromsgrove Private Clinic was located near established routes, with a bus stop and a train station a short distance away. Patients were also able to use free and accessible car parking. The car park had two disabled bays which patients used.
- The service offered a range of appointment times and days to meet the needs of the patients who used the service.
- MRI scanning appointments were provided three days per week on Mondays, Wednesdays and Thursdays. Appointment times ranged between 9am until 5pm.
- Appointments for private scans were booked using either the providers website or patients could ring the administration team who would book them into an appointment which best suited their requirements.

Diagnostic imaging

- There was sufficient space in the clinic room for individuals to accompany a patient, for example, carers, family, partners as well as patients.
- All appointments were confirmed two days prior to the patient's appointment by letter or a text message reminder. This helped to reduce the number of patients who did not attend (DNA) their appointment.

Meeting people's individual needs

- Patients' individual needs were accounted for. Staff delivered care in a way that took account of the needs of different people on the grounds of age, disability, gender, race, religion or belief and sexual orientation.
- Staff told us they rarely had patients attend their clinics for a scan who had complex needs, for example, learning disability and dementia. However, when they did, staff ensured the patient's needs were met and facilitated their relatives or carers to accompany them during their ultrasound scan. Appointment times would also be extended to ensure patients were not rushed.
- All patients received an appointment letter or email and were encouraged to contact the unit if they had any concerns or questions about their examination.
- Patients were advised should they wish to stop their examination, staff would assist them and discuss coping mechanisms to complete the procedure.
- Staff could access telephone interpreting services for patients whose first language was not English, when needed. Staff we spoke with knew how to access this, although none had needed to use it.
- Patients felt they were given enough information about their treatment options and what the treatment involved. People felt involved in the choice of treatments they required.
- The service provided flexible individual appointments to allow for ad hoc early access to accommodate the working patient. It also allocated longer appointment times to patients requiring extra support when attending clinics.

Access and flow

- People could access the service when they needed it. Waiting times for MRI, x-rays and ultrasound scans was within one week, this was well below the six weeks standard wait within the local acute hospitals. Information provided about this service showed staff from the service were willing to be flexible where possible with clinic appointments.
- From November 2017 to November 2018 there had been no cancelled planned scans.
- Most patients arranged an appointment within a day or two of contacting the service, or within a timeframe which suited them.
- Patients could access the service by self-referring or on referral from another clinician. The team carried out procedures by prior arrangement with patients.
- Scans were available by appointment only and each patient was allocated enough time for their appointment.
- Radiologists reported on scans and x-rays and sent reports within 24-48 hours highlighting if there were issues with the report. The clinic manager sent reports to the referrers within 24 hours. Patients who self-referred could either choose to have their results sent to their GP or not.
- There was a process in place to monitor DNA (did not attend) appointments. For example, where a patient DNA their appointment, staff contacted them and recorded it on patient notes. Staff offered patients another appointment if required.
- Waiting times in the unit were short. Evidence showed there were very few delays and appointment times were closely adhered to.

Learning from complaints and concerns

- The service treated concerns and complaints seriously, investigated them and shared any learning with staff.
- The service had a complaints policy in place, which was last updated in July 2018. This provided staff with the details of action to take if a complaint was made either by telephone or email.
- Staff demonstrated good understanding of the complaints policy and said the attentive, small-scale nature of the service meant they could address minor concerns as they arose.

Requires improvement

Diagnostic imaging

- The service recorded four complaints from November 2017 to November 2018. All complaints had been formally raised with the service by the patient. Of the four complaints raised by patients, three were due to image quality. All complaints were dealt with confidentially and impartially.
- Complaints were investigated by the clinic manager. All complaints were responded to within five working days. The clinic manager issued a full response within 20 working days. Patients received a letter keeping them informed of the progress if for some reason the process could not be completed within 20 days.
- Staff were encouraged to resolve complaints and concerns locally, which was reflected in the low numbers of formal complaints made against the service.
- Staff monitored the views of patients through the complaints and compliments received through the patient complaints procedure. They analysed and investigated complaints and concerns thoroughly in keeping with indemnity rules and regulations.
- In the reporting period from November 2017 to November 2018, the service had received 15 compliments online. Some of the compliments were centred around access to scans.

Are diagnostic imaging services well-led?

Inadequate

We previously did not have the authority to rate this service. We rated it as **inadequate.**

Leadership

- The corporate management structure consisted a director and a clinic manager. They were supported by radiologists and Medical Physics expert.
- We were not assured that leaders had the skills, knowledge, experience, and integrity they needed to ensure the service met patient needs. However, the management team described how they strived to be professional, open and inclusive.
- Leaders did not understand the challenges to quality and sustainability, therefore prior to inspection they had not identified the actions needed to address them.
- They had not established suitable and effective policies and procedures to fulfil the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)
- The registered manager held one stop clinics as an orthopaedic surgeon and was contactable for any queries or discussion needs that arose with regards to diagnostic imaging. However, expert knowledge in diagnostic imaging was limited.
- Staff spoke positively about the leaders of the service, from their direct line manager to the director of the company.
- Staff we spoke with found the manager to be approachable, supportive, and effective in their roles. They all spoke positively about the management of the service.
- The clinic manager was primarily responsible for the day-to-day running of the service and line managed the receptionist and radiographer.

Vision and strategy

- Bromsgrove Private Clinic had an annual plan. The objectives for 2018/2019 were to secure the image management portal, the General Data Protection Regulation (GDPR) policies and to continue to manage a well led, evidence and outcome based service.
- While the staff we spoke with were unable to fully articulate the vision, it was evident they always worked within the ethos of it.
- Due to the small nature of the service, there was no robust strategy for achieving priorities in the service.

Culture

- All staff we spoke with told us they felt respected and valued by their managers and fellow colleagues. Staff told us working for the service had a very 'family feel' to the service as many had started to work for the service in the earlier days. If they had any concerns, staff felt they were able to approach anybody for help and advice.

Diagnostic imaging

- Staff we spoke with told us they felt proud to work for the service and they enjoyed the work they did within the clinic.
- The service had an open and honest culture. Any complaints raised would have an open and honest 'no blame' approach to the investigation. In circumstances where errors had been made, apologies would always be offered to the patient and staff would ensure steps were taken to rectify any errors.
- Staff demonstrated pride and positivity in their work and the service they delivered to patients and their service partners. Staff were happy with the amount of time they had to support patients and that was one of the things they enjoyed about their role.
- Staff also told us teamwork was excellent both within the MRI unit and with the knee clinic. They felt this enhanced a seamless transition for patients.

Governance

- There was a lack of effective governance framework to support the delivery of quality patient care. There was no clear oversight of the day to day working of the service. For example, the service failed to identify risks associated with lack of radiation protection signs, compliance with IR(ME)R and IRR 2017, lack of compliance with infection prevention and control practices, lack of practical competencies and lack of emergency equipment. This meant that the governance system in relation to the management of risk did not operate effectively to ensure that leaders have clear oversight of the risk of harm to patients and their relatives. However, following the inspection, some of the governance framework improved. For example, the radiation protection signs, access to emergency equipment and some staff competencies.
- Some guidelines such as the IR(ME)R employers' procedures were out of date. Staff were not always aware of the most up-to-date versions of procedures and policies and we were not assured that there was consistency of practice. We were not assured that there was a robust system of review for procedures and radiology protocols.
- The provider required individual practitioners to hold their own indemnity insurance, all staff working for the service were covered under their own indemnity cover. We saw copies of indemnity cover in staff files.
- There was a monthly morbidity and case-mix meetings to discuss cases and complications. Reflection and learning processes were established to learn and improve from complications. We saw these meetings were mostly around patients who had attended knee clinics and who had later been referred for a scan.
- The registered manager held an audit meeting in October 2018 with radiologists. We looked at the minutes and patient after care and second opinion was discussed. However, senior staff held no team meetings with radiographers and vital information was not always disseminated to staff.
- Minutes of clinical governance meeting held in September 2018 contained agenda items such as referral and telephone call management. Staff discussed referral management and Saturday extra clinics to ensure patient referrals were well managed.

Managing risks, issues and performance

- The service did not always have processes to identify, understand, monitor, and address current and future risks. Risks found on inspection had not been recognised by senior staff. For example, there was no robust arrangement for identifying, recording and managing risks in place, risk assessments seen did not comply with IRR regulation 2017 and there was no incident reporting system in place. We saw clinical incidents relating to images which had not been reported correctly due to a lack of incident reporting system.
- The service had a risk management policy in place which was due for review in September 2019. However, there was not an effective process in place for reviewing and managing compliance with Governance around risk assessments, equipment quality assurance and diagnostic reference levels (DRLs) as required under IR(ME)R was poor with no evidence of dose audits. Following inspection, the service commenced analysis and monitoring of DRLs and equipment quality assurance.

Diagnostic imaging

- The service had a risk register in place to identify and manage risks to the service. The registered manager maintained a tracking document for risks and updated it every six months. The risk register comprised of three open risks. An example of risk included within the risk register was budget risk. No clinical risk had been recorded within the risk register.
- Findings from audits were not widely shared within the service. For example, staff we spoke with could not tell us if image peer review audits were carried out. There was no evidence that audit findings were discussed and disseminated with staff. This meant we could not be assured that learning from audits were identified, taken forward and implemented. We raised this with the registered manager who in response to our feedback said audit findings will be stored on a drive for staff to read.
- Information management systems were in place to protect patients against breaches of confidentiality and to prevent data loss. This included a back-up server for electronic records and controlled access to paper records in the clinic.

Managing information

- Staff had access to the organisation's computer systems. They could access policies and resource material.
- All staff we spoke with demonstrated they could locate and access relevant and key records very easily and this enabled them to carry out their day to day roles.
- Electronic patient records could be accessed easily but were kept secure to prevent unauthorised access to data.
- The service had adopted a cyber essentials certification programme to make sure that the clinic IT systems were safe and secure. They were certified in October 2018.
- The service was aware of the requirements of managing a patient's personal information in accordance with relevant legislation and regulations. Staff told us when the General Data Protection Regulations (GDPR) were released, they were reviewed to ensure they were operating within the regulations. They viewed breaches of patient personal information as a serious incident and would therefore manage this as a serious incident and escalate to the appropriate bodies.
- Information governance training formed part of the mandatory training programme for the service and at the time of our inspection, all the clinic assistants had completed this training. Staff we spoke with understood their responsibilities regarding information management.

Engagement

- Bromsgrove Private Clinic engaged with patients, staff, and local organisations to plan and manage appropriate services.
- There was a website for members of the public to use. This held information regarding the types of scans offered and what preparation was required for each type. There was also information about how patients could provide feedback regarding their experience.
- Patient views and experience were gathered to shape and improve the services and culture. For example, we saw patient feedback and comments were displayed on the service's website.
- Staff were encouraged to voice their opinions and help drive the direction of the service provided and suggest improvements to the examinations provided.

Learning, continuous improvement and innovation

- Whilst staff responded promptly to both our verbal and subsequent letter detailing our serious concerns, they had not recognised the concerns themselves. There was overall lack of awareness of what staff should be doing to provide a safe and sustainable service.
- The service offered an open weight bearing MRI scanner which was the second in the country to become functional.
- The Bromsgrove Private Clinic had undergone a refurbishment from December 2017 to May 2018.This involved relaying the internal structure of the clinic, and improving the reception and consulting room layout to improve service provision.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure there is a robust governance system in place to ensure incidents are recorded and investigated. Regulation 17(2)(a).
- The provider must ensure compliance with IR(ME)R and IRR 17 regulations. For example, they must;
  - Ensure a trained radiation protection supervisor is in post,
  - Ensure diagnostic reference levels are recorded and audited,
  - Ensure lead gowns are checked annually,
  - Ensure risk assessments comply with IRR 2017,
  - Ensure equipment quality assurance is carried out,
  - Ensure all employers' procedures are up-to-date. Regulation 17(2)(a).
- The provider must ensure that both locum/agency and substantive staff are competent to operate scanning machines. Regulation 18(2)(b).
- The provider must ensure induction checklists are completed for locum staff. Regulation 18 (2)(b).
- The provider must take prompt action to address a number of significant concerns identified during the inspection in relation to, staff competencies, availability of emergency equipment, compliance with IR(ME)R regulation, incident recording and reporting, and the governance of the service. Regulation 17(2)(b).

Action the provider SHOULD take to improve

- Ensure that audit results are disseminated to all staff.
- Ensure procedure cleaning schedules are in place and environmental audits are carried out
- Ensure hand hygiene audits are undertaken to measure compliance with the World Health Organisation's (WHO) '5 Moments for Hand Hygiene.'
- Ensure lead aprons are checked in accordance with guidance
- Continue to record optimisation of patient doses within the service in line with IR(ME)R regulation.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: • There was poor compliance with IR(ME)R and IRR 2017 regulations. • There was no robust governance system in place to ensure a system of recording incidents was put in place. • Risks found on inspection had not been recognised by the service.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: • There was lack of evidence on practical competencies, techniques and practical patient positioning. • Induction checklists were not completed for locum staff.