Baba Scans Limited

Baba Scans

Inspection report

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

Ratings

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

Summary of findings

Overall summary

We had not inspected this service before. We rated it as requires improvement because:

- Staff had training in key skills but staff had not updated their mandatory training.
- The service did not control infection risk well.
- The service did not always assess risks to women and act on them.
- The privacy and dignity of women was not always maintained.
- Leaders operated governance processes but there was no formal governance framework in place and there were gaps in the system for reviewing policies and procedures. Governance processes could be improved by having a written strategy and ensuring that all policies and procedures were reviewed within their review date.

However:

- The service had enough staff to care for women and keep them safe, understood how to protect women from abuse, and managed safety well. Staff kept good care records. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of women and supported them to make decisions about their care.
- Staff treated women with compassion and kindness, took account of their individual needs, and helped them understand their conditions. They provided emotional support to women, families and carers.
- The service planned care to meet the needs of local people, took account of women's individual needs, and made it easy for people to give feedback. People could access the service when they needed it.
- Leaders ran services using reliable information systems and supported staff to develop their skills. Staff felt respected, supported and valued. They were focused on the needs of women receiving care. Staff were clear about their roles and accountabilities. The service engaged well with women and the community to plan and manage services and all staff were committed to improving services.

Summary of findings

Our judgements about each of the main services

Service		Rating	Summary of each main service
Diagnostic imaging	**Requires Improvement**		See the overall summary above

Summary of findings

Contents

Summary of this inspection

Background to Baba Scans

Baba Scan is an independent baby scanning service in Rochdale offering 2D reassurance scans, 2D foetal gender scans, 3D/4D foetal bonding scans and 3D/4D HD live scans. They do not replace ultrasound scans provided by the NHS.

The service was registered for the following regulated activities:

- Diagnostic and Screening

At the time of our inspection the service was run by the owner, who carried out all the scans and a joint owner who acted as the administrator and receptionist.

The service did not offer non-invasive prenatal testing (NIPT). This is a blood test offered to women who may be carrying a baby identified from previous screening tests as having a higher chance of having either Down's syndrome, Edwards' syndrome, or Patau's syndrome.

The service did not administer or store controlled medicines.

The service has not previously been inspected but had been operating since 2015 before registering with the care quality commission (CQC) in 2019.

There was a registered manager in post who was the owner and sonographer for the service.

The service was open: Monday – Friday : 11am - 3pm and from 10am to 2pm on a Saturday, with more appointments available on request.

From January 2022 to the date of our inspection, the service had carried out 835 scans.

How we carried out this inspection

We carried out a comprehensive inspection of the service under our regulatory duties. The inspection team comprised of a lead CQC inspector and an offsite CQC inspection manager.

We inspected the service using our comprehensive methodology using the CQC Diagnostic Imaging and Baby Keepsake Scan Frameworks. We carried out a short notice announced inspection on 11 November 2022 to ensure the service was open at the time we planned to visit.

We spoke with 2 members of staff including the registered manager, and receptionist/administrator. We observed the environment and spoke with 3 people using the service. We reviewed records of women who had used the service. We also looked at a range of performance data and documents including policies, meeting minutes, audits and action plans.

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.

Summary of this 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:

- The provider must ensure that there are arrangements in place for all staff to undertake mandatory training. (Regulation 18)
- The provider must ensure that all staff have a good understanding of infection prevention and control practice to ensure that the service is run safely. (Regulation 12)
- The provider must ensure that all clinical waste, particularly offensive hygiene waste, is disposed of safely in clinical waste bins with foot pedal or no touch operation. (Regulation 15)
- The provider must ensure that clinical waste stored outside for collection is in a lockable bin or store. (Regulation 15)
- The provider must ensure that hazardous cleaning chemicals are kept in a locked cupboard in accordance with the relevant regulations. (Regulation 15)
- The provider must ensure that there are appropriate measures in place to check the age, identity and key pregnancy information and history of the woman. (Regulation 12)
- The provider must ensure that appropriate procedures are in place in the event of a medical emergency. (Regulation 12)
- The provider must ensure that there is access to independent interpreters to assist women whose first language is not English or who may have a hearing impairment to ensure that a relative does not act as an interpreter where there may be a safeguarding concern. (Regulation 9)
- The provider must ensure that policies and procedures are reviewed, and updated if necessary, in line with their own review dates. (Regulation 17)

Action the service SHOULD take to improve:

- The provider should ensure that there is a “pause and check” safety checklist displayed in the clinic as an aide memoire to staff to confirm identity and consent before any procedure is undertaken. (Regulation 12)
- The provider should ensure that the privacy and dignity of women is maintained at all times. (Regulation 10)

Our findings

Overview of ratings

Our ratings for this location are:

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

Requires Improvement

Diagnostic imaging

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

Are Diagnostic imaging safe?

Requires Improvement

We had not inspected this service before. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff but did not ensure that mandatory training was up to date.

The two staff members had undertaken online mandatory training courses in 2019 offered by a private training company, but the certificates for most of these had expired in 2021 and the courses needed to be repeated.

The mandatory training initially undertaken included equality, diversity and human rights; health, safety and welfare; conflict resolution; fire safety; infection prevention and control; moving and handling; resuscitation (level 1 and 2) and information governance and data security.

The mandatory training was comprehensive and met the needs of women and staff for this type of service.

The manager knew that the mandatory training needed to be repeated but this had not happened.

Safeguarding

Staff understood how to protect women from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training, specific for their role, on how to recognise and report abuse. They knew how to identify adults and children at risk of, or suffering, significant harm and how to make a safeguarding referral and who to inform if they had concerns but the manager told us that the service had never had a need to make any safeguarding referrals.

Diagnostic imaging

Both the manager and receptionist had undertaken level 1, 2 and 3 safeguarding courses in adults and children and these were in date. The training included female genital mutilation (FGM) and PREVENT, the government strategy, that was developed to assist in signposting organisations where there was a suspicion of an adult or child having been radicalised.

We reviewed the service safeguarding policy and procedure. This was due to have been reviewed in November 2020 but had not been. The policy contained the contact details of the local safeguarding team in Rochdale but not for those of neighbouring areas. Some women travelled from outside the Rochdale area.

Staff followed safe procedures for children visiting the service. The consulting room was secure during each appointment with each appointment spaced so that no other people were waiting in the waiting room at any one time.

The service did not scan any women under the age of 18.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. They kept equipment and the premises visibly clean. Staff did not manage clinical waste safely.

Clinical areas were visibly clean and had suitable furnishings which were clean and well-maintained.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Staff cleaned equipment after patient contact.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). Masks were not always worn correctly by the staff and were not disposable. Disposable masks were available in the clinic but not used during the inspection. Surgical gloves were available in the scanning room and we saw that the manager used these when scanning women. However, the manager did not follow infection control principles on being bare below the elbows.

Clinical waste was not disposed of safely. The manager was unaware that used PPE was clinical waste and it was not disposed of safely. There was a swing bin in the scanning room that had a non-clinical waste bin liner. The bin was not a clinical standard waste bin that was foot pedal operated or no touch operation. Similarly, the waste bin in the toilet area was not a pedal bin. There was no clinical waste disposal contract in place. We saw an infection prevention and control audit carried out by the manager three years previously where they had identified the need to purchase foot pedal operated waste bins for the scanning room, toilet area and kitchen but this had not happened. There was no lockable clinical waste bin that could be left outside the premises for the collection of clinical waste.

The service had a clinical waste management protocol in place that identified the different types of clinical waste and how these should be disposed of. This was due to have been reviewed in November 2020 but had not been. There was also an infection control policy and a cleaning and decontamination of surfaces policy that had also not been reviewed on or by the due date in 2020.

The infection control policy had evidently been adapted from a different type of provider and contained phrases that were not appropriate to a baby scanning service. For example, the policy stated food and drink could not be consumed in any clinical areas of any Baba Scans vehicle i.e. the back of ambulances. The service did not use vehicles in its day to day activities.

Diagnostic imaging

Hand hygiene audits had not been carried out since the service was registered. However, we noted that hand gel was available for staff, women and visitors to use at the reception desk and in the scanning room. Handwashing facilities were available in the scanning room.

We saw that cleaning products for the premises were not stored securely and in accordance with the law that requires employers to control substances that are hazardous to health (COSHH). They were kept in an unlocked cupboard in the toilet area and this cupboard was at ground level which could have posed a risk to young children using the facilities as they were fully accessible to all visitors to the premises.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them.

Staff carried out daily safety checks of specialist equipment and had an external contract for the maintenance of equipment, including the scanning machine. There were up to date servicing records in place.

All electrical equipment in the clinic was PAT tested (portable appliance testing) annually and this was next due in 2023.

Fire equipment was tested, and staff knew what to do in case of a fire. There were current servicing records in place for the fire extinguisher.

The service had suitable facilities to meet the needs of women and their families. The premises were large enough to accommodate the business with an ultrasound room, large reception/waiting area, an office, kitchen area/stock room and toilet.

The waiting area was large enough to allow for social distancing between waiting families and appointments were spaced so that there was generally only one woman and family members in the premises at one time.

The couch in the scanning room was adjustable and could be lowered and raised. This meant that it was easier and safer for women to use.

The clinic kept a first aid box.

The provider kept adequate stocks of personal protective equipment (PPE) such as masks and gloves. Customers were asked to wear masks whilst in the premises.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each woman and remove or minimise risks. We were not assured that staff knew what to do and would act quickly when there was a medical emergency.

The clinic did not offer diagnostic imaging services. The provider consent form advised women that the scans were for non-diagnostic, keepsake purposes only and they did not look for abnormalities.

Diagnostic imaging

We were not assured that the service had appropriate arrangements in place to assess and manage risks to women and their babies. Women were not asked to bring their NHS pregnancy notes with them to the scan to check how many weeks pregnant they were and when they last received an ultrasound scan to allow them to make informed decision about whether to receive additional non-clinical exposure to ultrasound. The clinic records system showed when a woman had last received a scan from the provider.

Women were not asked to complete a pre-scan questionnaire about their pregnancy history, for example, previous miscarriages, stillbirths or abnormalities. Women were advised that they would not be scanned if experiencing any abdominal pain or vaginal bleeding.

The service used latex free gloves and women were asked whether they had an allergy to the gel used for the scan before a scan took place.

The provider only scanned women over the age of 18 years of age. However, women were not asked to bring proof of identity or age with them though a date of birth was asked for at booking and on the consent form.

We did not see any “pause and check” list in the scanning room. This is a list devised by the British Medical Ultrasound Society and Society of Radiographers to ensure that sonographers completed checks during the scan that included confirming the woman’s identity (name, address and date of birth) and consent, providing clear information and instructions and informing the woman about the results. However, the registered manager told us that they carried out the relevant checks before performing the scan.

Staff shared key information to keep women safe when handing over their care to others. The clinic had an adverse outcome procedure in the rare event that a foetal abnormality or other concerns such as no heartbeat were suspected. In such an event, a report was completed by the sonographer to take to the hospital gynaecology assessment unit and permission was asked from the woman for the service to contact the local early pregnancy unit to pass on the concerns at the earliest opportunity. We saw a number of adverse outcome reports that had all been completed by the sonographer. They contained full information about the concerns.

We were not assured that all staff knew what to do in the event of a medical emergency. For example, the manager told us that a suspected ectopic pregnancy would be a medical emergency. However, we were told they would not call an ambulance to transfer the woman to hospital for immediate treatment and would advise the woman to seek medical treatment as soon as possible.

In the event of concerns about the pregnancy being suspected women had to travel to a neighbouring town to receive further assessments. There did not appear to be any follow-up checks by the clinic to ensure that women had attended an NHS facility for further assessments.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care.

The service had enough staff to keep women safe.

The clinic was managed by the registered manager who acted as the sole sonographer. There was one receptionist/ administrator.

Diagnostic imaging

The registered manager was a member of the British Medical Ultrasound Society (BMUS), had a diploma in medical ultrasound and was registered with the college of radiographers.

The clinic opening hours were worked around the availability of staff and number of customers using the service. The service did not use any bank or agency staff or other sonographers.

The manager told us that staff did not work alone in the clinic.

Records

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

Consent forms were kept in secure storage, post scan and the service had a general data protection regulation (GDPR) policy in place.

Notes were made to the reverse of the consent forms by the person carrying out the scan if there was anything of significance, such as the woman was asked to go for a walk to get the baby moving or the gender could not be identified.

Patient notes were comprehensive and could be accessed easily by staff in the service. Where concerns were identified on scan, a report was written and shared with the general practitioner or receiving maternity service to ensure continuity of care. All women were informed of this and consent confirmed at booking.

Details of the women who had attended for a scan were stored securely on a password protected computer. All staff with access to the records had a separate sign in password.

Medicines

The service did not use any medicines or controlled drugs.

Incidents

The service had a process for managing safety incidents. Staff could recognise and report incidents and near misses but had never had to do so.

The manager knew what incidents to report and how to report them. They said they had not had any incidents to report but could say what actions they would take.

The manager knew the principles of duty of candour but reported never having had to use it as feedback had always been positive.

The service had a significant and critical event toolkit that enabled the recording and review of any incidents and the recording of an action plan. The toolkit was due to have been reviewed in 2020 and had not been.

Requires Improvement

Diagnostic imaging

Are Diagnostic imaging effective?

Inspected but not rated

We have not inspected this service before. We inspected the effective domain but do not rate this for diagnostic services.

Evidence-based care and treatment

The service provided care and procedures based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. However, policies had not been reviewed.

Staff followed policies to plan and deliver high quality care according to best practice and national guidance.

The service provided care based on national guidance and referred people who used the service to the British Medical Ultrasound Society (BMUS) (Guidelines for Professional Ultrasound Practice) for further information on ultrasound.

The manager told us that they kept updated on national guidance issued by the National Institute of Care Excellence (NICE) and Royal College of Gynaecology.

The service followed the BMUS guidelines on "as low as reasonably achievable" (ALARA). This meant that ultrasound exposure was kept as low as reasonably achievable and that scans were conducted within minimal timescales and the thermal index or the amount of heat that may be produced, was kept to the minimum level, dependent on the type of scan being conducted.

Foetal measurements were based on BMUS guidelines and the equipment was calibrated against these guidelines.

This information was displayed on the provider website

Patient outcomes

Staff monitored the effectiveness of care. They used the findings to make improvements. However, there was no formal monitoring in place to review quality assurance and clinical safety.

Managers monitored the effectiveness of care and used the findings to improve them.

The clinic requested feedback from all women who used the service on their experience. The registered manager collated comments received via the website and social media pages.

Feedback from women was positive, consistent and met expectations.

The manager had carried out a clinical audit on miscarriages identified to compare gestational age and ethnicity though it is not clear what the outcomes were or how the results were used, given that only a small number of miscarriages were identified. The service had no formal audit programme in place to review quality assurance and clinical safety such as waiting times, image quality satisfaction, complaints received, incorrect genders identified.

Diagnostic imaging

The service had well-defined pathways for NHS referrals where anomalies were found.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance provided support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women.

The manager supported the other staff member through yearly, constructive appraisal of their work. We saw that there were written appraisal records and clear objectives.

The manager had carried out a self-appraisal and set themselves actions for improvement. However, they had been unable to have their images peer reviewed by another sonographer as no other sonographers were employed by the service.

The manager held team meetings with the other staff member and these were documented.

Multidisciplinary working

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

We saw that staff worked well together. Women and their families were greeted as they arrived at the service and supported to fill in the paperwork. The manager had worked with the local NHS maternity service to refer women with any abnormalities on their ultrasound scans. They had a built a relationship with the early pregnancy unit so that they were happy to take telephone referrals from the clinic following a discussion about the concerns. The manager told us that they also had good links with the community midwives.

Seven-day services

Services were available to support timely patient care.

The clinic was open six days a week and the manager told us that they had tried to give as much flexibility as possible in opening hours to enable women to make a convenient appointment time, whether this being in the evening, during a weekday or at the weekend. The website stated that emergency appointments were available on Sundays, dependent on the availability of the manager though did not explain what constituted an emergency appointment or why a woman would not be signposted to the NHS in the event that they suspected that something may be wrong.

At the time of our inspection, the clinic was open on six days a week. On Monday to Friday the advertised opening times were 11am to 3pm and on Saturdays from 10am to 2pm.

Health promotion

Staff gave women practical support and advice to lead healthier lives but this was very limited.

Requires Improvement

Diagnostic imaging

There was a poster promoting smoking cessation in the waiting area. The manager said that they would ask about smoker status if a foetus was smaller than expected.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not always support women to make informed decisions about their care. Staff followed the service policy and procedures when a woman could not give consent.

Staff understood how and when to assess whether a woman had the capacity to make decisions about their care. The service had a Mental Capacity Act policy in place which staff knew how to access. Staff received training in the Mental Capacity Act.

When women could not give consent, they were referred back to the NHS for any scanning procedures because the service did not carry out any procedures without signed consent.

Staff did not always make sure women consented to treatment based on all the information available. Staff gained consent from women for their care and treatment. However, the consent form made no reference to the British Medical Ultrasound Society guidelines for the safe use of diagnostic ultrasound equipment. These describe the risks of ultrasound scanning and would enable a woman to make a fully informed choice of whether they received additional scans other than those received in the NHS as part of their maternity care pathway.

There were separate consent forms for those receiving early pregnancy scans and bonding scans that described the primary purpose and potential limitations of the scans. The consent forms were sent electronically to the women before their appointment. They did not indicate the minimum age requirement of 18 for the service and, although the forms asked for a date of birth, we did not see photo identification being requested to prove the age of the woman being scanned.

Are Diagnostic imaging caring?

Good

We had not inspected this service before. We rated it as good.

Compassionate care

Staff treated women with compassion and kindness. They generally respected their privacy and dignity and took account of their individual needs.

Staff were discreet and responsive when caring for women. Staff took time to interact with women and those close to them in a respectful and considerate way.

Women said staff treated them well and with kindness.

Diagnostic imaging

Ultrasound scans were carried out in a separate room. However, we noted that the door was kept open and it was possible to hear the conversation. There were no other clients in the service at the time but had there been, the privacy of the woman receiving a scan would have been compromised.

Staff understood and respected the personal, cultural, social and religious needs of women and how they may relate to care needs.

We reviewed feedback from many people who used the service. Women were very positive about the service they had received and we saw no negative comments. Feedback was received from a questionnaire on the reverse of the disclaimer/consent form and on social media platforms.

We spoke with three women and their families who told us that they had a very positive experience, had received compassionate care and the sonographer always made time to answer questions in a way that they could understand and put them at ease.

Emotional support

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

We saw that staff provided emotional support to people who used the service to minimise their distress.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them

The manager told us that, if a potential concern was detected during the scan, then this was fully explained to the woman who was kept in the scanning room whilst the form was completed for them to take to an early pregnancy unit.

We saw that scans were not rushed and that if good images could not be obtained the woman was advised to go for a walk and then come back for a further attempt. Free rescans were offered where images could not be obtained, or the gender of the baby could not be seen.

Understanding and involvement of women and those close to them

Staff supported women, families and carers to understand their condition and make decisions about their care and treatment.

Staff involved people who used the service and those close to them in decisions about their care. Information was given to women phoning to book an appointment about the best time to have the scan based on the number of weeks pregnant and appointments were made during the optimum window when the best images were likely to be obtained.

People who used the service were given full information on the cost of their scan, packages available and the cost of added extras, such as confetti cannons or balloons.

Requires Improvement

Diagnostic imaging

The clinic website showed the scan packages that were available along with the cost so people who used the service could make a choice about what they wanted. People who used the service were able to choose the photographs they received from all the available computerised images. People who used the service were able to change their mind about the package they received and pay the balance outstanding.

Are Diagnostic imaging responsive?

Requires Improvement

We had not inspected this service before. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served.

The service offered a range of ultrasound scan procedures for private fee paying pregnant women over the age of 18.

The manager planned and organised services, so they met the changing needs of the local population. Clinic opening times meant those people who were working could book an appointment in the evening (by request) or at the weekend and there were appointments available on five weekdays.

Facilities and premises were appropriate for the services being delivered. The treatment room was spacious and provided a suitable and relaxed environment for women and their loved ones to undergo scan procedures.

The premises were located close to Rochdale town centre. There was ample parking in the vicinity and the clinic was close to a transport interchange with trams and buses. It was convenient for women to travel there by public transport from Rochdale, Oldham and surrounding areas.

Appointments were booked in advance by telephone, and this allowed staff to plan the scan procedures before women attended their appointment.

Managers ensured that women who could not attend appointments were offered a rearranged date at the earliest opportunity.

Meeting people’s individual needs

The service was inclusive but did not always take account of women's individual needs and preferences and the provider was not always compliant with the Accessible Information Standards. Staff made reasonable adjustments to help them access services. They directed women to other services where necessary.

The service did not provide separate sessions for women receiving early pregnancy scans. This would have ensured that women who were there for reassurance about their pregnancy, for example those who had suffered previous miscarriages, did not have to share the waiting room with others who were much later on in their pregnancy.

Diagnostic imaging

Women receiving an early pregnancy scan, were given a longer appointment to allow time for them to ask any questions.

The service had an equality and diversity policy and the staff had received equality and diversity training though this needed to be refreshed and the policy was due to have been reviewed two year previously.

The service did not have information leaflets available in common languages spoken by the women in the local community. The manager told us that she could speak some Asian languages. Women were encouraged to attend with someone who could assist with interpreting and allow them to understand the consent form. The service did not have access to an independent translation service.

The service did not have a hearing loop for women with hearing impairments or access to information in braille for women with sight impairments.

The service was accessible for people with limited mobility. It was on the ground floor of a building with wide doorways and access directly from the street.

The service did not have specific admission or exclusion criteria, but the clinic would not scan women who were unable to give consent or could not be safely scanned.

Ultrasound scan prices were clearly displayed on the service's website. There was information for prospective clients about what to do before arriving at the clinic, what would happen on arrival and the scan itself. There were also frequently asked questions on the website. Women could also telephone for additional information.

Access and flow

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

All women attending the service were self-referred. They could book their appointments at a time and date of their choice in advance. Appointment bookings were made in person or by telephone.

Women were given appointments based on their preference. There was no waiting list for appointments, and they could be seen promptly (including the same day in some instances). Women who had to cancel their appointments were given an alternative date and time.

Women were given an appointment time of around 30 minutes dependent on the type of scan they were receiving but this could be extended if needed.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included women in the investigation of their complaint.

Requires Improvement

Diagnostic imaging

Women, relatives and carers knew how to complain or raise concerns. Information about how to complain and response times was clearly displayed on the website. Complaint forms were available in clinic and included suggestions for improvements.

Staff understood the policy on complaints and knew how to handle them.

Women received feedback from managers after the investigation into their complaint. The manager shared feedback from complaints with the other staff member and learning was used to improve the service.

The manager told us that they had never received any formal complaints but a few customers were dissatisfied with image quality and they would generally offer a free re-scan if this was the case.

The manager told us that they had carried out an audit on incorrect gender identification.

The service was not a member of the Independent Sector Complaints Adjudication Service (ISCAS).

Are Diagnostic imaging well-led?

Requires Improvement

We had not inspected this service before. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service, but they did not always understand and manage the priorities and issues the service faced. They were visible and approachable in the service for women and staff. They supported staff to develop their skills.

The manager was in the clinic when it was open and delivered the scans. However, they lacked an understanding of some requirements relating to infection prevention and control.

We also found gaps in the manager’s understanding and management of the priorities of the service such as maintaining mandatory training for all staff and updating policies and procedures.

Vision and Strategy

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

We discussed this with the manager and at the time of the inspection, the provider did not have a formal vision and strategy in place.

Culture

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

Diagnostic imaging

The registered manager and receptionist were motivated and positive about their work. They told us that there was a friendly, client-focused and open culture and that they worked well as a team.

There were anti-bullying, grievances and whistleblowing policies in place to allow staff to raise concerns without fear.

Governance

Leaders operated governance processes but there was no formal governance framework in place and there were gaps in the system for reviewing policies and procedures. Staff were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The registered manager had overall responsibility for clinical governance and quality monitoring though there was no formal governance framework in place or quality assurance audit programme.

The service had systems and procedures in place to ensure that policies referenced relevant guidelines. However, all the policies and procedures in place had a review date of November 2020 so we could not be assured that all policies remained current. The provider needed to review all the policies and set appropriate review dates for each.

Policies and procedures were available to staff in electronic format.

The provider had statutory professional indemnity insurance arrangements, in accordance with British Medical Ultrasound Society (BMUS) guidelines.

We saw that there were quarterly staff meetings. We reviewed 3 sets of minutes from March, June and October 2022 that showed that key subjects such as finances, operations and commercial factors were discussed.

There was a Fit and Proper Persons recruitment policy in place and we reviewed the staff files for the manager and receptionist. Both staff members had current enhanced disclosure and barring service (DBS) checks in place. Staff files held the qualifications and training undertaken.

Management of risk, issues and performance

Staff used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

There was a risk register in place in the clinic. This detailed the risk, who might be harmed, the risk controls in place, further action required to mitigate the risk, who carried out the actions, by when and the date complete.

We reviewed the risks on the register. The top three risks identified were slips, trips and falls; fire risks and the heavy front door.

Information Management

Diagnostic imaging

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

Staff received training for information governance and the General Data Protection Regulations.

Computer terminals were password protected, and the scanning machine was also password protected. However, the manager was unsure how long images were stored for.

The service had policies on data protection and confidentiality in place.

Engagement

Leaders and staff actively and openly engaged with women to plan and manage services. They collaborated with partner organisations to help improve services for women.

Staff routinely engaged with women during their scan procedures to gain feedback about the services.

The registered manager told us client feedback was regularly reviewed. All women were encouraged to provide feedback about the service.

The service was mainly promoted through their website, social media platforms and through word of mouth from people that had used the service.

Staff engagement took place through daily communication and routine staff meetings.

Learning, continuous improvement and innovation

Staff were committed to improving services. They had an understanding of quality improvement methods.

The clinic had invested in high quality scanning equipment and paper to print pictures to ensure that they were competitive in the market and customer satisfaction remained high.