BPAS - London East

Quality Report

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Date of inspection visit: 2, 3 and 10 June 2016
Date of publication: 06/03/2017

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

Summary of findings

Letter from the Chief Inspector of Hospitals

BPAS London East is part of the provider group British Pregnancy Advisory Service (BPAS). It provides a range of termination of pregnancy services for early medical abortion (EMA) up to a gestation of 10 weeks, surgical termination of pregnancy using vacuum aspiration with local anaesthetic up to a gestation of 12 weeks and surgical termination of pregnancy with conscious sedation up to a gestation of 13 weeks 6 days. The service also provides pregnancy testing, unplanned pregnancy counselling/consultation, abortion aftercare, sexually transmitted infection testing, vasectomy, and contraceptive advice and contraception supply.

We carried out this announced comprehensive inspection on 2 and 3 June 2016 and a follow up unannounced inspection on 10 June 2016. We inspected this service as part of our independent healthcare inspection programme.

We have not provided ratings for this service because we do not currently have a legal duty to rate this type of service or the regulated activities which it provides. Our key findings were as follows:

Is the service safe?

- Between January and December 2015 the service reported compliance rates with the World Health Organization (WHO) Surgical Safety Checklist ranging from 89% to 100% for surgical termination of pregnancy and vasectomy. Areas for improvement included ensuring the pre-operative checks were fully documented. However, we found there was no pre-operative briefing and no de-briefing after surgery. Both of these elements contribute to the five steps.
- There were ineffective processes for the proper and safe management of medicines. We found discrepancies in the stock of abortifacient medicines which senior managers could not account for. This was investigated by the provider after our inspection and remedial action taken.
- Some medicines were stored in three unlocked cupboards in the recovery area, including a cupboard under the sink. We brought this to the immediate attention of the registered manager and saw that medicines were transferred to a locked cupboard. On our unannounced inspection all medicines were stored correctly.
- National specifications for infection prevention and control were not always adhered to. Cleaning instructions and monitoring of cleaning standards were not in place. There was a lack of segregation of clean and dirty surgical equipment in the dirty utility room and no cleaning checklist in the treatment room.
- Calibration checks were not carried out on some equipment on a regular planned basis, including equipment used for the diagnosis and management of patient treatment and care.
- The standard BPAS incident reporting process and documentation was in place. The incident form booklets were located in the registered manager's office in the clinical administration area. All incidents were escalated to BPAS head office by the clinic registered manager, which was current BPAS policy. This meant that staff were unable to report concerns independently and staff and managers acknowledged this could lead to under reporting.
- Staff demonstrated their understanding of safeguarding adults and children. They described actions to take in cases of suspected abuse, knew how to access policies and had completed recent safeguarding training to an appropriate level.
- Patient records were stored securely, were legible and were mainly completed in accordance with prescribed practice.
- All the patients undergoing abortion underwent a risk assessment to determine their individual risk of developing blood clots.
- There were sufficient numbers of suitably trained staff available to meet patients' needs.
- Arrangements and instructions were in place to manage emergencies and transfer patients to another health care provider where needed and were known by staff.

Summary of findings

Is the service effective?

- Staff had access to relevant guidelines, policies and procedures. Care was provided in line with Department of Health Required Standard Operating Procedures (RSOPs) and national best practice guidance such as NICE and Royal Colleges and professional regulatory standards such as those produced by GMC and NMC. The service had completed a programme of clinical audits depending on risk assessments.
- The exception was the use of simultaneous administration of abortifacient drugs for early medical abortion (EMA), which is outside of current Royal College of Obstetrician and Gynaecologist (RCOG) guidance. We saw that a structured governance system was in place and had been followed to introduce this treatment option.
- There were systems for the effective management and development of staff which included an annual appraisal.
- Patients were offered pain relief, prophylactic antibiotic treatments and post-abortion contraceptives.
- Staff providing counselling participated in group counselling supervision in line with best practice guidance.

Is the service caring?

- We observed that staff were caring and compassionate and treated patients with dignity and respect. Feedback from patients highlighted that their wishes were respected and their beliefs and needs were taken into account.
- We saw during the initial assessment, nurses and midwives explained to patients all the available methods for termination of pregnancy that were appropriate and safe and this was recorded in patients' notes. Staff considered gestational age and other clinical needs whilst discussing these options.
- Patients considering termination of pregnancy or vasectomy had access to pre and post counselling, with no time limits attached, but were not obliged to use the counselling service.
- We could not observe how staff treated male patients because there were no vasectomy clinics in progress during our inspection. However, we spoke with staff, considered patient feedback and information, and reviewed five records for patients who had undergone vasectomy procedures. Vasectomy patients gave positive feedback in the BPAS patient satisfaction reports submitted between September and December 2015.

Is the service responsive?

- Patients either referred themselves or were referred by their GP. They were able to book appointments through the BPAS telephone booking service which was open 24 hours a day throughout the year. This also enabled patients to choose the location they attended.
- There was no formal monitoring of waiting times or the reasons for any delays. However, staff told us they could not recall any significant delays.
- Patients were referred to other services for termination of pregnancy, where appropriate, for example due to a medical condition or late gestational age. Patients could attend other local BPAS clinics for treatment if BPAS London East was closed.
- Patients were provided with information to help them to make decisions.
- The service had systems in place to ensure pregnancy remains were disposed of according to national guidance.
- A professional interpreter service was available for patients whose first language was not English, to enable them to communicate with staff. We saw this used effectively and in a timely manner.
- Complaints were managed locally and, where unresolved, were escalated to the central office to be managed by the complaints manager and client engagement manager. Feedback was given to staff and the complainant. The clinic identified trends in complaints, which included delays in clinic start times.

Is the service well led?

Summary of findings

- There were corporate governance arrangements to manage risk and monitor quality. This included an audit programme and an established system to cascade learning. However, the arrangements for governance mainly took place at national and regional levels and did not always operate effectively locally. Risks were not always identified or acted upon at the clinic by people with the authority to do so. In particular, monitoring and review of medicines management and infection prevention and control were not effectively managed.
- Legislation requires that for an abortion to be legal, two doctors must each independently reach an opinion in good faith as to whether one or more of the legal grounds for a termination is met. They must be in agreement that at least one and the same ground is met for the termination to be lawful, and sign a form to indicate their agreement (HSA1 Form). All of the records we looked at met these requirements.
- The culture within the service was caring, non-judgmental and supportive to patients. Staff spoke positively about the need for and value of the service to patients.
- Service development was encouraged: for example the introduction of surgical termination under conscious sedation in May 2016.
- Staff felt supported by their registered manager and regional operations director.

There were areas of practice where the provider needs to make improvements.

Importantly the provider must ensure:

- A formal review of the pharmacy service and a consistent approach to medicines management audit to ensure delivery, stock control and storage of medicines is managed in accordance with legislation, provider policy, and professional standards and national guidance.
- A list of authorised signatories is kept at the clinic to identify named practitioners who order, receive and administer medicines.
- Ensure briefings and de-briefings are fully implemented and documented in accordance with the World Health Organization (WHO) Surgical Safety Checklist.
- National specifications for infection prevention and control and cleanliness are adhered to including: segregation of clean and dirty equipment and waste in all clinical areas, and staff comply with national dress code standards for infection prevention and control.
- All areas in which patients are treated are clean and cleaning schedules and checklists are maintained in sufficient detail to demonstrate this.
- Safety checks including calibration are carried out on all equipment including that used for clinical diagnosis on a regular planned basis.

The provider should ensure:

- All staff at the clinic are actively involved in assessing local risks, local audit and clinical review. This should be proportionate and relevant to their role. Staff should be given training and support to take responsibility for maintaining standards.
- Staff are supported to independently report incidents of all kinds, including those with a potential to cause harm to patients or staff, even when no harm occurred. All staff should receive prompt feedback to reduce the risk of recurrence of incidents.
- Ensure documentary evidence that demonstrates men undergoing vasectomy have their pain assessed using a recognised pain score and that pain is treated.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Termination of pregnancy		We have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities which it provides.

Summary of findings

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BPAS - London East

Services we looked at
Termination of pregnancy

Summary of this inspection

Background to BPAS - London East

BPAS London East is part of the provider group British Pregnancy Advisory Service (BPAS). The service is located in a dedicated suite of rooms occupied solely by BPAS, and is provided under contract with London clinical commissioning groups (CCGs) for NHS patients. The service also accepts self-referrals and private patients.

BPAS London East is contracted by Clinical Commissioning Groups (CCGs) in the London area to provide a termination of pregnancy service and vasectomy service. The service also accepts self-referrals and private patients. It is located in a dedicated suite of rooms occupied solely by BPAS, and is available six days per week.

The following services are provided at BPAS London East :

- pregnancy testing
- unplanned pregnancy counselling/consultation
- medical abortion up to 10 weeks of pregnancy
- surgical abortion up to 13 weeks 6 days of pregnancy
- abortion aftercare
- sexually transmitted infection testing
- vasectomy
- contraceptive advice and contraception supply.

BPAS London East undertook 1655 (86%) medical abortions, 264 (14%) surgical abortions and 155 vasectomy procedures between January and December 2015 (the reporting period).

Our inspection team

Our inspection team included two inspectors and two specialist advisors in midwifery.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We carried out this announced comprehensive inspection on 2 and 3 June 2016 and followed it up with an unannounced inspection on 10 June 2016 as part of the first wave of inspection of services providing a termination of pregnancy service. The inspection was conducted using the Care Quality Commission's (CQC) new methodology.

We spoke with 11 members of staff in the clinic including: a midwife, consultant surgeon, nurses, client care coordinators, administrative staff, the registered manager, and the associate director of nursing for BPAS. We looked at 15 records of patients who had used the service, including four of patients under the age of 18, and five patients who had undergone vasectomy surgery.

During our announced inspection we also spoke with four patients and two supporters of patients, and observed how staff interacted with them.

Information about BPAS - London East

The British Pregnancy Advisory Service was established as a registered charity (Registered Charity Number 289145) in 1968 to provide a safe, legal abortion service following the 1967 Abortion Act. The mission statement

Summary of this inspection

for BPAS is that it supports reproductive choice and health by advocating and providing high quality, affordable services to prevent pregnancies with contraception or end them by abortion.

The clinic holds a license from the Department of Health (DH) to undertake termination of pregnancy services in accordance with the Abortion Act 1967.

BPAS London East was registered with CQC in July 2011. The service is easily accessible by public transport. It is registered as a single specialty service for termination of pregnancy services to NHS and self-funded patients.

The service is managed by a registered manager who is supported by doctors, nurses, midwives and clinical care coordinators/administrators.

The clinic consists of:

- reception area with secure access
- one private consulting room/treatment room
- two private consulting rooms
- recovery area
- two waiting areas
- administration and office areas.

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?

- There were ineffective processes for the proper and safe management of medicines. We found discrepancies in the stock of abortifacient medicines which senior managers could not account for. Some medicines were stored unlocked cupboards in the recovery area, including a cupboard under the sink. These issues were addressed subsequent to our inspection.
- National specifications for infection prevention and control were not always adhered to. There was a lack of segregation of clean and dirty equipment. In some areas monitoring of cleaning standards and equipment were not in place.
- Calibration checks were not carried out on some equipment on a regular planned basis, including equipment used for the diagnosis and management of patient treatment and care.
- The standard BPAS incident reporting process and documentation was in place. The incident form booklets were located in the registered manager's office in the clinical administration area. All incidents were escalated to BPAS head office by the clinic registered manager, which was current BPAS policy. This meant that staff were unable to report concerns independently and staff and managers acknowledged this could lead to under reporting.
- Staff demonstrated their understanding of safeguarding adults and children. They described actions to take in cases of suspected abuse, knew how to access policies and had completed recent safeguarding training to an appropriate level.
- Patient records were stored securely, were legible and were mainly completed in accordance with prescribed practice.
- All the patients undergoing abortion underwent risk assessment to determine their individual risk of developing blood clots.
- There were sufficient numbers of suitably trained staff available to meet patients' needs.
- Arrangements and instructions were in place to manage emergencies and transfer patients to another health care provider where needed and known by staff.

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Are services effective?

- Staff had access to relevant guidelines, policies and procedures. Care was generally provided in line with Department of Health (DH) Required Standard Operating Procedures (RSOPs) and national best practice guidance.
- The exception was the use of simultaneous administration of abortifacient drugs for early medical abortion (EMA), which is outside of current Royal College of Obstetrician and Gynaecologist (RCOG) guidance. We saw that a structured governance system was in place and had been followed to introduce this treatment option.
- The service had completed a programme of clinical audits depending on risk assessments.
- There were systems for the effective management and development of staff which included an annual appraisal.
- Patients were offered pain relief, prophylactic antibiotic treatments and post-abortion contraceptives.
- Staff providing counselling participated in group counselling supervision in line with best practice guidance.

Are services caring?

- Staff were caring and compassionate and treated patients with dignity and respect. Patients' wishes were respected and their beliefs and needs were taken into account.
- Clients gave consistently positive feedback.
- During the initial assessment, nurses and midwives explained to patients all the available methods for termination of pregnancy that were appropriate and safe. Staff considered gestational age and other clinical needs whilst discussing these options.
- Patients considering termination of pregnancy or vasectomy had access to pre and post counselling, with no time limits attached, but were not obliged to use the counselling service.
- Vasectomy patients gave positive feedback in the BPAS patient satisfaction reports submitted between September and December 2015.

Are services responsive?

- Patients either referred themselves or were referred by their GP. They were able to book appointments through the BPAS telephone booking service which was open 24 hours a day throughout the year. This also enabled patients to choose the location they attended.

Summary of this inspection

- There was no formal monitoring of waiting times or the reasons for any delays. However, staff told us they could not recall any significant delays.
- Patients were referred to other services for termination of pregnancy, where appropriate, for example due to a medical condition or late gestational date.
- Patients were provided with information to help them to make decisions.
- A professional interpreter service was available for patients whose first language was not English, to enable them to communicate with staff. We saw this used effectively and in a timely manner.
- Complaints were managed locally and, where unresolved, were escalated to the central office to be managed by the complaints manager and client engagement manager. Feedback was given to staff and the complainant.

Are services well-led?

- There were corporate governance arrangements to manage risk and quality. This included an audit programme and an established system to cascade learning. However, the arrangements for governance mainly took place at national and regional levels and did not always operate effectively locally. Risks were not always identified or acted upon at the clinic by people with the authority to do so. In particular, monitoring and review of medicines management and infection prevention and control was not effectively managed.
- Legislation requires that for an abortion to be legal, two doctors must each independently reach an opinion in good faith as to whether one or more of the legal grounds for a termination is met. They must be in agreement that at least one and the same ground is met for the termination to be lawful, and sign a form to indicate their agreement (HSA1 Form). All of the records we looked at met these requirements.
- The culture within the service was caring, non-judgmental and supportive to patients. Staff spoke positively about the need for and value of the service to patients.
- Service development was encouraged: for example the introduction of surgical termination under conscious sedation in May 2016.
- Staff felt supported by their registered manager and regional operations director.

Detailed findings from this inspection

Termination of pregnancy

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are termination of pregnancy services safe?

By safe we mean people are protected from abuse and avoidable harm.

- There were ineffective processes for the proper and safe management of medicines. There was no clear audit trail for the request and receipt of medicines' stock, and no formal audit to monitor medicines' management against policy. There were discrepancies in the stock of abortifacient medicines that senior management could not account for.
- Some medicines were stored in three unlocked cupboards in the recovery area, including a cupboard under the sink. However, when we returned for our unannounced visit all medicines were stored in locked cupboards.
- Service cleanliness audit results were mostly 100%. However, we saw national specifications for infection prevention and control were not adhered to. There was a lack of clear segregation of clean and dirty surgical instruments and clinical waste.
- Not all staff complied with the dress code for effective infection prevention and control.
- We witnessed clinicians placing medical equipment in its packaging on floors in the treatment room which were to be used during a clinical procedure.
- Checklists to provide sufficient cleaning instructions and monitoring of cleaning standards and equipment were not in place.
- There was enough equipment to allow staff to carry out their duties. However, safety checks such as calibration were not carried out on some equipment on a regular, planned basis. This included: two blood pressure monitors, three pulsometers, and weighing scales in all consulting rooms. Staff were unaware of the requirements for calibration. This could lead to faults remaining undetected, and the associated risks of misdiagnosis or ineffective treatment. We brought this to the immediate attention of the registered manager who told us corrective action would be taken.
- Staff told us all incidents had to be reported to the registered manager who would assess whether a report needed to be raised. Staff and managers told us this could lead to under reporting.
- Building maintenance concerns were not responded to in a timely way to prevent health and safety hazards on the premises. For example, during our two inspections there was a water leak in the waiting area. This was fixed after our inspection.
- There were sufficient numbers of suitably trained staff available to meet patients' needs.
- Staff demonstrated their understanding of safeguarding adults and children. They could describe actions to take in cases of suspected abuse, knew how to access policies and had completed recent safeguarding training to an appropriate level. All patient records we looked at showed that the initial assessment included a 'safe at home' trigger question, which was in line with NICE guidelines [PH50] 'Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively'.
- There was a specialist placement team to source appointments within the NHS for patients who were not suitable for treatment at BPAS on medical grounds.
- Patient records contained pre-printed patient pathways, depending on the procedure planned together by the patient and nurse assessor. Records were stored securely, were legible and were mainly completed in accordance with prescribed practice. However there were some incomplete entries in the surgical register.
- All patients undergoing abortion underwent a venous thromboembolism (VTE) risk assessment to determine their individual risk of developing blood clots.

- Arrangements and instructions were in place to manage emergencies and transfer patients to another provider where needed and known by staff.

Incidents

- BPAS' 'Patient Safety Incidents Policy and Procedure' sets out the procedures for reporting and reviewing incidents. This was supported by a trigger list for staff to help guide them on what constitutes a reportable incident. All staff we spoke with were familiar with the policy, procedures, and trigger list and how to report incidents, and some gave examples of incidents that they had personally reported. The BPAS 'Client Safety Incidents Policy and Procedure' provided detailed guidelines on thresholds and process for senior staff to conduct incident investigations.
- The system for reporting clinical and non-clinical incidents was paper based using an incident reporting book, that was located in the registered manager's office in the clinical administration area. Reported incidents were escalated to the corporate risk and safety team who would record them on a central electronic register. We looked at paper records of safety incidents held at the clinic. 16 incidents were reported between September 2015 and April 2016. The most frequently reported incident was retained products of conception (failed abortion).
- Three copies of each incident report were made, one remained in the patient notes, one remained in the book and one was sent to the BPAS corporate risk team.
- There were no never events reported at BPAS London East between January 2015 and December 2015. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- There were no serious incidents requiring investigation at BPAS London East between January 2015 and December 2015. Eight serious incidents had occurred in other BPAS clinics in the reporting period. Notes from the most recent London and South East Regional Management meeting held on 2 March 2016 confirmed learning about complaints and serious incidents requiring investigation had been discussed, and action points agreed. We also saw in the notes that the safety issues we have reported on relating to the need to improve cleaning schedules and checklists had been discussed by the regional operations directors, however; there was no evidence that any action was agreed or implemented.
- Serious incidents were discussed at quarterly BPAS clinical governance meetings. We saw that where serious incidents had occurred investigations and analysis of the root causes were carried out by the national risk management and safety lead and the clinical director. Regional and registered managers then disseminated lessons learned to staff, and action plans were developed to reduce the risk of a similar incident reoccurring. This was generally managed regionally and learning was shared across all clinics in the region.
- An internal bulletin known as 'the red top alert' informed staff of any safety issues. We saw examples of bulletins that included learning points arising from safety incidents at other BPAS clinics, for example, related to information governance, and to medicines management.

Cleanliness, infection control and hygiene

- As a corporate provider BPAS had an infection prevention and control (IPC) strategy and audit plan, and a range of policies and procedures to guide practice. The plan included monitoring compliance of the whole organisation against different standards of infection prevention and control. Required actions should be implemented when issues were identified.
- The most recent IPC audit completed in May 2016 demonstrated 96% compliance with IPC standards. Six areas of concern were documented. Four of these were resolved by the time of our inspection: the exceptions being the correct use of 'I am clean' tape on the ultrasound scanner, and effective medicines' storage to negate the risk of infection.
- We found some sterile clinical supplies stored in cupboards in the dirty utility room. During our inspection, cleaning buckets and a stainless steel trolley were also stored dirty utility room. We could not be assured that these were not cross-contaminated by other items in the room. There was no dedicated clean utility area on the premises, however, most sterile clinical equipment and supplies were stored in cupboards in clinical rooms. Department of Health guidance Health Building Note 00-09 Infection Control in

the Built Environment requires that in the absence of a clean utility or preparation room for treatment, a suitable alternative location for the storage of clean and sterile supplies should be provided.

- During our unannounced inspection we found clean diagnostic and clinical equipment stored in the dirty utility room, and medicines stored in a cupboard under a sink in the recovery area that also contained cleaning materials. This meant the environment was not managed in a way that facilitated good infection prevention and control. When we carried out our follow up unannounced inspection the majority of clean and dirty equipment was properly segregated and stored. The exception was that some disposable airways and an emergency kit to be used in the event of a patient bleeding were in cardboard boxes on the treatment room floor due to a lack of storage space.
- Cleaning was carried out daily by a contracted cleaning company, when the clinic was closed to patients. This meant staff had little opportunity to monitor the cleaning service, and relied on verbal feedback about specific concerns. Staff told us they were satisfied with the service provided.
- Cleaning standards did not comply with national specification 'The Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance'. Cleaning schedules did not detail the required standard and arrangements for cleaning at the point of use and cleaning checklists required by the code were not in place. Although we saw that the clinic was clean, the lack of a checklist did not provide adequate assurance that cleaning had taken place.
- Protective personal equipment (PPE) such as disposable gloves and aprons was readily available, and correctly stored. Not all staff adhered to the dress requirements set out in the code to minimise the risk of health care acquired infections, or best practice guidance on uniform published by Royal College of Nursing, 2013.
- Theatre scrubs were worn by all staff to minimise the risk of cross contamination of healthcare practitioner's clothing.
- We also witnessed medical equipment which was to be used during a clinical procedure, being placed in its packaging on the treatment room floor.
- Staff we spoke with were unclear about the uniform policy and one staff member was unclear the rationale for wearing theatre scrubs and PPE.
- Handwashing sinks, soap, and alcohol hand rubs were in good supply and we saw instructions for their use clearly displayed. We saw staff regularly washed their hands and generally complied with the handwashing policy. The BPAS Infection Control Essential Steps Audit tool facilitated audit of hand hygiene, personal protective equipment, aseptic technique and sharps management. BPAS London East was 100% compliant with the audits conducted in October, November and December 2015.
- Staff were dressed bare below the elbow while conducting clinical tasks. However, during our announced visit we saw that one nurse and a client care coordinator were not dressed bare below the elbow while in a clinical area. While this did not contravene 'bare below the elbow' guidance published by the National Institute for Health and Care Excellence (NICE), it did mean there was a potential risk that good hand hygiene could be impaired should the staff member be called to an emergency or respond quickly or unexpectedly to an incident. We brought this to the attention of the registered manager and were told corrective action would be taken. When we conducted our unannounced visit all staff were bare below the elbow in the clinical areas.
- There were no reported health acquired infections or Meticillin Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (C. Diff) from January 2015 to December 2015.
- Disposable curtains with an antibacterial covering were used in all treatment areas and were clearly labelled with a date to show when they were last changed.
- Spillage kits for the safe disposal of body fluids were provided and were within date. Staff knew where to locate them, and correctly described the procedure for managing this situation in accordance with the local policy.

Environment and equipment

- The service was provided in a suite of rooms with controlled access used solely by BPAS, and included facilities and access for people with a disability.
- We saw a leaking roof in the waiting area at the time of our inspection. We were told this had been reported one week prior to our visit. When we returned for our unannounced visit the problem remained unresolved and there was no confirmation of when it would be

repaired. Signs to inform patients not to sit in the area were visible and seating was rearranged away from the leak area. The clinic's registered manager had liaised with the building landlord but this had not resulted in resolution because the landlord was not permitted to enter the residential accommodation in the floor above without consent. This had been escalated to the BPAS senior executive team but remained unresolved at the time of our unannounced inspection. However following our inspection the registered manager informed us that the leak had been fixed.

- Patients attended medical consultations and treatment in a private room to allow for their privacy and dignity to be upheld. We saw this happened at all times.
- Patients undergoing surgery were treated in a small treatment room which was used as a consulting room on days when there were no surgical lists running. Following surgical procedures patients were cared for in a dedicated recovery area on reclining chairs. Staff told us they found the lack of a dedicated treatment room and the cramped conditions of the treatment room and recovery area very challenging. However they also told us the recovery area had been extended recently, as a result of a local risk assessment carried out by the senior management team, and that this had improved the environment considerably as it had created extra space between each patient's recovery area should access be required in the event of an emergency.
- An environmental health and safety audit was performed annually as part of the BPAS ongoing quality assurance programme. The most recent audit before our inspection was undertaken in September 2015, which concluded there were no significant risks. There was no recording of potential environmental risks on the BPAS central risk register. Managers confirmed that a local risk register was not in place.
- Some of the clinical equipment we saw had no up to date calibration check. This included: two blood pressure monitors, three pulsometers, and weighing scales in all consulting rooms. Staff were unaware of the requirements for calibration. This could lead to faults remaining undetected, and the associated risks of misdiagnosis or ineffective treatment. We brought this to the immediate attention of the registered manager who told us corrective action would be taken.
- All electrical appliances on the premises had been inspected and tested for electrical safety to the requirements of the electricity at work regulations, and had a valid certificate until June 2016.
- Oxygen cylinders were stored securely.
- First aid and resuscitation equipment was available and accessible in case of an emergency. We saw records that demonstrated the equipment was checked on the days the clinic was open to ensure it was available and fit to use. Single-use items were sealed and in date, and emergency equipment had been serviced.

Medicines

- Staff involved in the supply and administration of medicines were required to comply with the BPAS medicines' management policy which set out systems and staff responsibilities in line with national standards and guidance.
- We found discrepancies in the stock of Misoprostol and Mifepristone (abortifacient medicines), that could not be accounted for by senior managers. There were greater amounts of Misoprostol and less stock of Mifepristone than the records showed. We raised our concerns with the registered manager who told us that this would be reported as an incident and an investigation would be undertaken. We saw an incident report was immediately completed and escalated to the risk management and patient safety lead. However when we returned to the clinic eight days after the incident had been reported we were told the investigation had not begun and would formally commence, two weeks after the incident occurred. This did not demonstrate good practice in the timely investigation of incidents.
- Following our inspection, BPAS had conducted an investigation into the medicines discrepancies and shared the report and action plan with us. The report confirmed that a detailed count had taken place, that discrepancies were found, and remedial action was taken. We were informed that the report had been shared across BPAS clinics to disseminate learning.
- BPAS had a centrally managed contract for the purchasing of medicines. Medicines were supplied by an approved pharmacy supplier. Orders for medicines were placed electronically and checked by an authorised person. Supplies were sent direct to the clinic. Nurses' signatures were required to confirm ordering, receiving and administering medicines. A number of the nurses'

signatures were illegible. Managers told us they recognised all of the signatures. We asked to see a list of authorised signatures to confirm the identity and none was available.

- There were inadequate systems for monitoring and recording stocks of medicines. Medicines orders were submitted by email to the BPAS procurement team by the lead nurse. The emails were not readily accessible so it was not possible to check what had been requested and what had been received. A check was performed when the medicine was delivered to the clinic to ensure the contents of the order corresponded with the delivery note; however, there was no evidence of a reconciliation process with the original order.
- Staff we spoke with were unclear about how to obtain pharmaceutical advice and could not recall a situation when they had needed to do so. Managers confirmed there was no formal review of the pharmacy service or consistent approach to medicines management audit.
- BPAS central office disseminated national patient safety alerts such as those issued by the medicines and healthcare products regulatory agency (MHRA) to all BPAS clinics and we saw that these were available in the registered manager's office for staff to access.
- Medicines that induced termination of pregnancy (abortifacient medicines) were prescribed for all patients undergoing medical termination of pregnancy. The prescription was instigated following a face to face consultation with a member of the nursing team, written consent and completion of the HSA1 form (the legal document to allow an abortion to be carried out). Medication administration records formed part of the patient records and were clear, concise and fully completed.
- BPAS medicines management policy, 2015, required that all medicines should be stored in a locked cupboard. We found large quantities of prescription only medicines for injection, tablets and intravenous infusions stored in three unlocked cupboards in the recovery area, including a cupboard under the sink. These included antibiotics, pain killers and intravenous fluids. We brought this to the immediate attention of the registered manager who told us that the recovery would not be left unattended by nurses during opening hours. We were also told that corrective action would be taken to improve secure storage. When we carried out our follow up inspection we found all of the medicines were stored in locked cupboards and that the cupboard under the sink was no longer used to store medicines.
- Other medicines (non-abortifacient medicines) were either prescribed remotely by doctors working at other BPAS licensed premises using a secure electronic prescribing system or they were supplied and administered under Patient Group Directions (PGDs). PGDs provide a legal framework which allows some registered health professionals to supply and/or administer specified medicines, such as painkillers, to a predefined group of patients without them having to see a doctor.
- We saw examples of PGDs. Legislationprevents abortifacients (medicines which cause miscarriage), being supplied and administered under a PGD. When using a PGD for supply and administration BPAS London East set out the specific conditions for use: for example to supply and administer Misoprostol for treatment of retained products of pregnancy following a medical or surgical abortion.
- All PGDs at BPAS London East were authorised by the director of nursing and operations, BPAS consultant pharmacist, the medical director, clinical governance committee and BPAS chief executive officer. In addition each PGD required the signature of the registered manager to authorise the local use of the PGD in each specific location. We saw this happened. In line with the BPAS policy for PGDs, training records and signatures of the nurses and midwife using PGDs at BPAS London East were kept at the location and showed that all nurses and the midwife using PGDs had the required training and authority to use a particular PGD.
- BPAS policy states that the practices surrounding PGDs should be audited every six months. At the time of our inspection the most recent audit at BPAS London East was conducted in March 2016.
- There was no evidence of any pharmacy review or medicines management audits and the manager confirmed this was the case. This meant that any non-compliance with medicines management policies may be undetected.
- Where medicines needed to be stored in cool conditions a designated refrigerator was used for this sole purpose. The minimum and maximum temperature of the fridge used to store medicines were monitored and recorded

to ensure that medicines were kept at the required temperature. The fridge used for this purpose was locked, clean and tidy and we found no surplus or expired stock in evidence.

- There were some controlled drugs (medicines subject to additional security measures) stored and administered at this location for people undergoing surgery under conscious sedation. We saw the controlled drugs stock was monitored daily and was correct at the time of our visit. We noticed that there had been amendments made in the register of controlled drugs which had not been witnessed by a second health care professional. This meant staff were not complying with national or local guidance. We brought this to the attention of the accountable officer for controlled drugs (the registered manager) who told us corrective action would be taken and staff would be reminded of their responsibilities.
- Conscious sedation is medicine that produces a state of depression of the central nervous system enabling treatment to be carried out, but during which verbal contact with the patient is maintained. Medicines used for conscious sedation, can cause severe drowsiness or dizziness, which may last for several hours. We saw that, following conscious sedation, all patients were accompanied on leaving the clinic, and this was recorded in patient notes.
- There were systems in place to check for expired medicines. All the medicines we looked at were in date and correctly stored in line with manufacturers' instructions.
- Patients were asked if they had any known allergies. We reviewed fifteen records and saw that nine had a record of whether or not the patient was allergic to anything. However we noted that there was no specific place for this to be recorded on the documentation used for vasectomy patients.
- Post-procedure antibiotics were prescribed to reduce the risk of infection. There were six different antibiotics used in accordance with guidelines on when they should be used.
- There was a system in place for the safe disposal of medicines that could be tracked to their original place of origin.

Records

- Patient records were mainly paper based and only accessed by relevant staff.
- Patient information and records were held securely in locked cupboards.
- Monthly audits of consultation notes had been carried out. Information provided by the organisation showed that the most recent report was dated April 2016, and there was above 90% compliance with record keeping standards. Where there was non-compliance there were no common themes emerging. Staff had been reminded of the policy.
- All of the records we looked at were well maintained and completed with clear dates, times and designation of the person documenting.

Safeguarding

- There were no safeguarding concerns at the time of our visit.
- Safeguarding policies were easily accessible for staff. Staff knew how to access the safeguarding policies and demonstrated a good understanding of the processes involved for raising a safeguarding alert. The BPAS policies and processes reflected up to date national guidance on sexual exploitation of children and young people, and female genital mutilation. Staff we spoke with recalled these principles being included in their most recent safeguarding training.
- The registered manager was the designated member of staff (safeguarding lead) responsible for acting upon adult or child safeguarding concerns locally, coordinating action within the clinic, escalating to the BPAS national safeguarding leads as necessary, and liaising with other agencies.
- All staff we spoke with correctly identified the safeguarding lead, described what may constitute a safeguarding concern and understood the process for reporting concerns. Staff described the relationship with the local safeguarding teams as good.
- The registered manager ensured that staff were adequately trained on issues related to safeguarding through completion of the BPAS 'safeguarding vulnerable groups' training. Records we saw confirmed that 100% of staff were trained to safeguarding level safeguarding level three for children, which was the required level for their area of responsibility.
- Patients had access to information about local organisations to support them in case of domestic abuse.
- All safeguarding concerns would be reported to the registered manager who was the clinic safeguarding

lead. They were the designated member of staff responsible for acting upon adult or child safeguarding concerns locally, coordinating action within the clinic, escalating concerns to the BPAS national safeguarding leads and liaising with other agencies.

- Staff told us they routinely took the opportunity to ask patients about domestic abuse in line with NICE guidelines [PH50] 'Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively'. This guidance is for everyone working in health and social care whose work brings them into contact with people who experience or perpetrate domestic violence and abuse. All patients were seen in a one to one consultation with a nurse or midwife. All the records we looked at showed that a routine question was asked to confirm that the patient was 'safe at home'.
- All patients under the age of 18 had a safeguarding assessment at initial consultation. Patients under the age of 16 years were encouraged to involve their parent or another adult who could provide support. Staff discussed the assessment of patients under the age of 14 with the safeguarding lead. Any patients aged 13 or under were referred to safeguarding.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- The registered manager told us there had been discussion about the duty of candour at team meetings; however staff we spoke with were not aware when asked what the duty of candour was. There was a degree of understanding about being open and honest when an error occurred, but nursing staff were not aware of the full regulatory requirements, such as formally apologising in writing. Staff could not provide us with any examples of the duty of candour being applied.

Mandatory training

- Mandatory training covered a range of topics: life support, fire safety, health and safety, life support, safeguarding, moving and handling, infection control and information governance. We were told that there were reminder systems for staff to prompt them when they were overdue for their mandatory training.
- Staff told us and data confirmed that managers supported staff to maintain mandatory training
- The organisational target for completing mandatory training was 100%. Staff told us they had all completed mandatory training. Records supplied by the provider confirmed this.
- BPAS had introduced a 12 week competency based training programme for newly employed staff which included all the mandatory training topics, along with patient support skills training, and topics including sexually transmitted infection training, ultrasound scanning and HIV training.

Assessing and responding to patient risk

- The 'BPAS Suitability for Treatment Guidelines' set out which medical conditions would exclude patients for accessing treatment, and those medical conditions which, although not an automatic exclusion required careful risk assessment by a doctor, usually a regional clinical lead or the BPAS medical director. BPAS had a specialist placement team to source appointments within the NHS for patients who were not suitable for treatment at BPAS on medical grounds, for example.
- All patients were assessed for their general fitness to proceed. The assessment included obtaining a full medical and obstetric history, measurement of vital signs, including blood pressure, pulse and temperature. An ultrasound scan confirming pregnancy dates, viability and multiple gestations was carried out in all cases. Relevant laboratory testing was undertaken as appropriate: for example haemoglobin level.
- It was recommended by the National Patient Safety Agency in 2010 that The World Health Organisation (WHO) 'five steps to safer surgery' checklist should be used for every patient undergoing a surgical procedure. The process involves specific safety checks before, during and after surgery. Within the reporting period of January to December 2015, the service reported compliance rates with WHO safety checks ranging from 89% to 100% for surgical termination of pregnancy and vasectomy. Areas for improvement included ensuring

the pre-operative checks were fully documented; however, we found there was no pre-operative brief and no de-brief after surgery took place. Both of these elements contribute to the five steps.

- A white board was used in the treatment room to highlight information from the surgical safety checklist. A designated member of staff was identified to fill in the details on the board, which included a record of the number of swabs and needles used during the procedure. This information was also recorded in the surgical register. We saw that some of the signatures in the register had not been witnessed by a second practitioner. We brought this to the attention of the registered manager, who told us that they would address this with the staff member concerned.
- All staff had completed basic or intermediate life support training and accurately described the necessary steps they would take to manage emergency treatment. There were staff trained in advanced life support available during conscious sedation procedures.
- Following surgical procedures patients were monitored in the immediate post-operative period by a registered nurse in the recovery area until they were fit for discharge. A systematic and regular assessment of patients was undertaken, which included recording their blood pressure and heart rate, as well as monitoring for pain during this period. Patients were not discharged until they were deemed sufficiently well.
- Clinical and non-clinical staff we spoke with described the actions required in the event of a medical emergency and how to act in case of emergency.
- There were clear patient pathways for termination of pregnancy care which included escalation policies for the deteriorating patients. There was good access to medical support in the event that a patient's condition might deteriorate. Patients who had a surgical termination of pregnancy using conscious sedation were assessed using a modified early warning system (MEWS) in order for staff to assess and monitor the condition of patients, and in particular, to identify any deterioration.
- The modified early warning system (MEWS) had been introduced to staff at a training day in April 2016 and we saw it was used by staff to assess and monitor the condition of patients, and in particular to identify any deterioration. Staff told us that the policy to guide the use of the tool was under development, and we saw this to be the case.
- There was a formal transfer agreement in place with a local NHS hospital, should an individual require transfer in an emergency. This was clearly displayed and known to staff. There had been no emergency transfers in the reporting period.
- Clinical and non-clinical staff we spoke with were able to describe the actions required in the event of a medical emergency and how to summon emergency assistance. In the case of medical emergency BPAS transferred patients to the neighbouring NHS Trust hospital. Staff could not recollect a time when they had transferred a patient under these circumstances.
- First aiders had been trained and appointed and accurately described their role and responsibilities.

Nursing staffing

- The service employed 7 nurses including a nurse who was also a midwife (3.8 whole time equivalent (WTE)). There were no vacancies at the time of our inspection. When patients attended the clinic there would be at least one registered nurse or midwife on duty.
- Nursing staff were supported by eight (4.9 WTE) client care coordinators and administration staff.
- Staff rotas were managed locally with access to regional nurses. All staff were given a clinical passport which demonstrated their competencies, level of training and recruitment status. This allowed the managerial staff to arrange cover by equally competent nurses and client care coordinators in the event of holidays or sickness absence, for example, so that the service needs were met without having to use agency or locum staff.

Medical staffing

- There were no vacancies for doctors at the time of our inspection.
- There was one doctor who worked at the clinic to provide consultations and medical termination of pregnancy under practising privileges, which is the term used to describe the permission granted by BPAS, in this case, to a doctor to practise at their clinic.
- At other times doctors working remotely provided a telephone service and completed the HSA1 form and wrote prescriptions from BPAS premises licensed by the DoH to carry out termination of pregnancy.
- Abortion surgical procedures were carried out one day per week and vasectomy surgical procedure once per month by surgeons with practising privileges.

Termination of pregnancy

Major incident awareness and training

- BPAS major incident and business continuity plans provided guidance on actions to be taken in the event of a major incident or emergency. Staff we spoke with were aware of the procedure for managing major incidents and could not recall any examples of when these had happened. Managers and staff could not provide examples of any major incident training.

Are termination of pregnancy services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- Staff had access to relevant guidelines, policies and procedures in relation to termination of pregnancy and vasectomy services. Staff could access policy documents on the BPAS intranet and in paper files.
- Care was provided in line with Department of Health Required Standard Operating Procedures (RSOPs) and national best practice guidance. The service had completed a programme of clinical audits depending on risk assessments.
- The exception was the use of simultaneous administration of abortifacient drugs for early medical abortion (EMA), which is outside of current Royal College of Obstetricians and Gynaecologists (RCOG) guidance. We saw that a structured governance system was in place and had been followed to introduce this treatment option.
- Provider records confirmed that the complication rates for retained products of conception were 5 in 100 if medicines are taken at the same time (simultaneous administration) compared to 3 in 100 if taken 24-72 hours apart.
- Patients were cared for by a multidisciplinary team working in a coordinated way and staff had the appropriate experience, skills and competence.
- There were effective systems for the ongoing management and development of staff which included an annual appraisal. Doctors were employed through practising privileges and provided evidence to prove their suitability for their role.
- Patients were offered pain relief.
- All care records we reviewed contained signed consent from clients. Staff were clear about their roles and responsibilities about the Mental Capacity Act (2005) and Deprivation of Liberty Standards (DoLS).
- Staff providing counselling participated in group counselling supervision in line with best practice guidance. However, not all staff providing counselling were able to provide evidence of recent training in this area.
- The BPAS Aftercare Line, a telephone service, was accessible to patients over 24 hours a day and for seven days a week. Staff told us that clients rarely attended the clinic following their procedure.

Evidence-based care and treatment

- Policies were accessible for staff and were developed in line with Department of Health Required Standard Operating Procedures (RSOP) and professional guidance. However; some polices did not follow national guidance.
- BPAS introduced simultaneous administration of mifepristone and misoprostol (medicines used to bring about abortion) in March 2015. This is outside of Royal College of Obstetrician and Gynaecologist (RCOG) guidance which recommends that mifepristone is administered first followed by the administration of misoprostol 24 – 48 hours later. A structured approach had been taken when planning and implementing the simultaneous pathway and it was kept under regular review.
- The introduction of simultaneous administration followed a national BPAS pilot study of almost 2000 clients between March 2014 and January 2015. This pilot study demonstrated that simultaneous administration was associated with an increased need for surgical treatment in comparison to a dosing interval of 6 – 72 hours (7% compared to 3.3%). Acceptability and differences were almost the same between simultaneous administration and a dosing interval of 6 – 72 hours (89% compared to 90%).
- National complication rates according to treatment regime (simultaneous treatment at nine weeks, interval treatment at 9 weeks and interval treatment at ten weeks) for September 2015 to December 2015 were reported at the clinical governance committee meeting in February 2016. Complications reported on were continuing pregnancy, incomplete abortion and retained non-viable pregnancy.

Termination of pregnancy

- Continuing pregnancy was the most common complication: 1.52% for simultaneous treatment at nine weeks and 3.23% for interval treatment at ten weeks. Incomplete abortion was more prevalent at nine weeks regardless of the regime followed: 1.34% for simultaneous treatment and 1.33% for interval treatment. The non-viable pregnancy rate was similar for each treatment regime.
- The clinic adhered to RCOG guidelines for the treatment of patients with specific conditions, such as ectopic pregnancy.
- All patients underwent an ultrasound scan at the clinic to determine gestation of the pregnancy. This was in line with the BPAS clinical guideline for all abortions but outside the guidance issued by the RCOG which states that the use of routine pre-abortion ultrasound scanning is unnecessary (The Care of Patients Requesting Induced Abortion; Nov 2011).
- Blood was tested at the initial assessment to determine Rhesus factor. Anti-D immunoglobulin was administered to patients who were rhesus negative.
- RCOG guidance and RSOP 13: contraception and sexually transmitted infection (STI) screening state that information about the prevention of sexually transmitted infections (STI) should be made available, and all methods of contraception discussed with patients at the initial assessment, with an agreed plan for contraception after the abortion. Records we looked at showed that some clients declined STI and contraception advice.
- Contraceptive options were discussed with patients at the initial assessments and a plan was agreed for contraception after the abortion. The patients were provided with contraceptive options and devices at the clinic. These included Long Acting Reversible methods (LARC) which are considered to be most effective as suggested by the National Collaborating Clinic for Patients' and Children's Health.
- Audit showed that the clinic was 100% compliant in following discussion around contraceptive advice.

Pain relief

- Pre and post procedural pain relief was prescribed on individual medication records for patients undergoing termination of pregnancy. Best practice was followed as non-steroidal anti-inflammatory drugs (NSAIDs) were usually prescribed. These are recognised as being effective for the pain experienced during the termination of pregnancy.
- Staff were clear about which medicines would be offered and in which order.
- Patients were advised to purchase over the counter medicines for use at home and were advised about when and how to take them.
- There was a lack of evidence in all of the records we looked at to show that men undergoing vasectomy had their pain assessed using a recognised pain score or that pain was treated. However there was no patient feedback that pain was a problem for any of the patients who had responded to the client satisfaction survey, and there was no record of pain in patient records or on the complaints log or incident reports.

Patient outcomes

- Between January 2015 and December 2015, BPAS London East carried out 1655 (86%) medical abortions, 264 (14%) surgical terminations and 155 vasectomies.
- BPAS London East had a dashboard that measured ten standards. These were: medicines management, safe staffing levels, clinical supervision, record keeping audits, safeguarding, treatment audits, complaints, lab sampling/labelling errors and sickness absence. We saw that the clinic reported that they achieved compliance with all standards in December 2015.
- Patients undergoing medical abortions were asked to complete a pregnancy test two weeks after treatment to ensure that the termination had been successful. Patients could contact the BPAS Aftercare Line and were invited back to the clinic if there were any concerns.
- Staff told us that in order to monitor outcomes they relied on other staff reporting back to them or patients contacting BPAS by using BPAS Aftercare Line. If staff were informed that there had been a complication a form would be completed and it would be documented in patients' notes. This was monitored by the quality leads and cascaded through staff meetings.
- Abortifacient medicines were administered using three options. They could be administered in two visits, over 24 or 48 hours, or both the medicines could be administered simultaneously in one visit. The patient's choice was taken into account, although simultaneous administration was encouraged.

- BPAS introduced simultaneous administration of mifepristone and misoprostol (medicines used to bring about abortion) in March 2015. The provider undertook an evaluation of the effectiveness and feasibility of simultaneous administration in 2015. BPAS informs patients of the risks through information available on their website and at initial consultation. However the provider has found that many patients prefer to take the medications simultaneously as it negates the need for return to the centre.
- The service monitored the outcomes of this new method which were reported to the clinical governance committee. Minutes of the clinical governance committee meeting in June 2015 stated 'there was an increase in complications since the introduction of simultaneous administration of mifepristone and misoprostol for EMA, but that these were within what was quoted in the 'BPAS guide'. The 'my BPAS guide' states the risk of continuing pregnancy is five in 100 if the medicines are taken at the same time, and three in 100 if medicines are taken 24 – 72 hours apart. The risk of requiring surgical treatment for failed medical treatment is seven in 100 if the medicines are taken at the same time and three in 100 if medicines are taken 24 – 72 hours apart.
- Minutes of the clinical governance committee meeting in March 2015 stated that the complication rate for simultaneous administration was significantly higher and acknowledged this process is outside the national guidance. The minutes also stated: 'an additional benefit of simultaneous administration is that fewer resources are needed at BPAS and for the woman if a routine second visit is not needed'. The minutes of the clinical governance committee meeting in November 2015 stated there was a 'large increase (of complications) driven by EMA with simultaneous administration of mifepristone and misoprostol'.
- Staff told us that they were seeing an increasing number of patients returning with complications such as continuing pregnancy and retained products of conception necessitating further administration of misoprostol or referral for surgical treatment. BPAS was continuing to monitor complication rates.
- BPAS had a planned programme of clinical audit that included audits recommended by RCOG: consenting for treatment, discussions related to different options of abortion, contraception discussion, confirmation of gestation, point of care testing, infection control, safeguarding and medical assessments audits. Audit outcomes and service reviews were reported to governance committees such as infection control and regional quality, assessment and improvement forums (RQuAIF).
- BPAS London East demonstrated compliance rates between 93% to 100% for the outcomes measured in the clinical audit programme (December 2015) with improvements required in : including EMA failure rates on consent forms, patient discussion related to different treatment options , where to seek help with their chosen method, and the provision of goggles for infection prevention and control. Action plans were developed and implemented to address the areas where improvements were identified, with responsibility allocated to specific staff and completion dates set.

Competent staff

- Suitable checks were carried out to enable medical staff to practise at the clinic: for example professional registration, qualifications, insurance, disclosure and barring and revalidation.
- Staff told us they had annual appraisals. The provider's records confirmed 100% of doctors, 25% of nurses and midwives and 84% of administrative staff had completed an appraisal between January 2015 and December 2015. Gaps in completion were attributed to new staff. Staff were further supported through 'job chats' which records showed took place at least once a year.
- All staff were supported through an induction process and competence based training relevant to their role. For example, the introduction in May 2016 of a conscious sedation service for patients having surgical termination of pregnancy was underpinned by training and assessment of medical and nursing staff who were following national and local guidelines. BPAS required that only doctors and nurses who had successfully completed the BPAS conscious sedation training programme worked in this area. Records we looked at, including duty rotas, confirmed this happened.
- Staff undertook training and assessment of competence in ultrasound scanning. For accreditation of first trimester scans (up to 12 weeks of pregnancy), staff were required to undertake 50 abdominal, 20 vaginal and five

gynaecology scans. For second trimester accreditation (from 13 to 27 weeks of pregnancy), they were required to undertake 50 scans of the fetal head and five scans of the placental site.

- The RSOP 14: 'Counselling' sets out that all the staff involved in pre assessment counselling should be trained to diploma level in counselling patients. Staff referred to as 'client care coordinators', who provided the pre and post abortion counselling service had completed 'BPAS Patient Support Skills and Counselling and Self Awareness' course and had successfully completed the client care coordinator competencies framework.
- Group supervision for staff providing counselling was available and was provided at least once a year. We saw evidence that some staff had participated in group supervision; however a counsellor we spoke with told us she had not been able to attend.
- Initial contact for any of the services provided by BPAS was made through a national contact clinic. The clinic was run by dedicated BPAS staff who had completed a competence based training specific to the role.

Multidisciplinary working (related to this core service)

- Medical staff, nursing staff, client care coordinators and other administrative staff worked well together as a team. There were clear lines of accountability set out in job descriptions that contributed to the effective planning and delivery of patient care.
- Managers told us BPAS London East had close links with the NHS and other agencies and services such as the local safeguarding team.

Seven-day services

- BPAS provided counselling and assessment sessions to patients at the clinic and via the Aftercare Line which was available 24 hours per day and seven days a week. Callers to the BPAS Aftercare Line could speak to a registered nurse or midwife who performed triage and gave advice. The dedicated team of nurses and midwives had received training for the role from BPAS. Patients were followed up by staff at the clinic they had attended, either by a phone call or by appointment at the clinic.

Access to information

- RSOP 3: Post Procedure recommends that wherever possible the woman's GP should be informed about treatment. Patients were asked if they wanted their GP to be informed by letter about the care and treatment they received and were given a letter for their GP upon discharge Patients' decisions were recorded and their wishes were respected.
- Staff at the clinic ensured that patient care records were transferred in a timely and accessible way and in line with BPAS protocols, if the woman was referred to a different BPAS clinic or provider for further treatment.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We asked about the consent process. The BPAS policy: 'Consent to examination and treatment' was under review at the time of our inspection. Staff demonstrated clear and concise explanations of the options for terminating pregnancy and for ongoing contraception.
- The patient records we reviewed contained signed consent from patients in all cases. Staff told us that the consent form and My BPAS Guide were produced in different languages, for example Spanish, Arabic, Chinese, Hungarian, and Turkish when needed they could print them for patients.
- Staff could not recall a situation at BPAS London East where they had cared for a patient who lacked the mental capacity to give consent to treatment, however they demonstrated an understanding of the principles of the Mental Capacity Act as this was an area that had been included in the BPAS mandatory safeguarding training.
- A trained pregnancy counsellor offered patients the opportunity to discuss their options and choices as part of the consent process.
- All patients under 18 years discussed their options with a counsellor prior to being asked for their consent.
- Staff assessed patients aged younger than 16 years by using Gillick competence and Fraser guidelines which helped to assess whether a child had the maturity to make their owns decisions and understand the implications of those decisions
- Nurses and midwives completed a checklist to assess whether a child under 16 was competent to give consent.
- Staff were clear about their roles and responsibilities regarding the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DOLs). Staff we spoke with discussed the need to ensure that patients had capacity to make an informed decision.

Termination of pregnancy

Are termination of pregnancy services caring?

By caring we mean that staff involved and treated people with compassion, kindness, dignity and respect.

- Staff were caring and compassionate and treated patients with dignity and respect. Patients' wishes were respected and their beliefs and needs were taken into account. Clients felt safe and well cared for and consistently reported about the non-judgmental approach of staff.
- During the initial assessment, nurses and midwives explained to patients all the appropriate available methods for termination of pregnancy. Staff considered gestational age and other clinical needs whilst discussing these options.
- Patients considering termination of pregnancy or vasectomy had access to pre and post counselling, with no time limits attached, but were not obliged to use the counselling service.
- Vasectomy patients gave positive feedback in the BPAS patient satisfaction reports submitted between September and December 2015.
- Clients' emotional and social needs were valued by staff and embedded in their care.

Compassionate care

- We observed all patients and those close to them being treated with compassion, dignity and respect. All consultations took place in a private room and privacy was respected at all times in all areas at the clinic.
- Patients and their supporters were positive about the way they had been treated by staff. Comments from patients included: 'I was treated with dignity which I really appreciated'; 'everyone was lovely and made me feel comfortable', 'very good care and great staff'. People commented positively about the 'non-judgmental approach' shown by staff they interacted with.
- Patients' preferences for sharing information with a supporter were established, respected and reviewed throughout their care. Supporters told us they felt accepted and included in discussions with staff where appropriate.

Understanding and involvement of patients and those close to them

- We saw that during the initial consultation, staff explained to patients all the appropriate available methods for termination of pregnancy. The staff considered gestational age (measure of pregnancy in weeks) and other clinical needs whilst setting out these options.
- Patients who had surgical terminations were provided with clear explanations throughout their treatment.
- Patients were given leaflets and the 'My BPAS Guide' which had information regarding different methods and options available for abortion and how pregnancy remains would be disposed of. If patients needed time to make a decision, this was supported by the staff, and patients were offered an alternative date for further consultation.
- All of the records we reviewed showed that post discharge support available for patients at home had been considered and recorded. Patients were given written information about accessing the 24 hour BPAS Aftercare Line: the telephone service for support following abortion procedures.
- Patients were involved in their care, and were given the option to administer their own pessaries (prescribed medication inserted directly into the vagina or cervix) and given instructions on how to do this. Male patients were given written and verbal information about the surgical vasectomy procedure.
- We asked staff if there were occasions when patients changed their minds about a procedure. We were told that men and patients could attend for counselling only and that they may change their minds or use another service if they wanted a different procedure.

Emotional support

- All the patients who attended the clinic were had access to pre-termination counselling at BPAS London East. This was undertaken by experienced support workers (client care coordinators) who had completed the BPAS Patient Support Skills and Counselling and Self-Awareness courses and were required to be fully competent with the client care coordinator competencies framework.
- Patients also had access to advice and counselling before and after their procedures, either face to face or by telephone. The BPAS Aftercare Line, a telephone service operated by registered nurses and midwives, was available 24 hours 7 days a week.

- We observed that patients, and those close to them, who were anxious or unsure about their decision were provided with extra support.

Are termination of pregnancy services responsive?

By responsive, we mean that services are organised so that they meet people's needs.

- Patients either referred themselves or were referred by their GP. They were able to book appointments through the BPAS telephone booking service which was open 24 hours a day throughout the year. This also enabled patients to choose the location they attended.
- There was no formal monitoring of waiting times or the reasons for any delays. However, staff told us they could not recall any significant delays.
- Patients were referred to other NHS services for termination of pregnancy, where appropriate, for example due to a medical condition or late gestational date. Patients were also able to attend other local BPAS clinics for treatment if BPAS London East was closed.
- Patients were provided with information to help them to make decisions.
- A professional interpreter service was available for patients whose first language was not English, to enable them to communicate with staff. We saw this used effectively and in a timely manner.
- Complaints were managed locally and, where unresolved, were escalated to the central office to be managed by the complaints manager and client engagement manager. Feedback was given to staff and the complainant.

Service planning and delivery to meet the needs of local people

- The senior management team was involved in developing the facilities and the planning of the service along with commissioners.
- Patients could book their appointments through the BPAS telephone booking service, which was available 24 hours a day throughout the year. The electronic triage booking system offered patients a choice of appointment to help ensure patients were able to access the most suitable appointment for their needs and as early as possible.
- BPAS offered a web chat service, via their internet page, for patients who wanted to know more about the services provided.
- A fast track appointment system was available for patients with higher gestational age or those with any complex needs.
- BPAS was able to offer treatment at other BPAS clinics within the region for patients who preferred a different location, or where a convenient appointment was not available at BPAS London East.
- If patients chose the treatment option of medicines' administration 24 – 48 hours apart, they were required to attend another local BPAS clinic if BPAS London East was closed when the second medicine was due.

Access and flow

- Patients were referred from a variety of sources including GPs, and also through self-referral. The clinic undertook all aspects of pre-assessment including counselling, dating scans to confirm pregnancy and determine gestational age, and other assessments of health and wellbeing.
- RSOP 11: Access to Timely Abortion Services states that patients should be offered an appointment within five working days of referral and they should be offered the abortion treatment within five working days of the decision to proceed. The service monitored its performance against the waiting time guidelines set by the Department of Health. BPAS measured the number of patients who had their consultation within seven days. Between July 2015 and September 2015, 74% of patients had their consultation within seven working days of referral. The actual number that could have been seen at the clinic was 99%. Staff told us that the discrepancy was due to patients being treated at another clinic or because they needed more time to consider their decision.
- BPAS measured the number of patients who waited longer than 10 days from first appointment to treatment. We saw documentary evidence that 19 patients had waited longer than 10 days from first appointment to treatment within the reporting period.
- Staff told us that appointments were timed to ensure that patients could be accommodated comfortably and to ensure there were no more than three patients in the recovery area at any one time. We saw this happened.
- Staff told us that treatment lists could be delayed because waiting for the doctor to sign and return the

HSA1 form and the remote prescription could take between half an hour to one and a half hours. This meant that patients could be delayed and spent longer than anticipated at the clinic.

Meeting people's individual needs

- The clinic had controlled access and was accessible to wheelchairs users and disabled toilets were available. There was a dedicated counselling room to ensure there were no interruptions.
- A professional interpreter service was available to enable staff to communicate with patients for whom English was not their first language. Staff told us that this included using the interpreter service to ensure the patient understood and could weigh up the decision to continue with the treatment.
- There was a clearly defined referral process for patients who required a specialist service. BPAS treated fit and healthy patients without an unstable medical condition. For patients who did not meet these criteria a referral form was completed and managed by a specialist referral placement team. This was a seven day service. Patients were referred to the most appropriate NHS provider to ensure that they received the treatment they required in a timely and safe way. We saw two examples of where this had happened in two records we looked at.
- A general guide for patients attending any BPAS clinic was available called 'My BPAS Guide'. This provided information about different options available for termination of pregnancy and the associated potential risks. This leaflet was also available in Braille for patients with sight loss.
- Leaflets were given to patients to inform them what to expect after the treatment. This included a 24 hour telephone number of where patients could seek advice if they were worried.
- The 'My BPAS' guide' also provided relevant information about disposal of pregnancy remains. Staff told us that they would discuss patients' expectations and choice about sensitive disposal of pregnancy remains.
- Midwives and nurses undertaking assessments had a range of information they could give to patients as required. This included advice on contraception, sexually transmitted infections, miscarriage and services to support patients who were victims of domestic abuse and how to access sexual health clinics.
- We saw a folder containing information about local and national support organisations. For example, the contact details for Victim Support, NSPCC, Frank, MIND, Samaritans, Domestic Violence assistance, Muslim Patients Aid, Respect not Fear (a relationship website for young people) , Broken Rainbow (a support service for the lesbian, gay, bi-sexual, transgender community) and The Hideout (domestic abuse support for children and young people).
- Staff who worked at the clinic were required to be pro-choice, and were supported by the organisation to promote the values through training and ongoing support such as 'Welcoming Diversity' training to ensure they recognised different cultural needs and beliefs. Training records showed this had taken place. Staff confirmed they had undertaken such training.

Learning from complaints and concerns

- Staff told us that the registered manager was the first point of call for complaints so concerns could be addressed with the patient at clinic level. All unresolved complaints would be managed centrally by the BPAS client engagement manager. A full investigation of a complaint would be carried out and feedback was given to the staff.
- The clinic kept a record of verbal and written complaints. Between January 2015 and December 2015, BPAS London East received no written complaints. There were four informal (verbal) complaints between January 2016 and June 2016, none of which had been upheld. These had included complaints about an ectopic pregnancy following EMA treatment, an uncomfortable scan, and two relating to information provision. The details of each complaint were shared with staff at staff meetings.
- Literature and posters were displayed advising patients and their supporters how they could raise a concern or complaint formally or informally. Information on how to make a complaint was also included in the 'My BPAS Guide'.
- A separate form entitled 'Your opinion counts' was available inviting patient feedback. The treatment midwife or nurse asked patients to complete this form before leaving the clinic. Staff told us that patients usually wanted to leave immediately after the treatment and the majority left without completing the form.

- We were told by staff that BPAS complaints procedures were discussed as part of the corporate induction days and saw the programme which confirmed this.

Are termination of pregnancy services well-led?

By well-led we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person centred care, supports learning and innovation, and promotes an open and fair culture.

- There were corporate governance arrangements to manage risk and quality. This included an audit programme and an established system to cascade learning. However, the arrangements for governance mainly took place at national and regional levels and did not always operate effectively locally.
- Risks were not always identified or acted upon at the clinic by people with the authority to do so. In particular, monitoring and review of medicines management and infection prevention and control was not effectively managed. There was a local risk register but it was not formalised and required further development to be effective.
- Legislation requires that for an abortion to be legal, two doctors must each independently reach an opinion in good faith as to whether one or more of the legal grounds for a termination is met. They must be in agreement that at least one and the same ground is met for the termination to be lawful, and sign a form to indicate their agreement (HSA1 Form). All of the records we looked at met these requirements.
- The culture within the service was caring, non-judgmental and supportive to patients. Staff spoke positively about the need for and value of the service to patients.
- Service development was encouraged: for example the introduction of surgical termination under conscious sedation in May 2016.
- Staff felt supported by their registered manager and regional operations director.

Vision and strategy

- BPAS aimed: 'to provide high quality, affordable sexual and reproductive health service'. There were clearly defined corporate objectives to support its aim.
- The organisation's ethos was to treat all patients with dignity and respect, and to provide a caring, confidential and non-judgmental service. Staff were supported to promote the values through training and ongoing support. BPAS policies and procedures reflected the patient's right to influence and make decisions about their care, in accordance with BPAS quality standards of confidentiality, dignity, privacy, and individual choice.
- There was no formal local strategy or plan for the BPAS London East service

Governance, risk management and quality measurement

- Governance took place at national and regional levels. The organisational structure chart supplied by the provider showed clear lines of accountability to the Chief Executive Officer and the Board of Trustees.
- There was a Clinical Governance Committee, Research and Ethics Committee and Regional Quality, Assessment and Improvement Forums (RQuAIF). The national medical director took a lead role in ensuring the organisation was working in line with current national guidance.
- The approach to anticipating and managing day-to-day risks to people tended to be led at a regional or corporate level rather than locally managed. This meant that opportunities to prevent or minimise harm could be missed.
- A director of infection prevention and control (DIPC), based at BPAS head office was responsible for leading the organisation's infection prevention team. The DIPC was part of the organisation's clinical governance and patient safety teams and structures. The DIPC was supported by the regional operations director, and the registered manager to ensure that local policies and practices were correctly implemented. However, we saw that these were not fully implemented. There were gaps in assessing the risk of and preventing, detecting and controlling the spread of infections, including those that are health related.
- Staff working at BPAS London East were not routinely involved in regional or national governance. Staff were not involved in formally identifying or managing risks specific to the clinic. They viewed risk as a head office (corporate) concern. BPAS had a central risk register which listed various areas of generic risks across all clinics. These risks were documented and a record of

the action being taken to reduce the level of risk was maintained. Managers confirmed that a formalised, fully developed local risk register was not in place; however there were plans to introduce one.

- The BPAS regional quality assessment and improvement forum (RQuAIF) met three times a year and maintained oversight of all services in the region The forum consists of a lead nurse, a client care manager, doctor, nurse, clinical lead, registered manager, client care coordinator and associate director of nursing. At each meeting members of the forum reviewed complaints, incidents, serious incidents, audit results, complications, patient satisfaction and quality assurance for point of care testing and declined treatments. We saw forum records that detailed information was shared with a focus on shared learning. This forum reported to the organisation's clinical governance committee.
- Minutes from RQuAIF were also shared at the regional management meetings, which were attended by regional operations director and the registered managers. Managers attending the meetings were expected to hold meetings within their clinic to ensure that learning was shared with local staff.
- We saw notes from the most recent London and South East Regional Management meeting held on 2 March 2016 which confirmed learning about complaints and serious incidents requiring investigation (SIRI) had been discussed and action points agreed. These were reviewed centrally and at clinic level. We also saw in the notes that the safety issues we have reported on relating to audit of patient group directions and the need to improve cleaning schedules and checklists had been discussed, however; there was no evidence that any action was agreed or implemented.
- Key policies were launched via a conference call which was accessible to all staff. These were also recorded and available for one month to enable staff to access them should they be unable to attend. A recent example of topics discussed in this way was the duty of candour.
- BPAS had a central risk register which listed various areas of generic risks across all clinics. These risks were documented and a record of the action being taken to reduce the level of risk was maintained.
- Legislation requires that for an abortion to be legal, two doctors must each independently reach an opinion in good faith as to whether one or more of the legal grounds for a termination is met. They must be in agreement that at least one and the same ground is met for the termination to be lawful, and sign a form to indicate their agreement (HSA1 Form). All of the records we looked at met these requirements.
- The Department of Health requires every provider undertaking termination of pregnancy to submit data following every termination (HSA4 form). This information had been correctly gathered and reported on within the required 14 day period.
- In the medical records we checked, all gestations were 10 weeks or fewer prior to termination. All HSA1 forms had the signatures of two registered medical practitioners.
- BPAS clinics completed monthly audits of completion of HSA1 forms to BPAS London East demonstrated full compliance (100%) with accurate completion of HSA1 forms.
- The Department of Health (DH) requires providers undertaking termination of pregnancy to notify them of terminations of pregnancy undertaken, by way of the completion of HSA4 forms. The HSA4 notifications were completed and uploaded to the DH electronic reporting system. Doctors working under practising privileges at BPAS clinics across the UK completed HSA4 notifications for those patients for whom they had prescribed medication. A record was made on the patients' notes that the HSA4 form was completed and submitted. An automatic reminder was sent out by the DH after two weeks if an HSA4 form had not been received.

Leadership of service

- Staff told us the registered manager was visible and had a daily presence at the clinic. Managers were supportive and, for clinical staff, a regional nurse and the associate director of nursing were accessible and available for advice and support for clinical or professional issues. Staff told us they felt supported.
- BPAS allocated dedicated time for the lead nurse to fulfil management responsibilities as well as clinical responsibilities. The lead nurse was also expected to demonstrate leadership competencies as set out in the BPAS competence framework.
- A director's brief was issued quarterly which was also discussed at regional team meetings. Registered managers then held local quarterly team meetings to cascade information to the unit staff. These meetings

were structured, had an agenda and were documented. There were clearly documented action points, however it was not clear how these were followed up or acted upon.
- BPAS held a bi-annual national managers day for all managers. Bi-annual clinical forums were held for all staff and clinics closed to facilitate attendance. The most recent clinical forum was held in April 2016 and had included presentations from the executive management team and external speakers. Topics included an organisational and legislative update the future direction of the company; conscious sedation (a combination of medicines to help patients to relax (a sedative) and to block pain (an anaesthetic) during the procedure, nurses' revalidation and scanning.
- Staff told us that if they were unable to attend meetings information including minutes of meetings was communicated to them by email.

Culture within the service

- Staff displayed a compassionate and caring manner. They recognised that it was a difficult decision for patients to seek and undergo a termination of pregnancy.
- Staff spoke positively about the high quality care and services they provided for patients and were proud to work for BPAS. They described BPAS as a good place to work and as having an open culture, and felt they could approach managers if they felt the need to seek advice and support. Senior staff told us they could approach regional or national managers if they needed advice and support
- Staff had access to a free counselling/support telephone service which they could call in relation to any work related or personal problems. We saw that details of the service were accessible through the staff intranet.

Public and staff engagement

- Patients using the service were given a survey to complete entitled 'Your opinion counts'. Staff told us that due to the sensitivity of the treatment and the emotional experience for the patients, it was sometimes a challenge to engage with patients and get a response. However the analysis of feedback from surveys showed overall satisfaction with the service.
- The analysis of feedback from 96 patients who responded to the patient satisfaction survey between September 2015 and December 2015 rated 9.6 out of ten for their overall satisfaction with the surgical termination of pregnancy service. 99% of patients surveyed would recommend the service. In the same period 27 patients who had undergone vasectomy rated the service 9.5 overall. This was the most recent data available to us.
- Staff surveys were completed to gain staff opinion of working at the clinic. The staff survey results for the BPAS organisation in 2015 were generally positive: 92% of staff across the organisation stated they were proud to work at BPAS and 86% of staff stated they would recommend BPAS as an organisation to work for.
- Staff meetings and team briefings took place at least quarterly to update staff on any changes to the service, finances, marketing and staffing.

Innovation, improvement and sustainability

- There were examples of innovative service delivery and clinical practice. This included the use of 24 hour telephone appointment service and web chat service for patients, and the introduction of surgical termination under conscious sedation.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- A formal review of the pharmacy service and a consistent approach to medicines management audit to ensure delivery, stock control and storage of medicines is managed in accordance with legislation, provider policy, and professional standards and national guidance.
- A list of authorised signatories is kept at the clinic to identify named practitioners who order, receive and administer medicines.
- Ensure briefings and de-briefings are fully implemented and documented in accordance with the World Health Organization (WHO) Surgical Safety Checklist.
- National specifications for infection prevention and control and cleanliness are adhered to including: segregation of clean and dirty equipment and waste in all clinical areas, and staff comply with national dress code standards for infection prevention and control.
- All areas in which patients are treated are clean and cleaning schedules and checklists are maintained in sufficient detail to demonstrate this.
- Safety checks including calibration are carried out on all equipment including that used for clinical diagnosis on a regular planned basis.

Action the provider SHOULD take to improve

- All staff at the clinic are actively involved in assessing local risks, local audit and clinical review. This should be proportionate and relevant to their role. Staff should be given training and support to take responsibility for maintaining standards.
- Staff are supported to independently report incidents of all kinds, including those with a potential to cause harm to patients or staff, even when no harm occurred. All staff should receive prompt feedback to reduce the risk of recurrence of incidents.
- Ensure documentary evidence that demonstrates men undergoing vasectomy have their pain assessed using a recognised pain score and that pain is treated.

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 Nursing care Surgical procedures Termination of pregnancies	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • There were discrepancies in the stock of abortifacient medicines that could not be accounted for by senior managers. • There was no list of authorised signatures to confirm the identity of staff ordering, receiving and administering medicines. A number of nurses' signatures were illegible. • There were inadequate systems for monitoring and recording stocks of medicines and no evidence of a reconciliation process with original orders. • There was no evidence of any pharmacy review or medicines management audits. This was a breach of regulation 12(2)(g): the proper and safe management of medicines; These policies and procedures should be in line with current legislation and guidance and address: - Supply and ordering. - Storage, dispensing and preparation. - Administration. - Disposal. - Recording; And: • National specifications for infection prevention and control were not always adhered to. • There was a lack of segregation of clean and dirty equipment. • Checklists to provide sufficient detail and monitor cleaning standards and equipment were not in place. This was a breach of regulation 12(2)(h): assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Nursing care Surgical procedures Termination of pregnancies	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment • Calibration checks were not carried out on all equipment on a regular planned basis, including calibration of equipment used for the diagnosis and management of patient treatment and care. This was a breach of regulation 15(1)(e): All premises and equipment used by the service provider must be properly maintained; There should be suitable arrangements for the purchase, service, maintenance, renewal and replacement of premises (including grounds) and equipment. These arrangements must make sure that they meet the requirements of current legislation and guidance, manufacturers' instructions and the provider's policies or procedures.