Care Quality Commission

Marie Stopes International Sandwell

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Summary of findings

Letter from the Chief Inspector of Hospitals

Marie Stopes International (MSI) Sandwell is operated by Marie Stopes International. MSI Sandwell was registered with the Care Quality Commission (CQC) in October 2010. The MSI Sandwell location holds a licence from the Department of Health (DH) to undertake termination of pregnancy services in accordance with The Abortion Act 1967.

Sandwell location provides medical and surgical abortion, contraception, face-to-face counselling, and screening for sexually transmitted infections. Services are provided to NHS-funded patients referred by local clinical commissioning groups, as well as private patients.

Facilities at the MSI Sandwell location include a surgical treatment room, a room used for recovery and preparation, and a consulting room. Patients waited in the shared waiting area until called through for consultation, after this they waited in a small waiting area outside the main treatment room.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced part of the inspection on 24 July 2017, along with a short notice announced visit on 26 July 2017.

We observed activity, including staff interaction with patients, and He checked the environment and equipment. We spoke with two medical staff on the five nursing staff, two reception staff, and two managers .We reviewed 28 sets of records and spoke with five patients. Before and after the inspection we reviewed information about MSI Sandwell.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well led.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Services we do not rate

We regulate termination of pregnancy services but at the time of the inspection we did not have a legal duty to rate them when they are provided as a single specialty service. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

We found the following issues that the service provider needs to improve:

- Out of 16 Termination of Pregnancy Early Warning Scores (TEWS) forms reviewed, two were completed correctly in accordance with the guidelines for completion of TEWS.
- The provider supplied mandatory training figures, which showed that safeguarding, manual handling, consent, advanced life support; basic life support, incident reporting, medical gases and scanning training did not meet the provider's own targets. The provider did not offer supervision.
- The provider supplied mandatory training figures for infection prevention and control (IPC), which showed targets for IPC training had not been met by clinical and non-clinical staff. Therefore, we could not be assured that staff were able to apply basic IPC practices.
- Handwashing and the wearing of gloves were variable in the preparation/recovery room and the consultation room.
- The provider told us that medical gases training was provided both electronically and as part of a three day anaesthetic and recovery training course. We saw that 87% of eligible staff had attended the anaesthetic and recovery training course. The training matrix however included medical gas training separately which showed that only 4% of eligible staff had completed it. Therefore, we could not be assured that the training matrix was kept up to date.

Summary of findings

- Staff had only checked the major haemorrhage pack once ever.
- The recovery room was small with very little space between patients; this made it difficult for staff to manoeuvre around patients to perform nursing care, and for staff to move the patients' bed from the treatment room into the recovery room after their procedure.
- Recording of Oromorph (a controlled drug morphine base) was inaccurate, there were no initials on amendments, and there were two different entries within the controlled drug register. Calculation of the remaining Oromorph appeared to show that 100 mls was possibly missing. We raised this at the time of inspection and the provider took immediate action to look into the matter.
- Managers told us that paper held records that were transferred to and from other MSI locations should be taken by courier to ensure their safe and secure delivery. However, staff told us they transported records to and from other MSI locations using a sealed secure bag, then styles. We raised this with the regional director at the time of inspection who said they would take immediate action to ensure staff did not do this.
- On the day of the announced inspection, we found two folders with patients' identifiable information out on top of the cabinet.
- We saw a patient could not have their surgical procedure on the day due to four patients attending for surgical termination. This was because there was a limitation on the number of people who could be cared for in the preparation /recovery room .There was no risk assessment completed on the day to decide which patient should be cancelled based on gestation. The service could not offer the patient another appointment until 23 weeks gestation. We wrote to the MSI nominated individual and asked for assurance of how the provider ensured these patients were subsequently safely treated, the patient had the procedure carried out within the lawful gestation period.
- We saw one patient who was displaying challenging behaviour towards staff. The provider told us that while they had a policy on conflict resolution this policy did not cover this aspect of behaviour. They planned to address this issue. We noted that only 17% of staff had training in conflict resolution. Therefore, we were not assured that staff were enabled to manage these issues.
- There was no provision of easy read documentation for people with learning disabilities. Staff told us they did not have any training or guidelines on communicating with people with learning disabilities.
- At the time of inspection the clinical operations manager identified three potential areas of risk however, these were not listed on the locations risk register.
- Early opportunities to learn from the March 2017 incident of haemorrhage and delayed emergency transfer to an acute service were missed.

However, we found the following areas of good practice:

- Staff knew how to report incidents and described that they got an email response containing the outcome of the incident investigation.
- The provider had a policy on female genital mutilation (FGM) which was in date. Staff asked patients at the consultation for both medical and surgical termination about this. This was documented on the individual patient safeguarding form. Staff knew to report this to the safeguarding lead and the police if the patient was less than 18 years of age.
- As of 17 August 2017 child sexual exploitation (87%) and PREVENT (88%) training levels met the provider standards of 85%. FGM training level was 84%

Summary of findings

- We saw decontamination procedures carried out after each surgical procedure in the treatment room. The provider loaned theatre packs and decontaminated and packaged instruments in accordance with Health Technical Memorandum01-01 decontamination of surgical instruments.
- The staff members who carried out the consultations on the day of the termination checked the electronic record for completeness and accuracy before they took the patient through to wait for their termination.
- Treatment was managed in accordance with the Royal College of Obstetricians and Gynaecologists (RCOG), including gestation limit for the types of treatment provided.
- Anaesthetic arrangements were in accordance with the Royal College of Anaesthetists (RCoA), Association of Anaesthetists of Great Britain, and Ireland (AAGBI).
- We observed staff talking with patients and giving contraception where required.
- Doctors and nurses administered pain relief in line with best practice. For example, staff offered patients nonsteroidal anti-inflammatory drug (NSAIDS) routinely, which is recognised as best practice.
- MSI had implemented a bespoke ultrasound training course to date pregnancy provided by a qualified external sonographer delivered in line with the requirements of MSI policy.
- We saw nurses explained the procedure, possible risks, and alternative options before taking written consent from patients at all times. Nurses asked patients if they wished to continue right up to the point of the termination.
- Staff were supportive and showed empathy when they talked with patients. One patient told us that the nurse held her hand all the way through because she was so nervous about the surgical termination. Another patient who originally went for a medical termination became very upset when she realised that the process would commence at home, was comforted by the nurse, who then discussed changing to a surgical termination, which the patient decided to do.
- At reception, staff were responsive to patients in relation to their identification. The services reception was directly adjacent to the GP service reception, therefore, staff confirmed patients' identification by using the first name only, and second part of their postcode. They also spoke in a hushed manner and wrote the answers to questions on paper rather than verbalising them if it was sensitive information.
- The MSUK vision that women be in control of their fertility was visible and clear in the clinics information and articulated by staff in all roles who, we found were committed to this.
- The provider organisation had a system in place for checking the registration of nurses and doctors and insurance for practitioners, the operations manager told us they receive a three months' notice prompt for when they these are due for review.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with one warning notice and four requirement notice(s). Details are at the end of the report.

Heidi Smoult
Deputy 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 regulate this service but at the time of the inspection, we did not have a legal duty to rate when it is provided as an independent healthcare single speciality service. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

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Background to Marie Stopes International Sandwell

MSI Sandwell was registered with the Care Quality Commission (CQC) in October 2010. The location holds a license from the Department of Health (DH) to undertake termination of pregnancy services in accordance with The Abortion Act 1967. The location is situated within a community health centre on the same floor as a GP practice and is not an MSI owned premises.

Services are provided predominantly to NHS-funded patient referred by local clinical commissioning groups and receive referrals from other areas as well as private patients.

Termination of Pregnancy (TOP) refers to the abortion of pregnancy by surgical or medical methods. Marie Stopes International (MSI) Sandwell is part of the provider group MSUK and MSI International, a not for profit organisation that was founded in 1976 to provide a safe, legal abortion service following the Abortion Act 1967. The organisation has expanded from one centre in London to a global network of more than 600 centres across 37 countries.

At the time of inspection there was no registered manager for MSI Sandwell with interim management arrangements in place, supported by a regional director. All staff working at the Sandwell location were based at the MSI Birmingham site.

There were no special reviews or ongoing investigations of the service by the CQC at any time during the 12 months before this inspection. The service had been previously inspected on 8 June 2016 by the CQC.

CQC undertook enforcement action, following an inspection of the governance systems at the MSI corporate (provider) level in late July and August 2016. There were several breaches in regulation that were relevant to this location, which we have followed up as part of this inspection.

The breaches were in respect of:

- Regulation 11 Consent
- Regulation 12 Care and treatment must be provided in a safe way for service users.
- Regulation 13 Service users must be protected from abuse and improper treatment in accordance with this regulation
- Regulation 17 Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (Good governance)

Our inspection team

The team that inspected the service comprised a CQC lead inspector, Tracy Baggaley, other CQC inspectors, and a specialist advisor with expertise in women's' and children's' services. Fiona Allinson, Head of Hospital Inspection, oversaw the inspection team.

Information about Marie Stopes International Sandwell

Regulated services are provided at MSI Sandwell location, that includes medical termination of pregnancy (MTOP) up to nine weeks and four days, consultations, ultrasound scans, counselling and support, family planning and advice on contraceptive options, and oral contraception. Sexually transmitted infection testing and screening are also provided. The service carried out 2334 medical abortions from April 2016 to March 2017. The service is also registered for surgical termination of

Summary of this inspection

pregnancy (STOP) without anesthesia or with sedation anesthesia up to 23 weeks and six days. From April 2016 to March 2017 MSI Sandwell carried out 989 surgical procedures.

General anaesthesia was not provided at the Sandwell location. If the patient required surgical treatment with a general anaesthetic, they were referred elsewhere.

Services provided at the centre under service level agreement:

- Clinical and or non-clinical waste removal
- Maintenance of medical equipment
- Central Sterile Services Department
- Emergency transfer of patients

We observed activity levels, staff interaction with patients, and made checks on the environment and equipment. Before and after our inspection we reviewed performance information submitted by the service. We spoke with ten members of staff including; managers, medical staff, registered nurses, health care support workers and reception staff. We also spoke with seven patients.

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?

We found areas where the service needed to improve:

- Out of 16 Termination of Pregnancy Early Warning Scores (TEWS) forms reviewed, two were completed correctly in accordance with the guidelines for completion of TEWS.
- The provider supplied mandatory training figures, which showed that a number of areas did not meet the provider's own targets. This was noted in the last inspection in June 2016 as an action for the provider to address. The provider did not offer supervision.
- As of August 2017, 57% of eligible staff were up to date with basic life support training, 69% of eligible staff were up to date with training in intermediate life support training, and 87% eligible staff were up to date with anaesthetic and recovery care training.
- Handwashing and the wearing of gloves were variable in the preparation/recovery room and the consultation room. We saw inconsistent practice ranging from good to poor among the nurses we observed. This was noted in the last inspection in June 2016 as an action for the provider to address.
- The provider's targets for IPC training had not been met by both clinical and non-clinical staff. Therefore, we could not be assured that staff were able to apply basic IPC practices.
- Handwashing and the wearing of gloves were variable in the preparation/recovery room and the consultation room.
- Staff had only checked the major haemorrhage pack once ever.
- The recovery room was small with very little space between patients; this made it difficult for staff to manoeuvre around patients to perform nursing care, and for staff to move the patients' bed from the treatment room into the recovery room after their procedure.
- Recording of Oromorph was inaccurate, there were no initials on amendments, and there were two different entries within the controlled drug register. Calculation of the remaining Oromorph appeared to show that 100 mls was possibly missing.
- There was 82% of staff trained in information governance, which did not meet the providers' target of 85%.

Summary of this inspection

- The staff kept the paper patient records in locked metal cabinets behind reception. However, on the day of the announced inspection, we found two folders with patients' identifiable information out on top of the cabinet.
- Staff picked up and took the paper records from Birmingham to the Sandwell location. This was not in line with the provider's policy on record keeping.

However we also found the following areas of good practice:

- Staff knew how to report incidents and described that they got an email response containing the outcome of the incident investigation. Management held staff meetings to discuss learning within the team.
- The provider had a policy on female genital mutilation (FGM) which was in date. Staff asked patients at the consultation for both medical and surgical termination about this, and documented it on the individual patient safeguarding form. Staff knew to report this to the safeguarding lead and the police if the patient was less than 18 years of age.
- As of 17 August 2017 child sexual exploitation (87%) and PREVENT (88%) training levels met the provider standards of 85%. FGM training level was 84%.
- Staff kept all surgical instruments in the sterile supplies room. A named member of the clinical team was responsible for checks and stock control.
- We saw decontamination procedures carried out after each surgical procedure in the treatment room. The provider loaned theatre packs and decontaminated and packaged instruments in accordance with Health Technical Memorandum01-01 decontamination of surgical instruments.
- The staff members who carried out the consultations on the day of the termination checked the electronic record for completeness and accuracy before they took the patient through to wait for their termination.

Are services effective?

We found the following areas of good practice:

- Anaesthetic arrangements were in accordance with the Royal College of Anaesthetists (RCoA), Association of Anaesthetists of Great Britain, and Ireland (AAGBI).

Summary of this inspection

- We observed staff talking with patients and giving contraception where required, we reviewed records which confirmed that this happened at the initial assessment and before the patient was discharged from the clinic.
- Doctors and nurses administered pain relief in line with best practice. For example, staff offered patients nonsteroidal anti-inflammatory drug (NSAIDS routinely) instead of paracetamol due to ineffectiveness.
- The provider carried out clinical audit on a quarterly basis for clinical complications; evacuation of retained products of conception for medical and surgical termination, haemorrhage, cervical laceration, uterine perforation, infection, unable to complete procedure, prolonged pain, unplanned return to theatre, adverse response to medication and continued pregnancy for medical and surgical termination.
- There were also audits regarding safeguarding referrals, transfers to hospital, serious incidents, and cases of female genital mutilation (FGM).
- MSI had implemented a bespoke ultrasound training course to date pregnancy provided by a qualified external sonographer delivered in line with the requirements of MSI policy.
- We saw nurses explained the procedure, possible risks, and alternative options before taking written consent at all times. Nurses asked patients if they wished to continue right up to the point of the termination.

However we also found areas where the service needed to improve:

- The RCOG advises that services should provide treatment as early as possible. Staff informed us during our inspection that the service had to cancel patients' appointments due to closing the centre for staff training. We saw a patient could not have their procedure on the day due to four patients attending for surgical termination. There was no risk assessment completed on the day to decide which patient should be cancelled based on gestation. The service could not offer the patient another appointment until 23 weeks gestation. We wrote to the MSI nominated individual and asked for assurance of how the regional manager ensured these patients were subsequently safely treated, the patient had the procedure carried out within the lawful gestation period
- We saw one patient who was displaying challenging behaviour towards staff. The provider told us that while they had a policy on conflict resolution this policy did not cover this aspect of

behaviour. They planned to address this issue. We noted that only 17% of staff had training in conflict resolution. Therefore, we were not assured that staff were enabled to manage these issues.

Are services caring?

We found the following areas of good practice:

- We saw patients attending for medical and surgical termination and the nurses continuously described the procedure for both methods, and checked that all patients were happy to proceed and had understood what staff had told them.
- During the consultation for medical termination, the nurses explained the surgical option including the process and the risks and benefits. They also fully explained the risks and side effects of medicines used for medical termination. Staff gave advice to contact the 24-hour helpline should the patient be concerned about their treatment.
- We spoke with six patients about emotional support; they all said that the staff were very supportive and showed empathy when they talked with them. One patient told us that the nurse held her hand all the way through because she was so nervous about the surgical termination. Another patient who originally went for a medical termination became very upset when she realised that process would commence at home, was comforted by the nurse, who then discussed changing to a surgical termination, which the patient decided to do.

Are services responsive?

We found the following areas of good practice:

- At reception, staff were responsive to patients in relation to their identification. The services reception was directly adjacent to the GP service reception, therefore, staff confirmed patients' identification by using the first name only, and second part of their postcode. They also spoke in a hushed manner and wrote the answers to questions on paper rather than verbalising them if it was sensitive information.
- We saw staff reminding patients they could access post abortion counselling throughout their treatment journey. MSI provided details on how to access counselling and the 24-hour number to contact in the patient information booklet.
- The MSI website translated the information on the website into 90 languages via the search engine translate feature.

Summary of this inspection

- Between April 2016 and March 2017, 96% of patients were seen by staff within 30 minutes of their appointment time.
- Information supplied by the provider showed that between April 2016 and March 2017; all patients were offered an appointment in less than five working days from the decision to proceed. This was in line with RCOG guidance.
- Between April 2016 and March 2017, all patients had a procedure less than 10 working days from their first attendance. This was in line with RCOG guidance.
- Patients could make a complaint by completing the patient questionnaire to every patient before leaving the centre, by telephoning the call centre, by email, in writing or by contacting the local clinical commissioning group or NHS England.Details on how to make a complaint were in the 'your treatment' information booklets. We saw reception staff give both the questionnaire and the booklet to all patients who attended on the days of the inspection.

However we also found areas where the service needed to improve:

- Administration staff at Sandwell clinic used an electronic system to manage appointments and waiting times. This meant they could give patients who required it, another appointment whilst they were at the clinic, and did not have to wait for it to be booked. However, achievement of the providers waiting time was variable throughout June and July 2017 also as there was no recordings for the first three months of the period, it was difficult to know if this was then usual position or if it was worse than usual.
- There was no provision of easy read documentation for people with learning disabilities. Staff told us they did not have any training or guidelines on communicating with people with learning disabilities. This was noted in the last inspection in June 2016 as an action for the provider to address.

Are services well-led?

We found areas where the service needed to improve:

- At the time of inspection the clinical operations manager identified three potential areas of risk however, these were not listed on the locations risk register.

Summary of this inspection

- Early opportunities to learn from the March 2017 incident of haemorrhage and delayed emergency transfer to an acute service were missed.

However we also found the following areas of good practice:

- The MSI vision that women be in control of their fertility was visible and clear in the clinics information and articulated by staff in all roles who, we found were committed to this.
- The provider organisation had a system in place for checking the registration of nurses and doctors and insurance for practitioners, the operations manager told us they receive a three months' notice prompt for when they these are due for review.

Termination of pregnancy

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are termination of pregnancy services safe?

Incidents and safety monitoring

- There were 41 clinical incidents, six non-clinical incidents and no serious incidents reported in the period September 2016 to August 2017. There was one incident resulting in moderate harm, with the rest being no or low harm.
- No never events were recorded at the location in the period September 2016 to August 2017. Never events are wholly preventable, where 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.
- Staff knew how to report incidents and described that they got an email response containing the outcome of the incident investigation. Management held staff meetings to discuss learning within the team.
- The percentage of staff trained in incident reporting was 81%, just below the providers' target of 85%.
- Staff were aware of and described how they would comply with the requirements of duty of candour if an incident occurred. There were no incidents that met duty of candour thresholds for the period September 2016 to August 2017. 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 provider encouraged a culture of openness and honesty.

Mandatory training

- MSI UK required that all staff completed mandatory training in a range of topics, and enabled protected time for this to be completed either on line or face to face. Topics included safeguarding vulnerable adults (adults at risk) and children, basic life support, intermediate life support, first aid, information governance, display screen equipment fire safety essentials, fire warden training, fire emergency evacuation and drill essentials, first aid, COSHH, lone working, conflict resolution, equality and diversity, informed consent, infection prevention and control, health and safety essentials, and moving and handling. There were reminder systems for staff to prompt them when they were overdue for their mandatory training.
- A 'live' MSI regional electronic training matrix detailed records of all contracted or sessional staff, including nurses, managers, health care assistants and administrative staff. As all nursing staff at MSI Sandwell could work across the Midlands region on a rotational basis, there was one training matrix for all West Midlands locations.
- The training matrix was maintained by the operations manager with a red, amber, green (RAG) rating system to indicate staff compliance. The provider supplied mandatory training figures which showed that some of the topics met the provider's' targets. However some, which included safeguarding, manual handling, consent, advanced life support, basic life support, incident reporting and scanning did not. This was noted in the last inspection in June 2016 as an action for the provider to address.
- Staff had mandatory training in three forms. They had a one-day face-to-face training day and online training. They also had simulation training for basic and advanced life support. Staff recorded their training in an individual portfolio folder.

- We were informed by the provider that medical gases training was provided both electronically and as part of a three-day anaesthetic and recovery training course.
- We saw that 11 out of 13 staff (86%) required to undertake anaesthetic and recover training had attended the three-day course. However the training matrix included medical gas training separately and did not reflect this number, and showed only one member of staff out of 25 had attended. Therefore, we could not be assured that the matrix was kept up to date.
- As of August 2017 75% (24 of 32) staff were up to date with basic life support or intermediate life support training. The provider's target was 100%.

Safeguarding

- The provider had a policy on safeguarding for children and young people, which was in date. As of 17 August 2017, for children and adults, administration staff were trained to safeguarding Level 2 (91%), clinical staff were trained to safeguarding Level 3(89%) and the safeguarding leads were trained to level four (20%). Training for level two and three met the provider's standard of 85%; training for level four did not. The provider supplied information that showed five people were required to be trained to level four, and only one was upto date in this.
- A safeguarding lead was present at the location for the surgical termination clinic. The nurse working in the medical termination clinic knew how to contact a safeguarding lead if required.
- The provider had a safeguarding proforma for patients less than 18 years of age and one for over 18's. Staff completed these proformas at the clinic consultation. However there were two versions being used, the first did not contain prompts regarding learning disabilities, and the new one did. Staff advised that the new one should only be used. Staff told us the new one had recently been implemented, and they would ensure that the old ones were removed so they could not be used by mistake. Staff using the old version did not ask the patient if they had any learning problems. There were no safeguarding referrals for the period September 2016 to August 2017.
- The provider did not carry out terminations of pregnancy for children under 13 years of age at this location, in accordance with the provider's abortion policy version two December 2016.This states, "all clients less than 13 years will be designated as complex, will be referred to the NHS for management. The One-Call referral team will undertake this."
- The provider had a policy on female genital mutilation (FGM) which was in date. Staff asked patients at the consultation for both medical and surgical termination about this. This was documented in the individual patient safeguarding form. Staff knew to report this to the safeguarding lead and the police if the patient was under 18 years of age.
- The provider had child sexual exploitation (CSE) and child trafficking policies and procedures.
- As of 17 August 2017 child sexual exploitation (87%) and PREVENT (88%) training levels met the provider standards of 85%. FGM training level was 84%.

Cleanliness, infection control, and hygiene

- The clinic was visibly clean and tidy. The waiting area had six wipeable chairs. The clinical rooms were all visibly clean, tidy and clutter free. All rooms were furnished appropriately for clinical work to be undertaken in them. The storage rooms and clean and dirty utility were all clean and tidy. The patients' toilet and changing room were also tidy.
- Cleaning checklists for all areas were held in a folder at the nursing station in the preparation/recovery room. All checklists were up to date.
- We reviewed staff training compliance for infection prevention and control (IPC). As of August 2017 64% of clinical staff had completed level one and level two IPC training, and 44% of non-clinical staff had completed level one IPC training. The provider's target was 100%; therefore, we could not be assured that staff were able to apply basic IPC practices.
- Handwashing and the wearing of personal protective equipment (PPE) were varied. We observed the clinical area where ten nurses were carrying out clinical duties. Infection control procedures including handwashing and the wearing of PPE in line with MSI policy in the treatment room where staff carried out the procedures. Handwashing and the wearing of gloves were variable in the preparation/recovery room and the consultation room. Some wore gloves but did not wash their hands

and vice versa. We saw inconsistent practice ranging from good to poor among the nurses we observed. This was supported by a provider audit carried out between 6 and 8 March 2017, which reported the same observations. The provider supplied us with the audit report, however there was no action plan attached to this. This is direct conflict with the national institute for care excellence (NICE) quality standard 61, which states patients should "receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care." This was noted in the last inspection in June 2016 as an action for the provider to address.

- Staff in the treatment room wore theatre attire, however staff working in the consultation rooms and the preparation/recovery room were wearing items of jewellery that were not in line with good infection control. We raised this with the clinical location manager at the time of the inspection.
- Staff kept all surgical instruments in the sterile supplies room. Instruments were packed and sealed as single patient use, and all were in date. A named member of the clinical team was responsible for checks and stock control.
- We saw decontamination procedures carried out after each surgical procedure in the treatment room for equipment, such as trolleys.
- The provider loaned theatre packs and decontaminated and packaged instruments in accordance with Health Technical Memorandum01-01 decontamination of surgical instruments. We did not see a track and trace system for this.
- Waste was disposed of appropriately, with clinical waste bins and domestic waste bins clearly marked. Staff wore uniform appropriate to the clinical area.
- Staff had safely constructed sharps bins. Staff had clearly marked and secured containers close to the areas where medical sharps were used. None of the sharps bins was more than three quarters full. This was in line with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 (the Sharps Regulations).
- We saw posters displayed which outlined what action staff must take if a member of staff sustained a sharps injury. This was in accordance with the Health Technical Memorandum (HTM) 07-01: Safe Management of health care waste and control of substance hazardous to health (COSHH), health, and safety at work regulations.

Environment and equipment

- All equipment had evidence of an in date maintenance check. This was in line with Required Standard Operating Procedure (RSOP) 22.
- Staff checked all consumables such as dressings for expiry and stock levels. These were kept in the sterile supplies room, which was fully stocked with in date consumables.
- Staff kept the resuscitation equipment in the preparation/recovery room. Staff carried out weekly checks when the surgical clinic was held. Stock, equipment and medication was in date, however the emergency bag was not tag locked. Tags were available in the side pocket of the bag. We checked the bag at the time of the inspection and found it to be consistent with the last check by staff.
- Staff had only checked the major haemorrhage pack once ever. This was on the day of the announced inspection. There was a checklist that had been put in place that day.
- The clinics were held in a multi-use purpose built centre. Doors either had scan locking or passcode locks. Reception was shared with a local GP practice and staff kept sensitive information in locked cabinets. The keys were held securely and the cabinets were locked after each time they were used. We did observe, however that there were two folders containing identifiable, sensitive information about patients on top of a cabinet which could potentially be accessed by the public. We informed the provider and they secured them immediately, and raised an incident report.
- The clinic was accessed by stairs or lift up to the first floor.
- The recovery room was small with very little space between patients; this made it difficult for staff to manoeuvre around patients to perform nursing care, and for staff to move the patients' bed from the treatment room into the recovery room after their procedure. The room was 33.2m2. It contained a nurse's station and five bed spaces.

- The resuscitation equipment was stored within a beds space and it was difficult to remove it due to other equipment and patient belongings. We saw, and staff told us, the difficulty in working in the room when it was full. It was usual for the room to be full for the whole day when the surgical termination clinic was running. This environment was in conflict with the Association of Anaesthetists of Great Britain and Ireland, (AAGBI) guidelines on immediate post anaesthetic recovery. It states 'The beds should allow unobstructed access for trolleys, X-ray equipment, resuscitation carts, and clinical staff. The facility should be open-plan allowing each recovery area to be observed but with the provision of curtains for optional patient privacy'. The provider had tried to limit the risk of overcrowding by attempting to limit the number of patients in this room at one time; however, this still did not rectify the problem.
- We saw 'a planned preventative maintenance assurance' audit tool for January 2017 that showed all required maintenance had been undertaken. This tool ensured that equipment was operating correctly and was safe for patients and operators and aimed to extend the life of equipment and reduce failure rates. We saw that staff had done checks for all equipment.

Medicines Management

- The provider had a policy of giving preventative antibiotics after surgical termination in accordance NICE quality standard 61 statement 1, and we saw this in all cases.
- The service did not employ or use any nurse prescribers. Doctors prescribed all medication at the clinic. Nurses were only permitted to administer abortifacient medication that doctors had prescribed and we saw this was the practice in place. This was in line with The Abortion Act and regulations (1967).
- We observed staff administering medication to patients in line with the Nursing and Midwifery Council Standards for Medicine Management. Nurses informed patients of the purpose, action, and potential side effects of the drugs they were administering. Staff prescribed antibiotics in line with local antibiotic formularies.
- There was a medicines management policy, which was due for review in March 2016. The policy had been revised in February 2017; it was in draft form at the time of our inspection and needed to be approved. There were no medicines audits over the period September 2016 to August 2017. Nursing staff completed medicines management training on 19 July 2017. We did not have figures, however the managers told us that the location was closed for the day and all staff were invited to attend. Staff said that they had previously had a pharmacist assess drug calculation competency.
- There were eight medicines management incidents for the period October 2016 to July 2017. All resulted in no harm. Six were related to documentation of administration, one related to a missed dose of medication, and one related to missing Oromorph (noted in detail below).
- There was a controlled drugs cabinet in which contained midazolam and morphine oral solution (Oromorph) 10mg in 5mls. Although the strength of Oromorph does not meet controlled drugs schedule two criteria, the provider policy stated that it must be treated as such. Both medicines were stored securely and the keys were locked away in a passcode-controlled cabinet. However recording of Oromorph was inaccurate, there were no initials on amendments, and there were two different entries within the controlled drug register. Calculation of the remaining Oromorph appeared to show that 100mls was possibly missing. We raised this with the provider at the time of the inspection, and a summary report was presented to the medical director for consideration of a controlled drugs audit. The provider supplied us with a copy of the summary report.
- The medication for medical abortion was stored securely in the consultation room. The nurse responsible for this clinic monitored expiry dates and stock, however they did not record this.
- Other medicines were stored in a small locked cabinet, which was not adequate to hold the amount that was present at the time of the inspection. The boxes of medication were squashed inside and the door had to be forced to close. There were no audits of expiry or stock for these medications.

- Intravenous fluids (IV) were stored in the sterile supplies room. Healthcare support workers were responsible for stock control and monitoring of expiry dates. All IV fluids were in date.
- Staff carried out daily treatment room medication and equipment checks prior to each surgical list. We observed the recording of this.

Records

- Staff made up the paper patient records onsite on the day the patient attended for their termination or they transported them from Birmingham location, if the patient had attended there first. Each patient record was put into a coloured plastic wallet. The wallet was a different colour dependent on the treatment the patient was having. This helped staff to direct the records to the correct area of the clinic.
- Managers told us that paper held records that were transferred to and from other MSI locations should be taken by courier to ensure their safe and secure delivery. However, staff told us they transported records to and from other MSI locations using a sealed secure bag. We raised this with the regional director at the time of inspection who said they would take immediate action to ensure staff did not do this.
- There was 82% of staff trained in information governance, against the providers' target of 85%.
- The staff kept the paper patient records in locked metal cabinets behind reception. However, on the day of the announced inspection, we found two folders with patients' identifiable information out on top of the cabinet. We brought this to the attention of the provider on the day of the inspection who logged this as an incident and a locked the information away securely.
- Each patient had an electronic record, which was set up when the patient contacted MSI One Call centre to make an appointment. The electronic record consisted of a telephone consultation, which the staff completed with the patient before their face-to-face appointment. In addition, staff also completed a consultation template when the patient attended for their treatment. All recordings of observations were transferred from the paper form to the electronic record. This record also contained the forms signed by the doctors in order for the procedure is to go ahead. The doctors recorded their remote prescription on the electronic record. The staff member who carried out the consultation on the day of the termination checked the electronic record for completeness and accuracy before they took the patient through to wait for their termination.
- The provider carried out medical record audits; in January, March, May, and July 2017. In January, March and May, the audit showed that the provider target of 95% was met in these cases, 100%, 96% and 95% respectively. In July, 94% was achieved against the provider target of 95%. The provider had an action plan in place to address the specific issues highlighted in the audits, which was completion of the patient identification number and pain scores on the Termination of Pregnancy Early Warning Scores (TEWS) form.

Assessing and responding to patient risk

- Staff used the Termination of Pregnancy Early Warning Scores (TEWS) to complete patient observations and enable recognition of a deteriorating patient. Of the 16 patient records we looked at 14 were not completed accurately. This meant that there might be a risk that staff would not identify a deteriorating patient in a timely manner. The risk to patients was somewhat mitigated as they were nursed in a small room with staff present.
- The staff recorded rates of respiration with a tick instead of the exact value and in many cases did not record each time the observations were completed. Staff rarely completed pulse oximetry (the measurement of oxygen saturation in the blood).
- Staff did not always record patients' temperature and pulse. Patients' temperature, pulse, and blood pressure were also often recorded as numbers, across more than one box meaning it was not easy to score the value or attribute the time that it was taken. There were no black dots or lines to enable a trend to be documented or assessed. In some cases, the writing was illegible.
- Staff generally recorded pain with a tick rather than the score value. This was not recorded every time the observations were completed. Post- operative nausea and vomiting was not always recorded.
- Staff recorded level of consciousness incorrectly recorded in all cases. The letter 'U' was recorded on all

forms even though this is meant to represent an unconscious patient. The observations were taken in the post-operative phase; therefore, the patients were not unconscious.

- Staff sometimes recorded passing of urine, but not each time the observations were recorded. Very occasionally, the passing of urine was not recorded at all. The recording of vaginal blood loss was recorded with a tick; however, staff did not do this each time the observations were recorded. We could not see from the records what action had been taken when staff recorded blood loss. In some cases, the reported or witnessed box was completed, however in a good proportion of cases this was not completed at all. All heavy blood loss must be witnessed to accurately assess the severity.
- The total score was either missing or calculated incorrectly in every case. Each time staff recorded the observations, there was missing information. The total score depends on all of those fields where colour coding is used being completed each time. The inaccurate recording of the observations and the total score meant staff could not follow the trigger guidance advising what actions to take in the case of a deteriorating patient. In addition, where scores had been recorded as two or above, in most cases, staff did not record the observations every 15 minutes as advised in the guidance.
- All of the above omissions meant staff were not monitoring patients sufficiently or accurately, with staff not being in a position to recognise deterioration. In addition, when observations were taken which indicated further action was required, staff failed to do so. This meant patients were at risk of harm as the tools in place were not being used as designed and would be ineffective to identify and prevent further deterioration or recognise that escalation was required.
- The provider had mitigated this risk somewhat by adopting an early transfer of such patients to an emergency centre and medical staff remained on site until staff had discharged all patients.
- Following a surgical procedure, staff accompanied patients to the recovery room to relax and fully recover before staff discharged them. Nurses monitored patients for signs of sickness and pain. However, this did not fully mitigate the risk to patient safety arising from non-compliance with the TEWS charts.
- The Management of the Deteriorating Client and Clinical Emergencies Policy v4.2, dated December 2016 included details for the recognition and management of sepsis. In addition, the recognition and management of sepsis had been added to the clinical practice guide for registered nurses and midwives that was issued to staff in October 2016 and reviewed in December 2016.
- The provider had a service level agreement with local ambulance and acute NHS trusts for the transport and care of patients in the event of complications.
- Staff took medical history at the time of the telephone consultation to ensure that anyone with existing medical conditions was referred to an appropriate service. The staff completing the face-to-face consultation checked the patients' medical history again.
- We observed four patients undergoing surgical termination. The staff used the five steps to safer surgery World Health Organisation (WHO) checklist. Staff completed these in all cases; however, they did not carry out step five in a huddle format. This is where staff discuss the care required in recovery and afterwards for each patient.
- The general anaesthetic policy included the requirement that anaesthetists remained on site at locations until all patients were clinically fit for discharge. There was a clear discharge criteria outlined in the general anaesthetic policy that included patient observations, orientation, mobilisation, minimal bleeding and pain control, had passed urine and where applicable had arranged someone to accompany them home. This meant that there was a clinician on site to provide emergency support and treatment should a patient deteriorate.
- The patients were in the clinic for only part of one day; their observations were taken to detect possible infections during that time. Staff gave patients a booklet called 'your treatment information'... This booklet provided information on infection symptoms and aftercare.

- As of August 2017 57% of eligible staff were up to date with basic life support training, 69% of eligible staff were up to date with training in intermediate life support training, and 87% eligible staff were up to date with anaesthetic and recovery care training.

Staffing

- There were 13 registered nurses and eight health care assistants working at the clinic. On the days where only medical terminations were carried out, there was one registered nurse and one receptionist. There was an agreement with the GP practice who were housed on the same floor to support with an emergency situation.
- The provider planned staffing on excel documents, but they were in the process of rolling out a staffing tool across the country. The training for this happened on 9 August 2017 and the centres will be utilising the system by January 2018.
- There were registered nurses on duty at the time of inspection and the provider supplied information that showed this was the case for the last three months. This was in accordance with RSOP) 18 that requires that there should be a first level registered nurse or midwife on duty in the clinic at all times when there are patients who will need their care.
- Medical staff were on site at MSI Sandwell when the surgical service was open. The doctors worked remotely at other MSI locations, including the MSI 24 hour call centre. Their role was to review patient case notes and medical histories prior to signing the HSA1 forms and prescribing medicines. The HSA1 form is the certificate that has to be completed by two doctors before a termination of pregnancy is performed under the Abortion Act 1967.
- A clinical team leader managed the staffing rotas, and allocated the nursing staff to work at each of the centres on a day-to-day basis. This was in accordance with RSOP 18 staffing and emergency medical cover, which requires that a named senior manager should be responsible for ensuring that staff attended according to the staffing rota.
- The provider used the excel documents to plan which showed what staff were required for each clinic, however they could not provide information on how they could easily review planned versus actual staffing figures.
- Staff told us they were happy with the levels of staffing across all groups.
- Staff also worked at MSI Coventry, MSI Telford and MSI Birmingham locations on a rotational basis. The centre did not use bank or agency staff. Managers filled staff shortages by arranging for substantive staff to work overtime.
- There was a 0.4 whole time equivalent vacancy for a health care assistant at MSI Sandwell location. There were no other vacancies.

Major Incident awareness and training

- The provider had a business continuity plan, which was in date. The plan covered electricity, telephones, equipment failure, water, gas, fire alarms, bomb threats, and environmental issues. Emergency contact information was available in the plan for all situations. A copy was kept at reception.
- Fire training was completed and up to date by 29 out of 37 staff (78%), and 15 out of 37 staff (41%) had taken part in a fire drill in the past six months. Twenty out of 37 (54%) staff had completed a fire drill ever. This was not in line with the MSI policy, which required that evacuations should be practised at least twice a year.

Are termination of pregnancy services effective?

Evidence-based treatment

- Treatment was managed in accordance with the Royal College of Obstetricians and Gynaecologists (RCOG), including gestation limit for the types of treatment provided.
- Anaesthetic arrangements were in accordance with the Royal College of Anaesthetists (RCoA), Association of Anaesthetists of Great Britain, and Ireland (AAGBI).
- The (RCOG) recommend that where possible services should provide surgical termination without resorting to

general anaesthesia. General anaesthesia was not provided at the Sandwell location. If the patient required surgical treatment with a general anaesthetic, they were referred elsewhere.

- Required standard operating procedures (RSOP) 13: contraception recommends that termination of pregnancy (TOP) services should be able to provide all reversible methods of contraception, including long-acting methods (LARC) immediately after abortion. We observed staff talking with patients and giving contraception where required, we reviewed records which confirmed that this happened at the initial assessment and before the patient was discharged from hospital. The uptake of LARC was similar to other locations in the West Midlands region, with an average of 40% at Coventry, and 23% at Telford and 37% at Birmingham.
- RSOP 13: Contraception and sexually transmitted infections (STI) screening states that women should be offered testing for Chlamydia (C. trachomatis) and undergo a risk assessment for other sexually transmitted infections. A system for partner notification and follow-up for referral to a sexual health service should also be in place. We observed this at the time of inspection and on review of 16 sets of retrospective records.
- The service performed surgical termination of pregnancy only where pregnancy was confirmed by ultrasound scan to be 23 weeks and six days gestation or under, and performed medical termination to be nine weeks and four days gestation and under. The centre did not perform terminations beyond 23 weeks and six days.
- All medical terminations involved administering two separate medicines. This was in line with the RCOG recommendations for medical termination of pregnancy. Nurses advised patients that they were to return in 24 hours for the second dose. Nurses explained the benefits risks and success rates, however did not offer a choice between six, 24 and 72 hours. We were told that a clinic was held the following day, for administration of the second dose.
- The RCOG advises that services should provide treatment as early as possible. Staff informed us during our inspection that they had to cancel patients' appointments due to closure of the centre for staff training.
- A patient could not have their procedure on the day as four patients attended for surgical termination. Staff told us that the service books four patients per clinic, however there were usually people who did not attend. Three people attended on this day. There was no risk assessment completed on the day to decide which patient should be cancelled based on gestation.
- The service could not offer the patient another appointment until 23 weeks gestation. We wrote to the MSI nominated individual and asked for assurance of how these patients were subsequently safely treated, the patient had the procedure carried out within the lawful gestation period. The patient was 14+2 weeks gestation when they attended the Sandwell location on 26 July 2017, and received a surgical termination at another location at 18+5 weeks gestation. There were two similar cases where the patients had their procedure deferred due to capacity issues. They too had their procedure within the lawful gestation period.
- The clinic had arrangements in place for the disposal of pregnancy remains, including a register of disposal and we observed nurses asking patients during the consultation about their wishes. This was in keeping with RSOP 15.

Nutrition and hydration

- We saw staff informing patients that they could eat food up to six hours and clear fluids consumed up to two hours before surgery. This was in line RCoA guidance in relation to fasting before surgery.
- Staff offered patients hot and cold drinks and biscuits following their surgical procedure in the recovery room.

Pain relief

- We observed that staff routinely offered patients pain relief during medical and surgical abortions.
- Advice on pain relief was given to patients in the 'your treatment information' booklet and in the aftercare booklet. We saw staff reminding patients of pain relief options throughout their treatment journey.

- Doctors and nurses administered pain relief in line with best practice. For example, staff offered patients nonsteroidal anti-inflammatory drug (NSAIDS routinely) instead of paracetamol due to ineffectiveness.

Patient outcomes

- The provider recorded waiting times for medical and surgical terminations for June and July 2017. There were no recordings on the monthly dashboard for March, April, and May 2017. For June 2017, the provider met the target of 10 days for medical termination, (actual 8 days) and did not meet the 10 days target for July 2017(actual 14 days). For June and July, the provider did not meet the 10-day target for surgical termination under 14 weeks gestation (in June this was 16 days and in July this was 14 days. For June and July 2017, the provider did not meet the 10-day target for surgical termination over 14 week's gestation (for June this was 25 days and for July 20 days). As there were no recordings for the first three months of the period, it was difficult to know if this was then usual position or if it was worse than usual.
- The percentage of patients taking up long acting reversible contraceptives (LARC) was 18% in July 2017. From July 2016 to July 2017 the up take percentage was between 30% and 48% for 11 months and 53% for one month during that period. The providers target was 50%.
- At the time of the inspection, staff offered all patients testing for sexually transmitted infections. This was in line with RSOP guidance on Contraception and sexually transmitted infections (STI) screening. The provider supplied information for the period April 2016 to March 2017 that showed staff tested 57% of those attended for HIV, and 36% of those attending, for chlamydia. The provider had started the audit cycle for 2017 to 2018, which also included the monitoring of reasons why screening was not carried out on all attendees. The highest proportion of opt out reasons given was 'declined to give reason'. In addition, not all clinical commissioning groups funded chlamydia testing.
- For the period January 2017 to March 2017 the MSI quarterly patient survey response to both questions, 'did you leave the clinic without a method of contraception' and 'the amount of time and attention you were given' scored between 5% and 10% below the provider's agreed target. The clinic achieved over 10% below the target in April 2017 to June 2017 for 'the process of booking your appointment'
- Staff offered all patients counselling as part of their initial phone call when they make their first appointment. The provider had a failsafe system within the electronic patient record that would not let staff make an appointment until counselling had been offered. To audit this, MSI One Call (the MSI centre that booked appointments) performed call audits to monitor the quality of calls.
- The provider carried out clinical audit on a quarterly basis for clinical complications; evacuation of retained products of conception for medical and surgical termination, haemorrhage, cervical laceration, uterine perforation, infection, unable to complete procedure, prolonged pain, unplanned return to theatre, adverse response to medication and continued pregnancy for medical and surgical termination. The overall rate of complications for the period April 2016 to March 2017 was 1.22%.We did not see information from previous timeframes.
- There were also audits regarding safeguarding referrals, transfers to hospital, serious incidents, and cases of female genital mutilation (FGM). Audits for the period 1 April 2016 to 31 March 2017 there was one safeguarding referral, one case of FGM, no serious incidents and nine transfers to hospital.
- There was evidence from the provider's integrated governance meeting minutes and the regional meeting minutes that clinical audit and incidents were discussed and actions assigned.

Competent staff

- Some staff told us they were up to date with their appraisals; however, newer staff had not, although they had not been in post for more than 14 months. Managers told us they were currently working to ensure all staff had annual appraisals.
- We saw a 'Marie Stopes Induction, Probation, and Preceptorship, Workbook for Clinical Team Members'. This included areas such as an overview of Marie Stopes and reflective practice portfolio. This was due to be implemented in the location.

- Due to the high number of new staff at the Sandwell clinic, compliance with mandatory training and competency frameworks were not up to date. This meant managers could not assure the themselves of staff member's competencies. This restricted the areas of the service staff could work in. There were arrangements in place to ensure this happened, including recruitment strategies, job descriptions, ongoing learning, and development programmes.
- All staff had completed their revalidation. Revalidation is the process that all nurses, midwives, and doctors in the UK will need to follow to maintain their registration with the Nursing and Midwifery Council (NMC). We saw a national nurse revalidation tracker and General medical council (GMC) registration tracker update. Staff said that they had to seek clinical peer support outside of the organisation to complete evidence for their revalidation.
- All counsellors were accredited members of the British Association for Counselling and Psychotherapy.
- Staff told us that any nurse or health care assistant who performed ultrasound scans to determine gestational date would be required to successfully complete an in-house training programme and assessment of a competency framework in scanning. This was co-ordinated by a lead scanning trainer for MSI UK, supported by a regional scanning mentor. Training records showed 26% of eligible staff were up to date with ultrasound scanning training. A regional scanning mentor performed the scans when there was no other competent member of staff available. The mentor also worked with staff to complete the required training and assessment, in order to scan patients without supervision and would attend the centre to scan patients in the absence of a competent member of staff to do so. During our inspection, we saw that staff who had undertaken the relevant training and assessment performed scans.
- Regional managers had identified 'Induction, competency, and staff engagement' as an area of risk for the service through their 'supportive quality review' in July 2017 just prior to our inspection. An evidence-based clinical practice guide for registered nurses and midwives was issued to staff in October 2016 through roadshows. Staff were required to have the clinical competencies related to the practice guide signed off once they had successfully completed training and assessment, however; there were limited systems in place to monitor this.
- The provider did not support staff with clinical supervision. Clinical supervision is an activity that brings skilled supervisors and practitioners together in order to reflect upon their practice. It is a time for a nurse or midwife, to think about their knowledge and skills and how they may be developed to improve care.

Multidisciplinary working

- We saw good multi-disciplinary teamwork in the clinic. Surgeons and anaesthetists worked well with nurses and health care assistants during the procedure. Administrative and nursing staff had a clear and efficient system to manage the patients through the whole process on the day.
- The specialist doctors were responsible for the overall care and safe discharge of surgical patients.
- A 24-hour telephone helpline number was available for women to use after abortion if they had any concerns. Staff provided this in the patient booklet and aftercare booklet. We saw staff reminding patients of the number throughout their treatment journey.
- Staff told us they would contact other professionals such as the patients GP, or social worker, if they needed any further information to ensure their patients safety. They advised that they would obtain the patient's consent. We did not see any cases at the time of inspection here this was required.
- All patients had the opportunity to discuss options and choices with, and receive therapeutic support from, a trained pregnancy counsellor the. The counsellor also said that she regularly had empty appointments. They were currently working with staff to raise awareness of the service.

Access to information

- Nurses asked for patients consent to send a discharge summary letter to their GP. This would enable the GP to manage any complications following the termination of pregnancy. This was in line with RSOP guideline 3.
- Staff had access to a paper based and electronic patient record on the day of the consultation and procedure.

We observed the process of getting the notes ready at the start of the clinic, the route the paper notes then took, dependent on the type of appointment the patient had, and the subsequent filing and storage after the appointment.

Consent, Mental Capacity Act and Deprivation of Liberty

- RSOP 14 Counselling and RCOG guidelines say women attending an abortion service will require a discussion to determine the degree of certainty of their decision and their understanding of its implications as part of the process of gaining consent. We saw nurses explained the procedure, possible risks, and alternative options before taking written consent at all times. Nurses asked patients if they wished to continue right up to the point of the termination.
- We saw staff obtaining written consent for contraception choices.
- Staff used formal translation services for anyone whose first language was not English for consent to ensure the patient was not consenting under duress.
- There were no patients under the age of 16 attending for an appointment at the time of the inspection, however, staff knew to refer to Fraser guidelines when taking consent from patients under 16 without parental consent. The Fraser guidelines refer specifically to consent for sexual health services and are an additional guideline to the Gillick competency framework that relates to consent for any healthcare intervention. Both guidelines help practitioners balance children's rights and wishes with their responsibility to keep children safe from harm
- The MSI abortion policy stated the provider was unable to treat patients who did not have the capacity to consent to treatment. The policy indicated that where a patient did not have the capacity to consent to treatment, staff should refer the patient to the NHS for assessment and treatment. The lead safeguarding nurse confirmed this is what staff would do under the circumstances.
- Only nurses trained to Level 3 competence in safeguarding children and adults took patients' consent.
- The training matrix identified that the provider had trained 79% staff in informed consent and consent and capacity. The target was 85%. Consent and capacity training related to consent for patients who may not have capacity to consent themselves. At the time of the inspection, nurses with this training took consent.
- We saw one patient who was displaying challenging behaviour towards staff. The provider told us that while they had a policy on conflict resolution this policy did not cover this aspect of behaviour. They planned to address this issue. We noted that only 17% of staff had training in conflict resolution. Therefore, we were not assured that staff were enabled to manage these issues.
- We brought this to the attention of senior managers following the inspection and they informed us they would be developing and implementing a policy.

Are termination of pregnancy services caring?

Compassionate care

- We observed staff treating patients in a non-judgmental and supportive manner, in most instances. However, there were two patients who had waited for an extended period and were getting very concerned because of their personal circumstances. They felt that staff were not sympathetic to their needs as they were not reassured that they would be seen in time to be home at a time that ensured their safety and confidentiality was maintained. Staff said they had tried to communicate but could not offer reassurance of when the patients would be seen.
- We saw staff drawing curtains for examinations, and scans, to protect the patient's dignity. There was a single, lockable changing room, where patients got changed into theatre attire.
- Managers and staff told us that the facilities in for surgical services did not always allow patients' privacy and dignity to be maintained. For example, staff said due to the close proximity of the beds, patients recovering from anaesthesia or sedation did not have a sufficiently peaceful environment. The same room was used for patients' preparation prior to surgical procedures.
- The provider collected information from patients regarding dignity and respect for the period 1 January

2017 to 31 March 2017. Patient satisfaction forms were completed by 21% (51) of patients, and of those 98%, despite the above issues, said they were treated with dignity and respect. This was the same for the period 1 October 2016 to 31 December 2016. The results fell just short of the 100% target set by the provider. Ninety-seven per cent said they had enough privacy during their treatment for the period 1 January 2017 to 31 March 2017 and 95% for the period1 October 2016 to 31 December 2016. This was in line with the 95% target set by the provider.

- The provider collected information from patients regarding how they were treated for the period 1 January 2017 to 31 March 2017. They asked the question about the doctor and the anaesthetist 'were you treated with care and concern'? One hundred per cent of patients said they had by the doctor and 97% by the anaesthetist. They also asked the question about the doctor and the anaesthetist, did they 'listen to you and understand your feelings?' One hundred per cent of patients said they had by the doctor, and 97% by the anaesthetist.

Understanding and involvement of patients and those close to them

- We saw patients attending for medical and surgical termination and the nurses continuously described the procedure for both methods, and checked that all patients were happy to proceed and had understood what staff had told them.
- During the consultation for medical termination, the nurses explained the surgical option including the process and the risks and benefits and said that they could choose that option instead. They also fully explained the risks and side effects of medicines used for medical termination, including prolonged bleeding. Advice to contact the 24 hour helpline was given should the patient be concerned about their treatment.
- Staff gave all patients an information booklet called 'your treatment information'. This booklet contained information about fees, instructions on preparing and attending for both types of termination, the process for surgical option, and the medical option, aftercare for both including emergency contact numbers, infection prevention, contraception, counselling and chlamydia screening. There was also information about data protection, complaints, and patient satisfaction questionnaires.
- Staff did not always give information so that women were aware that the contents of the abortion notification form (HSA4) that this is used to inform the Chief Medical Officer of termination of pregnancy and is used for statistical purposes by the Department of Health (DH), although there was one poster in the waiting area.

Emotional support

- We saw staff addressing patients concerns in a caring and empathic manner, in all circumstances, apart from when dealing with the issues of waiting. For example, we saw a nurse repeating the low risk of complications and the relative ease of the procedure to a patient who was scared of going into surgery.
- Nursing staff, doctors and trained counsellors provided emotional support for patients either at the centre or by accessing the 24-hour telephone line provided by nurses trained in providing emotional support and advice at the MSI One Call centre.
- The 2014 Department of Health response to the Government review on Independent abortion providers, and the Royal College of Obstetricians & Gynaecologists (RCOG) guidelines state that mandatory counselling is not advisable. The MSI Counselling policy was revised in December 2016 so that patients had the choice of whether they accessed counselling or not. The exception to this was for patients under the age of 16. They received mandatory counselling on a different day to their termination.
- We spoke with six patients about emotional support; they all said that the staff were very supportive and showed empathy when they talked with them. One patient told us that the nurse held her hand all the way through because she was so nervous about the surgical termination. Another patient who originally went for a medical termination became very upset when she realised that process would commence at home, was comforted by the nurse, who then discussed changing to a surgical termination, which the patient decided to do.

Termination of pregnancy

Are termination of pregnancy services responsive?

Meeting the needs of local people and individuals

- The service that Marie stopes International (MSI) Sandwell provided was commissioned by the local clinical commissioning group (CCG) based on the profile of the local community. Commissioners set key performance indicators for MSI to achieve. These were reported by MSI to the CCG in their quarterly monitoring report.
- The service provided a range of services for medical termination of pregnancy up to a gestation of 9 + 4 weeks and surgical termination of pregnancy up to 23 + 6 weeks. The Royal college of Obstetricians and Gynaecologists (RCOG) best practice in comprehensive abortion care paper No. 2 June 2015 stated that medical termination should be performed up to 8 + 6 weeks, therefore; this practice was in line with best practice.
- MSI provided both NHS and privately funded treatment, with 98% of patients in 2017 NHS funded.
- The service saw patients from diverse ethnic origins, with 20% black afro-Caribbean, 31% Asian, 6% mixed origin, 39% white, 2% unknown. (Rounded to the nearest whole number).
- MSI Sandwell did not permit companions to sit with the patient in the treatment or recovery areas to protect other patients' confidentiality. Companions waited in the waiting area alongside people attending the GP practice that was housed in the same building.
- Marie Stopes offered private telephone counselling for patients with issues such as miscarriage, ectopic pregnancy fear of pregnancy or parenthood, relationships, self-worth, grief and managing emotions.
- Staff had access to telephone translation services for patients whose first language was not spoken English. Patients could also, access face-to-face interpreters in advance if required, including British sign language.
- The MSI website translated the information on the website into 90 languages via the search engine translate feature.
- The clinic only accepted patients with learning disabilities that had capacity to consent. There was no provision of easy read documentation for people with learning disabilities who they deemed to have capacity. Two members of staff told us they did not have any training or guidelines on communicating with people with learning disabilities. Staff told us that 'we just speak slower so they can understand'. We saw in two sets of notes that it was documented that the patient had learning difficulties, however there was no action recorded to state what staff would do in this instance. This was noted in the last inspection in June 2016 as an action for the provider to address.
- Patients were asked if they had any special requests for the disposal of pregnancy remains on request. A patient information leaflet was provided which detailed the options available. Patients were given the option to have pregnancy remains kept separately and this was acknowledged in the patient record system. Staff we spoke with said that patients were advised what documentation was required in order to procure a cremation or burial. Where possible (and with the patients permission) the centre liaised with the funeral directors to facilitate as smooth a process as possible to alleviate stress. There was a policy and procedure in place for the sensitive disposal of pregnancy remains following a surgical termination at MSI Coventry (MSI UK Management of fetal tissue policy dated May 2016). This complied with the Human Tissue Authority Code of Practice. Inspectors observed the storage and labelling processes on site, which complied with MSI policy. Staff documented any non-standard disposal option in the patient's record and on a freezer log sheet indicating the reason for storage and date for either collection or disposal.
- Pregnancy remains were only released to the patient or the police once stringent checks had taken place. Where pregnancy remains were uncollected, staff would contact the patient, if appropriate to do so, to ask for further instruction. If not, senior staff would make a decision to dispose of the pregnancy remains after three months.
- At the time of inspection, there was a female doctor present during the surgical termination clinic. Staff told us that this was usually the case, however, the availability of female doctors could not be guaranteed

due to the national shortage of female doctors. Staff could not identify a time when the female doctor was not present, therefore, did not ask about this at the time of the consultation.

- At reception, staff were responsive to patients in relation to their identification. The services reception was directly adjacent to the GP service reception, therefore, staff confirmed patients' identification by using the first name only, and second part of their postcode. They also spoke in a hushed manner and wrote the answers to questions on paper rather than verbalising them if it was sensitive information.
- The 'One Call' centre contact system booked patients into appropriate clinic for the patient across a defined geographical area.
- Staff referred some patients to the NHS for complex terminations including late stage medical and surgical terminations where a scan had showed a gestation stage later than the patient reported.

Access and flow

- Patients accessed the service through the call centre in Bristol ('One Call') which provided the booking service, telephone consultations, and the 365 day / 24hr aftercare support line.
- The provider accepted referrals form a range of sources. From April 2016 to March 2017, 36% self-referrals, 43% GP, 3% family planning, 0% walk in centre,1% health and wellbeing sexual health charities, 7% pregnancy advisory services, 6% previous client ,1% hospital sexual health clinics,4% other.
- Administration staff at Sandwell clinic used an electronic system to manage appointments and waiting times. This meant they could give patients who required it, another appointment whilst they were at the clinic, and did not have to wait. However, achievement of the providers waiting time was variable throughout June and July 2017 also as there was no recordings for the first three months of the period, it was difficult to know if this was then usual position or if it was worse than usual.
- A patient told us and staff confirmed that patients often attended one centre for consultation and a different centre for treatment. This meant not all patients received care in familiar surroundings.
- The clinical commissioning group (CCG) monitored waiting times for treatment. This ensured MSI was meeting CCG waiting time targets and contact to treatment time was in line with RCOG guidelines.
- Between April 2016 and March 2017, 96% of patients were seen by staff within 30 minutes of their appointment time
- Between April 2016 and March 2017, all patients were offered an appointment in less than five working days from the decision to proceed. This was in line with RCOG guidance.
- Between April 2016 and March 2017, all patients had a procedure less than 10 working days from their first attendance. This was in line with RCOG guidance.
- Between April 2016 and March 2017, 11% of patients did not attend for their planned treatment. This was in line with the average for the Midlands and North area. Managers informed us that as a rule they did not follow up patients who did not attend their appointments. This was because they did not want patients to feel staff were pressuring them in any way. However, managers did confirm that they would use their discretion if they had any safeguarding concerns.
- The provider cancelled treatment for eight patients, which was 2% between January 2017 and March 2017. There were no other cancellations for the year April 2016 to March 2017. The clinic followed a standard operating procedure for clinic cancellations.

Learning from concerns and complaints

- Patients could make a complaint by completing the patient questionnaire given to every patient before leaving the centre, by telephoning the call centre, by email, in writing or by contacting the local clinical commissioning group or NHS England.Details on how to make a complaint were in the 'your treatment' information booklets. We saw reception staff give both the questionnaire and the booklet to all patients who attended on the days of the inspection.
- The providers' policy was that they would acknowledge any written complaint within two working days of receipt and any telephone enquiries within 24 hours. Staff would then carry out a full investigation and a full response would be made in negotiation with the person who had complained.

- There were no formal complaints for Sandwell location for the period April 2016 to March 2017 and April 2017 to June 2017. The provider's target was 0.9%, which was the same as the NHS benchmark.

Are termination of pregnancy services well-led?

Leadership/culture of service related to this core service

- The Sandwell clinic is registered as a location with the CQC and also as an approved place to provide termination of pregnancy services in its own right by the Department of Health (DH). Sandwell clinic was run, managed and staffed by the Birmingham Centre clinic. This management and staff team administered further MSI clinics within the West Midlands from the Birmingham Centre, for example at Telford and Coventry and also a number of 'satellite' nurse led early medical abortion clinics within Birmingham.
- There was a newly formed leadership structure at Sandwell and this had impacted the level of governance and risk oversight.
- Staff told us that the managers would visit the centres on an as-needed basis, and that this was rare. Staff also told us they had telephone and email access to managers at all times and that they would respond to calls promptly.
- The deputy chief nurse assured us during our visit that robust alternative temporary arrangements were in place to manage the services at the Sandwell clinic. These arrangements at the time of our visit included access to the regional director for MSI northern region 'covering' day-to-day operational responsibilities from the Birmingham Centre clinic supported by the regional clinical operations manager and an interim operations manager. However we found this team, although focussed on bringing about change, were not routinely at the Sandwell clinic, including on the second day of our inspection visit until we asked to see them. They were not on top of the day-to-day quality of the service to patients at that time. For example, the poor level of completion of Termination of Pregnancy Early Warning Scores (TEWS) tools had not been identified. No managers were routinely present on Wednesdays when the surgical list was running except 'normally they try' to have a clinical manager on site because of the surgery list.
- Four weeks after our visit the provider told us a matron from a clinic in the provider's southern region was spending four days each week on a short term basis, at the Birmingham Centre, which supported the Sandwell location.
- We asked the operations manager to see the register of people who had undergone termination of pregnancy at the Sandwell clinic; this is a record that should be kept for three years in accordance with Records Management: NHS Code of Practice Part 2 retention of health records schedule. The manager told us the service kept lists of patients and their treatment and available across a number of different record keeping systems.
- We asked the provider for information about how it had safely managed this change to the local termination of pregnancy care services and the impact it had on the ability of local services to respond appropriately within the required time limits to gestational stage. MSI sent us their standard operating procedure for cancellation of clinics but no evidence of how the decision for each patient against their gestation time and preferred method was managed.

Vision and strategy for services

- The MSI vision that women be in control of their fertility was visible and clear in the clinic's information and articulated by staff in all roles who, we found were committed to this.
- The provider's mission statement was 'We're working towards a world in which every birth is wanted - where people are free to have children by choice, not chance'.
- We found responsibilities within the clinic were clearly defined in respect of medical staff and nursing staff. Also, for the administrative support staff, who managed the electronic records system for the effective use remote medical practitioner's input, and the reception staff who contributed to management of the appointments diary and lists We found the provider had protocols and procedures in place covering both methods of termination of pregnancy and gestation

bands in line with required standard operating procedures (RSOP) 2. These were integral to the appointment and treatment booking process of the clinic and the 'One Call' contact system flexibility to book patients into appropriate clinic and appointments across the geographical area.

Governance, risk, management and quality measures for this core service

- We saw the DH certificate displayed in a prominent place in the Sandwell clinic, as it should be to demonstrate the MSI clinic was an 'approved place' to carry out terminations of pregnancy.
- At the Sandwell clinic, a statement was on display informing patients the extent to which their data would have to be shared with the department of health as a legal requirement.
- Processes were in place to ensure that clinical practice was provided within the scope of the law (Abortion Act, 1967, Required Standard Operating Procedure 1 and 2). This included staff abiding by the MSI UK protocols, policies, and procedures in place for each type and method of termination of pregnancy procedure available, and the associated gestational limits. This was evidenced by the consultations we observed, by talking with staff about clinical practice and in the care records we reviewed.
- The service had a formal system in place to manage risk. We noted a risk register was kept and updated to identify and minimise any risks to patients and staff within the premises as required by RSOP 21. However, we found this register was not specifically tailored to the Sandwell clinic. For example, although the register identified the 'high' rated risk of 'admin and nurses and HCA's using computer screens with client information on' it did not specifically address the risks associated with sharing a reception desk space with other providers in a healthcare centre as is the case at the Sandwell clinic.
- Staff were expected to report risks they identified; however, the local interim managers could not effectively describe the risk management process. The three 'worry' areas identified by the operations manager for Sandwell clinic when we asked, were not on the clinic risk register. There were no paper record risk assessments held at the Sandwell clinic, the interim operations manager told us staff have access to updated assessments, policy, and clinical procedures on personal computers in the treatment rooms via the MSI UK intranet.
- A quality review of the surgical service was undertaken by members of the MSI executive management team in July 2017. This reported a number of areas for improvement and an action plan was developed. These areas included mitigating risks regarding infection prevention and control, out of date equipment and consumables, adequately trained staff to deliver long acting reversible contraception (LARC) and lack of governance arrangements.
- The action plan aimed to have these improvements in place by between the end of March 2017 and the end of May 2017. We noted the issues of infection and prevention practices and governance arrangements were still in evidence at our inspection visit at the end of July 2017.
- The regional director reported to the provider's senior leadership on 14 July 2017 to discuss the areas for improvement as part of a Birmingham wide review. This forum included the chief nurse, acting medical director, associate director for quality assurance, the medical director, and quality review participants including the regional manager. Some immediate changes were agreed and a programme of work to incorporate changes was put in place with review dates.
- There was a system in place for the Sandwell clinic services to connect and report on its services through the organisation. Governance meetings had been scheduled quarterly and these meetings reported to senior managers in the organisation and through to the Board. However, managers told us these were being conducted monthly at the time of our inspection 'to get on top of things'. We found this arrangement had slipped, as there had not been one in June or July 2017 missing opportunities to improve the service.
- The Sandwell clinic team meetings and governance issues were discussed as part of meetings for the Birmingham Centre. Local managers told us every staff member attends the team meetings and these meeting

discussed issues such as incidents, patient wait time, complaints, and the LARC take up for the clinic. We found no system in practice for 'debriefing' when they were involved in a serious incident.

- The provider had a process in place to notify the CQC of the death of any patient within 12 months of their treatment at the clinic.
- A new governance assistant post had recently been created to support governance arrangements at the location. Staff told us this role was to include undertaking clinical audit and incident report tracking to report to weekly regional incident review meetings. The post holder had yet to receive training in the reporting software system at the time of our visit. There was limited skill and knowledge available within the leadership team to access and interrogate the software system. Local managers were not familiar with the standard RCOG patient outcome audits we asked to see.
- The clinic followed the system put in place by the provider organisation to comply with documentation required by the Abortion Act and the Department of Health requirements, For example we found in keeping with RSOP 1, HSA1 forms were completed on each patient file we reviewed and included the signatures of two medical practitioners in good faith. Signatures were dated and timed to demonstrate the independent opinion of a single permissible criteria for the termination of pregnancy.
- At the Sandwell clinic, the HSA1 forms were signed by doctors who were present at the clinic one day each week or signed by registered medical practitioners working in other MS UK clinics around the country remotely.
- Staff had filed a completed copy of the HSA1 form in all of the patient records we reviewed. Department of Health 'Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy' (Abortion) considers this best practice. Two registered medical practitioners independent of each other and in good faith agreed, completed, signed, and dated the HSA1 forms before preforming a termination of pregnancy was carried out. This was in line with Section 1 (1) of the Abortion Act 1967.
- Registered practitioners must submit an abortion notification form (HSA4)for every abortion they carry out. The department of health checks these forms to ensure that their best practice guideline is followed and abortion data complies with the national statistics code of practice. The clinic's audit showed compliance with this was 100% from July 2016 to June 2017.
- Local managers told us they were not aware of and did not get feedback on outcomes from any Royal college of Gynaecologists (RCOG) audits at operations level within the organisation. They were aware local standards were audited (in line with RSOP 16) such as the uptake of patient choice of contraception and abortion methods and these were regularly reported via a dashboard to the clinical commissioning group (CCG).
- Medical records were also audited, including the completion and dispatch of the HSA4 forms by surgeons and the provider reported this to the clinic on a weekly basis.
- The provider organisation had a system in place for checking the registration of nurses and doctors and insurance for practitioners, the operations manager told us they receive a three months' notice prompt for when these are due for review.

Public and staff engagement

- The service collected feedback from people who have used the service through independent analysis of questionnaires; staff gave each patient to complete after treatment with a freepost envelope. This analysis was undertaken on a monthly basis and the provider received a quarterly report on a clinic-by-clinic basis and by comparisons with the previous month and against the provider's targets. This feedback was then sent to the clinic for local action. Although overall rates of satisfaction were high, we noted the response rate was very low with an average of only 17% of patients responding in November to December 2016. Staff we spoke with told us that due to the sensitive nature of the service and procedure it was sometimes a challenge to get a response.
- If there was a specific local complaint, the provider alerted the local manager who would investigate, form an action plan if appropriate and feedback to team meetings. Local managers told us the Sandwell clinic had not had a specific complaint in the 12 months prior to our inspection.

- Staff were very committed to the service they provided to give women choices and control over their fertility. We saw a poster on display for patients about the 'Client Choice Award' for supportive and empowering staff members.
- Staff told us nothing had taken place over the previous 12 months by way of awards and away days. They said staff morale had been low because the new management structure had 'jumped in feet first not explaining why changes were necessary, they were being left to their own devices and staff were leaving. There was a strain on just a few staff that have all the skills and they were the ones regularly sent to the nurse led EMA clinics while other new staff were trained up'.
- The regional director told us there was high turnover of nurses at the Birmingham Centre; this team also staffed the Sandwell clinic and this put pressure on the 'experienced all-rounders' needed to run the nurse led clinic on Mondays.
- The executive management team sent weekly bulletin updates directly to individual staff through email. We noted the 13 July update feature the first of the six objectives the provider had developed to improve the service and prompting feedback from the 'Fit for the Future' presentation. Staff told us 'things filter down [from the top of the organisation] but slowly'.

Innovation, improvement and sustainability

- We saw changes were in the early stages of development and needed time to be embedded in practice. In addition, changes to the management team were ongoing so we were unable to assess the sustainability or full impact of the improvements.
- As result of the supportive quality review carried out by the provider in July 2017, strategic changes in the configuration of services in this part of the region were to be proposed to the Board at the end of August 2017.
- The provider intends to develop the new electronic software-reporting tool within the service and aims to include a risk register function in the near future.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- Ensure that there is appropriate management oversight to assess, monitor, and improve the quality and monitoring of the services provided. Audit the use of the termination of pregnancy early warning score (TEWS) to ensure patients are being safely assessed and monitored for deterioration.
- Improve mandatory training uptake , for safeguarding, manual handling, consent, advanced life support; basic life support, incident reporting, infection prevention and control, scanning, conflict resolution, information governance, and offer supervision.
- Regular checks of the major haemorrhage pack. Handwashing and the wearing of gloves were variable in the preparation/recovery room and the consultation room.
- Ensure effective medicines management processes are in place and improve recording of controlled drugs to ensure stock levels and doses administered are recorded accurately.
- Improve risk assessment on the day if it is unsafe to proceed with all surgical terminations due to capacity to ensure the risk of breaching lawful gestation for termination is not breached.
- We saw one patient who was displaying challenging behaviour towards staff. Ensure that the policy on conflict resolution covers this aspect of behaviour
- Ensure all risks relating to surgical services are identified on the local risk register.
- Must have protocols in place to follow national safety standards for invasive procedures (NatSSIPs) which applies to all those providing NHS funded care.
- Ensure a consistent approach to action planning and ensuring lessons learnt from incidents are shared with all relevant staff locally and reviewed regionally to enable wider learning.

Action the provider SHOULD take to improve

- Consider the fitness of the room used as the recovery room. It was difficult for staff to manoeuvre around patients, and for staff to move the patients' bed from the treatment room into the recovery room.
- Ensure patient identifiable information is not kept on top of the cabinets, and locked away.
- Ensure that records that are stored offsite are picked up by the approved courier service.
- Provision of easy read documentation for people with learning disabilities
- Consider recording of the waiting times every month to monitor variability effectively.

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
Termination of pregnancies	Regulation 18 HSCA (RA) Regulations 2014 Staffing • Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed. • Persons employed must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Staff had not received required mandatory training. The provider did not offer supervision. Regulation 18 (1)(2)(a)

Regulated activity	Regulation
Termination of pregnancies	Regulation 17 HSCA (RA) Regulations 2014 Good governance • assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; • assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; Arrangements for the safe and appropriate storage of medicines and equipment were not met. The provider did not have a policy regarding 'challenging behaviour'. There was insufficient day-to-day management oversight and insufficient assessment and monitoring of the quality and safety of the service.

This section is primarily information for the provider

Requirement notices

Ensure all risks relating to surgical services are identified on the local risk register.

No protocols in place to follow national safety standards for invasive procedures.

Early opportunities to learn from incidents were missed.

Regulation 17(1)(2)(a)(b)

Regulated activity	Regulation
Termination of pregnancies	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • Care and treatment must be provided in a safe way for service users. • assessing the risks to the health and safety of service users of receiving the care or treatment; • doing all that is reasonably practicable to mitigate any such risks; • the proper and safe management of medicines; Arrangements for the safe and appropriate storage of medicines were not met. Appropriate risk assessments were not carried out at the point of care delivery. Hand washing was variable in the treatment room and consultation room. Regulation 12(1)(2)(a)(b)(g)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Termination of pregnancies	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • assessing the risks to the health and safety of service users of receiving the care or treatment; • doing all that is reasonably practicable to mitigate any such risks; • ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. Safety checklists were not fully completed or were not available. Regulation 12(1)(2)(a)(b)(c)

Regulated activity	Regulation
Termination of pregnancies	Regulation 17 HSCA (RA) Regulations 2014 Good governance • assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; • maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

This section is primarily information for the provider

Enforcement actions

There was insufficient management oversight and governance of the use of safety checklists. There were no effective systems in place at location level to assess compliance with safety checklists or to review and monitor the competencies of staff.

Regulation 17(1)(2)(a)(b)