

Marie Stopes International Maidstone Centre







Quality Report

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

Ratings

Overall rating for this location	Good	
Are services safe?	Good	
Are services effective?	Good	
Are services caring?	Good	
Are services responsive?	Good	
Are services well-led?	Good	

Overall summary

Marie Stopes International (MSI) Maidstone Centre is part of the provider Marie Stopes International UK (MSI UK). MSI UK is part of Marie Stopes International, a not for profit organisation that was founded in 1976 to provide a safe, legal abortion service following the Abortion Act 1967. The centre registered with the Care Quality Commission on 13 December 2010.

Maidstone centre offers early medical abortion (EMA), medical termination of pregnancy and surgical termination of pregnancy. Medical termination of pregnancy up to nine weeks plus four days gestation and surgical termination of pregnancy up to 14 weeks gestation. Surgical termination of pregnancy is carried out under 'conscious sedation' (a combination of

Summary of findings

medicines to help the patient relax during the procedure), or no anaesthetic according to patient choice. The centre also provides consultations, ultrasound scans, counselling, long acting reversible contraception and sexually transmitted infection screening services. In addition, the service also provides vasectomy (male sterilisation) under local anaesthetic.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 2 August 2018.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services are they safe, effective, caring, responsive to people's needs and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

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

At our previous inspection on 25 July 2017 we found breaches in regulations and we served requirement notices in respect of:

- Regulation 12 Health and Social Care Act (Regulated Activities) Regulations 2014 Safe care and treatment.
- Regulation 18 Health and Social Care Act (Regulated Activities) Regulations 2014 Notification of incidents.

At this inspection we checked to ensure that these breaches had been addressed.

We rated it as good overall.

Our key findings were as follows:

We found good practice in relation to:

- The service managed staffing effectively and services had enough staff with the appropriate skills, experience and training to keep patients safe and to meet their care needs.

- The centre ensured that all patients first consultation was without anyone else present to ensure the patient was protected and allowed them to discuss information in a safe environment.
- Staff could explain the procedures for safeguarding children, young people and vulnerable adults. They knew the needs and vulnerabilities of children and young people using their service to enable prompt safeguarding referrals.
- Staff were non-judgmental and treated patients with kindness.

However we also found:

- The centre had limited storage for waste. Waste was not separated into bulk storage bins in line with national guidance. All clinical waste was stored in a locked outside cupboard which we observed was extremely full and when opened bags fell out onto the floor posing a potential infection control risk to staff if items split.
- The environment was challenging throughout with regard to ensuring privacy and dignity for patients. This included consultation areas, waiting areas and recovery.
- Patients had to wait longer than the centres target to attend a surgical termination of pregnancy which is outside Royal College of Obstetricians and Gynaecologists (RCOG) guidance.


Following this inspection, we told the provider that it should make other improvements, even though a regulation had not been breached, to help the service improve.

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	Good 	<p>Marie Stopes International (MSI) Maidstone Centre is part of the provider Marie Stopes International UK (MSI UK). The centre provides surgical termination of pregnancy up to 14 weeks gestation and medical termination of pregnancy and early medical termination of pregnancy up to nine weeks plus four days gestation.</p> <p>The service also provides family planning services, including advice on contraceptive options. The service provides oral contraception and long acting reversible contraception (LARC) as well as male sterilisation (vasectomy). We rated this service as good in respect of all five domains and as good overall.</p>

Summary of findings

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Good 

Marie Stopes International Maidstone

Services we looked at

Termination of pregnancy

Summary of this inspection

Background to Marie Stopes International Maidstone Centre

Marie Stopes International (MSI) Maidstone (MSI Maidstone) opened in 2001 and is part of the provider group Marie Stopes International (MSI). The centre provides services to the local community and accepts referrals from outside this area. The current registered manager has been in post since 2016.

MSI Maidstone provides consultations, ultrasound scans, medical and surgical termination of pregnancy, and counselling for patients who use the service. Other

services offered are long acting reversible contraception (LARC), sexually transmitted infection testing (STI) and screening and vasectomy performed under local anaesthetic.

The service offers termination of pregnancy by surgical or medical methods. The centre offers early medical and medical termination up to nine weeks plus four days gestation and surgical termination of pregnancy is carried out up to 14 weeks gestation. Surgical termination of pregnancy is performed under 'conscious sedation', by vacuum aspiration or dilatation and evacuation or no anaesthetic according to patient choice.

Our inspection team

The team that inspected the service comprised of a CQC inspection manager (the lead inspector) and a CQC inspector.

The inspection team was overseen by Fiona Allinson, Head of Hospital Inspection.

Information about Marie Stopes International Maidstone Centre

The centre has a licence from the Department of Health to undertake termination of pregnancy services in accordance with the abortion Act 1967. Treatments are provided to NHS patients and privately funded patients. The licence is displayed in the reception area.

There were no special reviews or investigations of the service by CQC at the time of this inspection.

We previously inspected the centre in July 2017, where we identified a number of areas for improvement in the domains safe, effective, caring, responsive, and well-led.

The centre registered with CQC in December 2010 to provide the following regulated activities:

- Termination of pregnancies
- Family planning services
- Treatment of disease, disorder or injury
- Surgical procedures
- Diagnostic and screening procedures

Patients over 13 years of age are treated at the centre. Counselling services are offered to all patients before and after their treatment and are provided by independent counsellors face to face or by telephone. Face to face counselling was mandatory for patients under the age of 16. There is an aftercare support service via a 24-hour telephone service number. Appointments are made through a 24-hour registered pregnancy advisory team called (MSI One Call centre).

The building at MSI Maidstone has four consulting rooms, one counselling room, one treatment room, two waiting areas, and a recovery area. Metered car parking was available in the street or at a nearby car park. Disabled access into the building was not possible. People with a physical disability would be offered treatment at a different centre that could meet their specific needs.

During the inspection, we visited all areas. We spoke with 13 staff including; registered nurses, health care

Summary of this inspection

assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with two patients, and we reviewed 24 sets of patient records.

Between August 2017 to July 2018 there were 3246 medical termination of pregnancy performed, 1337 surgical terminations of pregnancy performed and 77 vasectomies.

The current track record on safety showed that:

There were zero reported never events between August 2017 to July 2018. Never events are serious incidents that

are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.

Between May 2018 and July 2018 there were zero serious incidents, 169 incidents were reported. The top three themes reported were, clinical complications, specimens and service delivery incidents.

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 rated safe as good because:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- Staff completed and updated risk assessments for each patient.
- The centre had implemented a system for counting swabs and equipment to ensure none were retained following the procedure.
- We reviewed the process and documentation of the World Health Organisation (WHO) and five steps to safer surgery checklist for surgical termination and found this was completed appropriately.
- We observed the action plan for the fire assessment undertaken in August 2017 and found all actions had been completed.
- The service followed best practice when prescribing, administering, recording and storing medicines.
- With the introduction of an electronic reporting system there had been improvements in reporting incidents. Staff were able to give examples of incidents they reported and learning.

However:

- The services' premises were challenging and limited space in the treatment room meant transfer of a patient in an emergency could be difficult.
- The centre had limited storage for waste. All clinical waste was stored in a locked outside cupboard which we observed was extremely full and when opened bags fell out onto the floor posing a risk to staff.
- Patient records were not always fully completed.

Good



Are services effective?

We rated effective as good because:

- The service provided care and treatment in line with evidence based guidance, standards and best practice. This was monitored to ensure consistency of practice.
- Staff assessed and monitored patients regularly to see if they were in pain and responded appropriately. We reviewed 10 patient records all showed that pain assessment had been completed.
- The centre monitored the effectiveness of care and treatment and used the findings to improve them.

Good



Summary of this inspection

- All staff worked together as a team, supporting each other to provide good care to patients.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.
- All staff had received an annual appraisal.

Are services caring?

We rated caring as good because:

- Staff cared for patients with compassion.
- Staff provided emotional support to patients to minimise their distress.
- Staff involved patients in decisions about their care and treatment.
- Feedback from patients confirmed that staff treated them with kindness and they were non-judgmental.

However:

- The environment was challenging throughout with regard to ensuring privacy and dignity for patients. This included consultation areas, waiting areas and recovery.

Good



Are services responsive?

We rated responsive as good because:

- Patients could self refer and book via the 24 hour MSI One Call centre to make an appointment.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.
- Translation services and hearing loop facilities were available.

However:

- The centre was not able to accommodate patients with a physical disability.
- Patients had to wait longer than the centres target to attend a surgical termination of pregnancy. Which is outside RCOG guidance.

Good



Are services well-led?

We rated well-led as good because:

- Managers had the right skills and abilities to undertake their role,
- The centre had a well-led framework with improvement action plans which were developed and in progress.

Good



Summary of this inspection

- Staff spoke highly of the leadership team and found them approachable and supportive.
- The service managed records appropriately in accordance with their policies and national policy.
- Staff felt more involved in developing the services provided to patients.

However:

- There was evidence of some improved governance, although old processes and systems had not been removed when new initiatives had been implemented.
- Staff were not able to explain the vision and values of the service.
- Team meetings were not always utilised to improve practice. For example, there was a lack of identified actions which meant we were not assured that oversight was in place to ensure improvements were made.






Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Termination of pregnancy	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Termination of pregnancy

Safe	Good 
Effective	Good 
Caring	Good 
Responsive	Good 
Well-led	Good 

Are termination of pregnancy services safe?

Good 

We rated safe as **good**.

Mandatory training

- Staff were encouraged to complete mandatory training. Modules were accessed on line or staff received face to face training sessions.
- Mandatory training modules included basic and intermediate life support skills, information governance, anti-fraud and bribery, infection prevention and control, manual handling, equality and diversity, information governance, safeguarding vulnerable adult and children and WRAP (workshop to raise awareness of Prevent) training. WRAP training was designed to help make staff aware about their contribution in preventing vulnerable people being exploited for extremist or terrorist purposes.
- Role specific training was provided for members of staff for example counselling and ultra sound scanning. Information provided post inspection demonstrated that staff attendance was 100% for all topics except basic life support training which was 88% compliance and WRAP training which was 92% compliance, against a target of 95%. This resulted in an overall compliance of 99%.
- The clinical manager monitored attendance by using an electronic live training matrix. Data could be broken down into overall compliance, compliance by topic and

compliance by individual. The system identified which staff roles required different levels of training and also provided a 90 day forthcoming expiry report by individual to ensure there was oversight when training updates needed to be booked. All nine staff required to undertake immediate life support (ILS) training had completed this training (100%). 100% of medical staff that work in MSI Maidstone had completed advanced life support (ALS) training.

Safeguarding

- All staff we spoke with understood how to keep patients safe from harm and abuse. They could describe their responsibilities and safeguarding procedures. We reviewed two referrals to social care which were completed correctly and timely on the day the concern was identified. Staff could access the adult safeguarding policy and the young person's safeguarding policy on the organisations intranet, we saw that both were in date.
- The mandatory training dashboard for MSI Maidstone demonstrated that 100% staff had completed safeguarding adults training levels one, two and three and safeguarding children training level one, two and three.
- Staff attended safeguarding adults and children training at the appropriate level in accordance with The Royal College of Paediatrics and Child Health intercollegiate document Safeguarding children and young people, 2014. This training included child sexual exploitation and female genital mutilation (FGM). Staff were required

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to complete core competencies following the training to assure the organisation that staff were competent. Staff were able to describe safeguarding processes and where to access further support.

- All patients under age 18 had the 'under 18' proforma completed by staff which included questions to identify if patients aged under 18 were at risk of child sexual exploitation and harm. Leaflets about child sexual exploitation were available in the waiting areas.
- MSI UK had a policy for FGM which was current, in line with national guidance and in date. Staff asked patients at each consultation about this as part of the safeguarding assessment. We saw this was documented on each individual patient safeguarding form we looked at. Staff could access the FGM policy and could describe the importance of reporting identified cases.
- Safeguarding themes and FGM cases identified were shared throughout the centre at a weekly complaints, litigation, incident and patient safety (CLIP) meeting. We reviewed minutes from July 2018 which shared themes across the organisation for example highlighting pathways of care for patients under 18 years old who self-harm.
- All patients were seen alone with staff initially, this enabled staff to ask patients about domestic abuse which was in line with NICE guidelines (PH50). We observed a consultation where a patient asked if information would be disclosed to her partner, the nurse sensitively explored if there was any domestic abuse from the partner. This meant women were supported to disclose any abuse and would be supported by staff if they reported any abuse. Patients under the age of 13 were not treated at the centre they were referred to an NHS hospital and safeguarding authorities for support and treatment.
- We reviewed two records of patients between the age of 13 and 18. The 'under 18 proforma' had been completed and timely referrals to social care had been completed. We observed the 'young people's care pathway' on display, this outlined action to be taken when dealing with young people under 18 years old.
- The clinical team leader was the designated safeguarding lead for the centre and had attended level

four safeguarding training. The operations manager and a registered nurse supported them. Staff told us that they knew who to contact for further safeguarding support if needed.

Cleanliness, infection control and hygiene

- There were systems and processes in place to monitor standards of cleanliness and hygiene. These included up to date policies, cleaning schedules and checklists, infection prevention and control training and quarterly deep cleaning schedules.
- Most areas of the centre were visibly clean. The stairway and entrance to the building appeared dirty and paint was peeling on the woodwork. The clinical areas were all visibly clean and the centre used 'I am clean' stickers to identify when equipment had been cleaned.
- Examination couches and chairs had wipeable covers and we saw disinfectant wipes were available throughout the centre.
- Disposable curtains were used in the consulting rooms and were in date. Staff told us that these were changed six monthly or before if contaminated.
- Staff completed IPC training, records demonstrated that as of August 2018 compliance was 100%. We observed that all staff were bare below the elbow and adhered to the uniform policy.
- Personal protective equipment was readily available for staff to use, such as gloves and aprons.
- We saw staff using the hand sanitising gel correctly, in line with the 'five moments of hand hygiene' before and after patient contact.
- We found that there were some improvements in the management of cleanliness and infection control practices since our last inspection. The overall infection control audit and hygiene audits showed that the compliance rate was 85% in May 2018 but this had improved in June 2018 to 100%. This was discussed at the June 2018 team meeting to share information with staff to improve compliance.
- There were suitable arrangements for the handling, storage and disposal of clinical waste, including sharps in the clinical areas. Waste was separated and disposed of in different coloured bags to indicate the different categories of waste in accordance with the Safe

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Management of health care waste and control of substance hazardous to health (COSHH), health, and safety at work regulations. Sharps bins were labelled and dated and were not more than half full to reduce the risk of needle stick injuries.

- Waste was removed from the centre weekly. There was a service level agreement with a contractor registered for healthcare waste and disposal, under the Hazardous Waste Regulations 2005. However, we found that the storage facility for waste was extremely limited. Waste was stored in an outside locked cupboard, we observed that it was extremely full and when opened bags fell out onto the floor which meant a potential infection control risk to staff if items split. In addition, the clinical waste and sharps bins were not kept in a separate bulk storage container; this did not comply with Health Technical Memorandum (HTM) 07-01, which states 'waste streams in the same store should be clearly separated, such that a leak from one waste category cannot contaminate the contents or packaging of another. This had been raised previously at the last inspection in July 2017. We raised this with the provider at the time of inspection and were informed this would be addressed and that the number of waste collections would be reviewed to consider increased collections.

Environment and equipment

- The building had been modified to provide services and treatment. There were four floors with care and treatment being provided on the first (basement) and second floor. The third floor was used as office and training space and the fourth floor was used for the staff room and staff changing rooms. There were no lifts, access to all floors was via stairs.
- The entrance to the building was below ground level and accessed by stairs, it appeared worn and in a need of repair, wooden frames were perishing and the paint was peeling. It was a dark area but the entrance was locked and access was gained by the front of house reception staff. This prevented any unauthorised access into the centre to ensure the safety of patients, staff and visitors. The service had plans to address the maintenance of the entrance area, however, this had been delayed due to contracting issues. Information

provided post inspection demonstrated that sensor lighting was in place and we were informed that replacement of windows at this level had been organised.

- The treatment room was extremely limited for space especially when staff were required to respond to an emergency. However, this had been risk assessed and practice drills completed which demonstrated that staff could deal with an emergency.
- The centre was air-conditioned to maintain a comfortable temperature for patients and staff on hot days.
- We checked 18 pieces of equipment all had in date stickers confirming maintenance checks had taken place.
- Emergency equipment was kept in sealed bags and contained equipment and medicines required to manage an emergency. The equipment included an automated external defibrillator (a portable device to check heart rhythms and shock the heart if necessary).
- Staff checked emergency and difficult intubation equipment, suction apparatus and oxygen cylinders daily. We reviewed records which showed this was completed which meant the equipment was safe and readily available to use.

Assessing and responding to patient risk

- Patients were assessed and risks identified responded to. All patients had an initial telephone consultation with MSI UK One Call to assess their suitability for treatment. Staff took a full medical history to assess that they were appropriate to attend the centre for treatment. Any patients identified as having specific needs (including those living with learning disabilities) would be identified at the time of booking. This would be recorded electronically and patients would be clinically triaged through the Right Care team at the One Call centre. Bookings would then be made at the most appropriate centre to ensure individual needs of the patient could be met.
- Patients booked for surgical termination of pregnancy attended a pre-assessment on the day treatment this

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included: a full medical history, measurement of vital signs, an ultrasound scan to confirm gestational age, haemoglobin level (check for anaemia) and sexual transmitted disease screening.

- If any risk factors were identified such as a patient with; a body mass index greater than 40, more than three caesarean sections, an ectopic pregnancy or significant medical conditions patients would be referred to an NHS hospital that provided termination of pregnancy services.
- All patients had a blood test to identify their blood group prior to the treatment. Patients with a rhesus negative blood group received treatment with an injection of Anti-D immunoglobulin (to protect against complications for future pregnancies).
- The centre introduced a daily huddle to identify risks or issues that may impact on the safety of patients. All staff on duty attended the huddle and provided input from the different areas of the centre, which meant all staff were aware of any potential problems.
- The centre used the 'Surgical Safety Checklist for Surgical Termination of Pregnancy' a modified version of the World Health Organisation (WHO) and five steps to safer surgery checklist to prevent avoidable mistakes during surgical procedures. We saw step one the 'team brief' documented clearly in the patient records we reviewed, which involved all members of the team. We observed steps two to five in practice and found all areas of the checklist to be fully implemented.
- We reviewed four patients' 'Pre-operative Checklists for Surgical Termination of Pregnancy' we found that the sections for checking contact lenses and dentures were blank, otherwise the rest of the check was fully completed. There was no question to check if nail varnish or false nails were worn which could compromise the oxygen monitoring if either were worn by the patient. We observed this on site when a patient had false nails and the pulse oximetry reading was intermittent. We asked if an ear probe was available as an alternative but were told by the operating department practitioner that there wasn't one but that they would look into ordering this.
- Swabs and instruments were now formally counted, with confirmation from a second counter, which was a requirement from the previous inspection. This meant there was not a risk to patients of retained foreign objects following the procedure.
- To enable early identification of patients at risk of a sudden deterioration in their condition. The centre used the termination of pregnancy early warning score (TEWS). We reviewed ten charts which showed that they were completed and scored correctly, however we tracked two records with high scores requiring a medical review, one had been escalated and one had not. The TEWS audit of 200 charts between December 2017 to March 2018 demonstrated 90% compliance, for escalation and action for scores greater than zero and in March a further 50 records were audited demonstrating 100% compliance. This was a significant improvement from the previous inspection in July 2017.
- Patients undergoing conscious sedation had their oxygen levels recorded. We saw a patient's oxygen level fall below the normal range whilst sedated. Staff administered additional oxygen which was only discontinued once the patient's oxygen levels had returned to normal.
- Following a surgical procedure and the patient's vital signs were stable a nurse would assess that the patient was fit to be discharged against the MSI discharge proforma that included assessment of their physical, social and emotional needs. Staff told us they would escalate any concerns to the anaesthetist who remained on site until the last patient was deemed to be fit for discharge. Patients were given the contact number of an MSI call centre for reporting any concerns after discharge. The call centre was open 24 hours a day, seven days a week.
- We observed staff ensuring a responsible person was available to accompany patient's home following treatment.
- A major haemorrhage kit was available if a patient bled excessively. All staff knew where this was located. Records reviewed demonstrated that staff completed the checklist daily when the centre was open.
- Posters displayed in the treatment room and recovery area included flow charts and actions for staff to take

Termination of pregnancy

and who to contact in the event of a patient deteriorating or a clinical emergency. In a clinical emergency the centre would call 999 for assistance to transfer the patient to an NHS hospital.

- The centre had a service level agreement 'NHS contract for the provision of emergency transfer services, 2017 to 2020', which outlined actions and responsibilities if a patient became unwell and required transfer to an acute NHS hospital.
- All patients received an ultrasound scan to provide an accurate gestational date which ensured that patients were offered the correct treatment. We observed a case where the patient was due to have a surgical termination of pregnancy but was unsure if they had miscarried the pregnancy. The nurse made an immediate referral for a scan to confirm if the pregnancy was viable or the procedure needed to be cancelled.

Nurse staffing

- The operations manager told us that the centre had improved staff shortages. At the time we inspected there were six registered nursing/midwifery staff and two healthcare assistants working at the centre. Gaps in staffing rotas were covered by agency nursing staff. Between May 2018 to July 2018, 63 nursing shifts were covered by qualified agency staff and 24 non-qualified shifts by unqualified staff. The centre used staff that were familiar with the centre. At the time of our inspection the service was actively recruiting qualified staff.
- The Department of Health Required Standing Operating Procedure (RSOP) 18: required that providers of a termination of pregnancy service should ensure there are a sufficient number of staff with the right competencies, knowledge, qualifications, skills and experience to safeguard the health, safety and welfare of all who use the service and meet their routine and non-routine needs. Staffing rotas showed that there was a registered nurse or midwife on duty at all times when patients attended appointments in the centre.
- The centre used agency staff to improve staffing levels and ensured one extra member of staff was on duty to cover unanticipated sickness. Staff working at the centre, worked flexibly across the centre and when necessary, provided short-term sickness and absence cover.

- To provide clinical leadership following our last inspection a full time clinical lead had been appointed who was responsible for the staffing rotas.
- The front of house staff managed reception and medical records. They also supported the nursing staff with the coordination of treatment lists and patient flow through the centre.

Medical staffing

- Medical staff worked remotely and within the centre. The centre employed sessional medical staff consisting of physicians, anaesthetists and surgeons. We observed that a surgeon, and an anaesthetist were available for surgical termination of pregnancy theatre lists.
- There was a formal process to ensure that suitable checks were carried out to enable staff to practice. The range of checks undertaken by human resources included qualification, insurance, registration, Disclosure and Barring Service checks (DBS), and revalidation reports.

Records

- Records were stored securely and maintained in a way that kept patient information safe. The centre used a combination of paper and electronic patient records. This included information such as past medical history, mental health illness, allergies and risk assessments. If the patient was under 16 there was an electronic alert that was visible on the system, to remind staff to review the important information.
- MSI UK policies stated that all records which included patient identifiable information must be stored securely and kept strictly confidential within the centre. We saw that only authorised staff had access to the patient records.
- Patient records were stored safely and stored at the centre for at least six months before being transferred to a secure off-site location.
- We reviewed 20 paper records and four electronic records. Documentation was legible in all records, signed, timed and dated in all 20 paper records. However, we found during the review of paper records that certain documentation had been updated by the provider but previous versions had not then been removed from process. This meant duplication was

Termination of pregnancy

taking place for certain pieces of paperwork, such as the early medical checklist and signature for administration of simultaneous medical abortion. A further example was the daily checklist for emergency equipment, where we found gaps in the records. Having raised this with senior staff they provided evidence that the same daily checks were recorded in another format. This meant efficiency could be compromised as staff were repeating documentation and we were not assured that data used for subsequent audits was correct.

- Patients were booked by the MSI UK one call service, staff told us that records were always readily available to book patients at their consultation appointment.
- Staff completed information governance training as part of their mandatory training. Compliance up to the time of inspection was 100% compliant.

Medicines

- Medicines were stored in a locked cupboard or where they needed to be stored below a certain temperature in a designated fridge. The minimum and maximum temperature of fridges used to store medicines were monitored and recorded to ensure that medicines were kept at the required temperature. We saw fridges used for this purpose were locked, clean and tidy and we found all stock was in date.
- Medical staff used a secure electronic prescribing system to prescribe medicines remotely.
- Medicines that induced a termination of pregnancy were prescribed for patients undergoing medical abortion only after a face to face consultation with a member of the nursing team had taken place, written consent and completion of the HSA1 form (the legal document to allow an abortion to be carried out) signed by two medical signatories.
- Patient records we looked at confirmed that doctors followed local protocols for prescribing antibiotics. This was in line with NICE QS61 which recommends that people are prescribed antibiotics in accordance with local antibiotic formularies.
- In all patient records we reviewed, staff had recorded allergies and taken relevant action to ensure known allergies were acted upon. We observed two women wearing red wrist bands to identify to staff they had known allergies.

- Qualified staff administered all prescribed medicines for patients undergoing medical abortion. Post-procedure antibiotics were prescribed to all patients to reduce the risk of infection.
- The medicine cupboard keys were held by the registered nurse/midwife in charge of that shift. They had to sign the key out of the key bank and back in when they keys were returned.
- There were systems in place to check for expired medicines and to rotate medicines with a shorter expiry date. We looked at a random sample of medicines which were within the expiry date. We observed a stock control checklist that had been completed each time new stock arrived. This enabled the centre to monitor usage and expenditure of medicines.
- Controlled drugs (CDs) were kept in a locked cupboard not accessible by the public. We observed a check of the medication and observed that two staff checked the drugs daily. On surgical treatment days, the CDs were checked at the beginning and end of the termination list. Staff recorded in the CD register the patient details, date, drug, dosage administered and running balance. Each entry was signed by the doctor that administered the drug and second check signed by the registered nurse / anaesthetic practitioner. However, the drug register in use was a schedule 2 CD register with headings for dispensing stock to doctors as authority to possess, rather than supply and administer. Best practice in a clinical setting would be to use a register to sign out supply, administration and also record wastage. Staff on site told us that this had been discussed locally and would be raised at provider level. Medications administered were also recorded on the patient electronic record.

Incidents

- Patients were protected from abuse and avoidable harm. All staff we spoke with were confident in reporting incidents, serious incidents and said they would challenge if they suspected poor practice.
- The centre had made improvements with reporting and the management of incidents following our last inspection with the introduction of a new electronic

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patient safety reporting system for incidents in February 2017. Training had been provided to inform staff about the new system and staff we spoke with were all confident in using the system.

- The MSI incident reporting policy required all incidents to have been reviewed and signed off by managers. Managers told us that incidents and lessons learnt were discussed at the regional monthly quality and governance meetings. Minutes we looked at confirmed this.
- Staff told us that there was an open culture to encourage a focus on patient safety and risk management practices.
- There were zero never events reported in the previous year. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- Between August 2017 to July 2018 there had been zero serious incidents reported.
- Staff we spoke with said they could ask for feedback on incidents they had reported.
- Between May 2018 and July 2018, 169 incidents were reported. The top three themes reported were, clinical complications, specimens and service delivery incidents. We saw an email informing staff that a new form had been developed to prevent medicine management incidents.
- We reviewed ten incidents from the electronic reporting system and saw that they were investigated using a 'root cause analysis' approach. We saw that appropriate actions were taken and shared with staff to reduce the risk of future incidents.
- Staff were aware and could describe the principles and application of duty of candour (DoC). The duty of candour is a regulatory duty under the Health and Social Care Act (Regulated Activities Regulations) 2014. Where, as soon as reasonably practicable after becoming aware that a notifiable safety incident had occurred a health service body must notify the relevant

person that the incident had occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology. We reviewed three examples where DoC was applied appropriately.

- There were arrangements in place for reporting deaths and there were no reported deaths within between July 2017 to August 2018.

Safety Thermometer (or equivalent)

- The centre had no reported incidents of sepsis between August 2017 to July 2018.
- All of the patient 20 records we reviewed contained venous thromboembolism (VTE) risk assessments which staff completed prior to treatment. VTE is where a blood clot forms in a vein. The risk assessments informed staff if preventive treatments were required.

Are termination of pregnancy services effective?

Good 

We rated effective as **good**.

Evidence-based care and treatment

- Care and treatment was delivered in line with evidence based guidance. Staff could access policies on the MSI UK intranet. Policies relating to termination of pregnancy and professional guidance were developed in line with Department of Health, Required Standard Operating Procedures (RSOPs). We reviewed 12 policies, all were in date, version controlled and contained evidence based references.
- The centre ensured patients were informed, and given a booklet on discharge, how to access a 24-hour helpline should they have concerns or need advice. The booklet explained post treatment symptoms and signs which suggest that the procedure had failed. This was in line with RCOG recommendations.
- All patients were offered a test for Chlamydia infection (Chlamydia is a sexually transmitted bacterial infection) prior to any treatment. Patients with positive test results

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were referred to sexual health services. Patients were offered and referred to sexual health services for further screening for other sexually transmitted infections (STI's) and treatment if needed.

- Contraception was discussed with patients at their initial assessment and a plan was agreed for contraception after the termination of pregnancy. Patients were provided with contraceptive options which included Long Acting Reversible methods (LARC).
- All patients were scanned during the surgical procedure to ensure products of conception had been removed completely.

Nutrition and hydration

- Patients were informed at their pre-assessment appointment not to eat for six hours and drink clear fluids for up to two hours before their appointment. This was in line with the Royal College of Anaesthetists guidance.
- We observed staff asking patients at reception when they last ate and drank. One patient had arrived drinking and staff rearranged their appointment for two hours later to enable the treatment to go ahead.
- In the recovery area whilst having observations taken, patients were given a snack and drink before being discharged home. We saw hot and cold drinks facilities available to provide this to patients.

Pain relief

- Patients were encouraged to take pain relief before and after the procedure. Post procedural pain relief for medical termination of pregnancy, was electronically prescribed on patient's medicines administration records.
- Best practice was followed with non-steroidal anti-inflammatory drugs (NSAIDs) prescribed. These are recognised as being effective for the pain experienced during the termination of pregnancy.
- Staff told us if patients continued to have pain they would prescribe an alternative medication for the patient to take home. All patients were given a heat pad post procedure to help with pain relief.

- Staff advised patients to call the advice line if they were experiencing significant pain and the NSAIDs were not effective.
- A pain score was completed within the termination early warning score observations chart using a nought to ten scoring system this was in line with RCOG guidance (2011). If patients pain score was high staff would alert the medical staff to ensure the patients pain was evaluated.

Patient outcomes

- The Department of Health RSOP 16 recommends that all providers should have in place clearly locally agreed standards against which performance can be audited, with specific focus on outcomes and processes. The centre completed a dashboard to enable benchmarking between centres. For example, key indicators such as: training, audits, complaints and treatment failures were monitored. This is in line with Department of Health RSOP 16, performance standards and audit.
- Between August 2017 to July 2018 the centre performed 1337 surgical terminations of pregnancies, 3246 early medical / medical abortions, and 77 vasectomies.
- Patients were given options of treatments according to the gestation of the pregnancy which was documented in the records we reviewed. Following the procedure patients were offered a follow up appointment which is in line with Department of Health RSOP three.
- The service monitored the patients who did not proceed to treatment, between August 2017 to July 2018, between 14% to 17% of patients did not proceed. The main reasons for this was the patient's gestation was too far for the centre to proceed staff informed patients which centres to book at if they wanted to continue to have a termination or where to access care if they were continuing with the pregnancy.
- The MSI target for the uptake of long acting reversible contraception (LARC) was 50%. Between August 2017 to July 2018 the centre consistently achieved 20-30% except one month being 36%. The records we reviewed were not always clear if this had been offered to patients. It was noted in the local integrated governance meeting (LIGM) minutes, March 2018, that the centre still

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had no implant trained nurses which was affecting LARC. In addition, there were ongoing issues with some doctors who would not fit implants. It was suggested that a LARC clinic would be run one day per month.

At the time of inspection there remained no LARC trained nurses at MSI Maidstone however training was booked for appropriate staff. The LARC clinic had been introduced with the service being delivered by the lead contraceptive and sexual health (CASH) nurse. It was noted, in the May 2018 LIGM minutes, that two sessions per month were taking place, with good uptake from patients. Front of house staff contacted patients 24hrs prior to appointment to confirm attendance.

- Complication rates such as retained products of conception, on-going pregnancy, post procedure infection and transfer to a local hospital trust were monitored. The data we reviewed showed that between August 2017 and July 2018 there were no patients that required transfer out.
- There were no failures for surgical termination of pregnancy between August 2017 to July 2019 the early medical abortion failure rate was below the organisations target of two percent for eight of the 12 months.

Competent staff

- Staff we spoke with said they received one to one support and annual appraisals. Information provided by the service showed that 100% of staff had received an annual appraisal at the time of our inspection which was an improvement from our last inspection. Staff who had completed an appraisal told us they were useful, their appraiser was supportive and they had discussions around performance, opportunities for training and development.
- All staff were supported through an induction process and competence based training relevant to their role which was signed off by their mentor.
- Staff who undertook ultrasound scans completed appropriate training and assessment of competence in ultrasound scanning.
- All contracted and sessional staff had completed LARC training to ensure patients were given informed choices regarding future contraception.
- The Department of Health RSOP 14 states that all staff involved in pre- assessment counselling should be trained. The centre used qualified independent counselling services.
- Staff had defined roles and responsibilities. Following our last inspection, the health care assistants were supporting nurses and not undertaking the same duties.
- Staff development was supported by the centre. We spoke with a member of staff who had been originally employed as front of house staff and had been supported and developed. They were now employed as a manager and were part of the senior team. Another member of staff was being encouraged to apply for registrant training in a theatre role.
- The service conducted annual checks to make sure all the nurses were registered with the Nursing and Midwifery Council (the regulatory body for nurses and midwives).
- New staff completed a corporate and local induction. We spoke with a new member of staff who said that management and colleagues were approachable and supportive. Staff confirmed that they were not able to practice any treatment or care alone before being assessed and signed off as competent. We were able to review a member of staff's competencies which included, safeguarding, vital sign observations, clinical assessments and clinical processes.
- A MSI UK responsible officer at corporate level monitored the recruitment of medical staff and ensured appraisals were completed in line with the regulatory body the General Medical Council (GMC). Medical staff told us they were required to provide evidence on checks on their competency and training as part of the GMC revalidation process. This included an annual appraisal.
- The anaesthetists administered conscious sedation, supported by a trained theatre practitioner / nurse. We observed that the surgeon and anaesthetist were present until the last patient was recovered and fit to be discharged.
- Members of staff were trained to perform ultrasound scans for dating purposes only. To be proficient they

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were required to perform a number of supervised scans prior to being signed off as competent. This was co-ordinated by a lead scanning trainer for MSI UK, supported by a regional scanning mentor.

- Patients were scanned during the procedure to identify any retained products of the pregnancy.

Multidisciplinary working

- We observed medical staff, nursing and other non-clinical staff working well together as a team. Staff showed respect for each other and were able to learn from each other.
- There were clear lines of accountability that contributed to the effective planning and delivery of care.
- Staff told us they had good relationships with the local acute hospital trusts who provided emergency treatment for patients who became unwell.
- Staff were aware of the need to work collaboratively with social services to safeguard vulnerable patients who were at risk of domestic abuse or sexual exploitation.
- The centre requested consent to share discharge information with the patient's general practitioner (GP). Following the patient's discharge, where appropriate, a letter was posted out to the GP.

Seven-day services

- The centre was open six days a week Monday to Saturday. Surgical lists were available on every other Tuesday and a Thursday. If a patient needed to have the procedure on another day the staff would signpost them to another MSI centre to suit their preferences and ensure they had timely treatment.
- The aftercare line MSI One Call was available 24 hours a day seven days a week. Patients who accessed the line could speak with a member of staff who gave advice and support.

Health promotion

- Staff discussed and gave patients advice on contraception which is in line with Department of Health RSOP 13, contraception and sexually transmitted infection screening. All qualified staff had completed a course on contraception.

- Staff advised and educated patients regarding sexually transmitted diseases and sexual health. Staff who gave results of tests such as chlamydia and human immunodeficiency virus testing would refer the patient to the genito-urinary clinic to access treatment where appropriate.

Consent and Mental Capacity Act

- Staff were given training regarding obtaining informed consent. Staff we spoke with were aware of Fraser guidelines and Gillick competence when gaining consent from patients under the age of 16 (Fraser guidelines are used specifically for patients under the age of 16 requesting contraceptive or sexual health advice and treatment). The centre had the 'young people's care pathway' on display, this outlined actions to take when caring for young people under 16. This included prompts for staff to ensure the Under-16 Fraser Guidelines form was completed.
- All patient treatment records we reviewed contained a signed consent form. Staff explained possible side effects and complications which were recorded. It was evident that these had been fully explained in the medical records we reviewed.
- Consent was checked prior to treatments taking place. We observed a consultation where a patient who was unsure regarding their decision. The nurse was empathetic, non-judgmental and gave the patient time to discuss their options and concerns. The patient decided not to have the procedure and have more time to think through their decision.
- The suitability for treatment assessment, at the point of initial booking, included reviewing patients understanding and capacity to consent. The Right Care team at MSI One Call would review the initial assessment and needs of patients. Any patient that lacked the capacity to consent would not be treated at MSI and would be referred to the local NHS.
- Legislation requires that for an abortion to be legal, two doctors must each, independently, reach an opinion in good faith as to whether one or more of the legal grounds for a termination has been met. They must indicate their agreement by signing the HSA1 form. In

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the 20 records we looked at we found that all the forms included indication of which of the grounds of the Abortion Act was met in each patient's case, and there were signatures of two doctors.

Are termination of pregnancy services caring?

Good 

We rated caring as **good**.

Compassionate care

- Staff displayed non-judgemental, compassionate care when consulting with patients. They recognised that it was a difficult decision for patients to seek and undergo a termination of pregnancy.
- All staff were friendly and welcoming, they introduced themselves to patients on entry to the centre. Patients or relatives making enquiries at reception were made to feel at ease and responded to in a polite manner.
- A sign on each treatment room door indicated whether the room was in use, this protected privacy and dignity of patients during consultations and procedures. However, we observed there was poor sound proofing in the rooms. Background music was played in all the waiting areas to prevent people overhearing conversations and treatments but this had to be quite loud. Patients had different levels of discomfort during procedures and despite background music during one procedure, a patient could be clearly heard in the recovery room area.
- The patient satisfaction survey showed 98% of patients between April to May 2018 felt they were treated with dignity and respect. However, we found that the design and layout of the building compromised the ability to provide privacy and enable patients to be treated with dignity and respect. The recovery room was a small area with six recliner recovery chairs with no curtains and due to a lack of space each chair was in close proximity to each other. This had been raised at the previous inspection. We saw evidence that this was being addressed and the dimensions had been submitted for

curtains to be installed. Whilst there was a mobile screen available this was not in use during the inspection. When asked staff stated they would use mobile screens if a patient became unwell.

- We observed four surgical procedures under conscious sedation. During the procedures staff provided continuing reassurance and explanations of the processes. The patient survey between April to May 2018 showed that 96% of patients found staff to be helpful and understanding.
- Post procedure, we observed staff caring in a positive engaging manner with patients in the recovery area. Despite the limited space on the first floor a separate room had been made available, in June 2018, that could be used for patient discharge. This meant staff could discuss the discharge process with patients in complete privacy.
- Disposal of pregnancy remains were managed respectfully, and were covered in a sealed container during removal from the treatment room.
- A patient we spoke with told us staff were kind, and sensitive to them throughout their experience. The client feedback survey between April to May 2018 showed 96% of patients rated the overall service as 'very good' or 'excellent'.
- The service used 'your opinion counts' survey cards at the centre. We observed staff encouraging patients to complete the survey to gain feedback. Posters were also displayed.
- We reviewed comment cards which were all positive for example, "They made the whole process comfortable and relaxed".

Emotional support

- All patients were offered counselling, which could be accessed by telephone or face to face at the centre. This enabled patients to discuss their options and choices whilst receiving non-judgemental emotional support. It was policy that all patients under the age of 16 had face to face counselling.
- Staff provided patients with emotional support in accordance to their needs in an unhurried empathetic manner.

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- We observed staff supporting patient's emotional wellbeing, especially during the procedure.
- One patient described staff as “really caring, reception and nurses really nice and non-judgemental”.

Understanding and involvement of patients and those close to them

- We observed a number of patient interventions and found that assessments were thorough and staff followed pathway guidance. We also observed staff giving information effectively.
- Staff within the treatment room provided patients with good explanations of their treatment throughout the procedure.
- We observed that staff answered patients' questions appropriately, and in a way, they could understand.
- One of the comment cards we reviewed the patient said “The nurse I had was lovely and provided information and was professional in her work”.
- We observed episodes of care which were thorough, involving patients and ensuring that the patient had understood the information given to them enabling them to make informed choices.
- During our inspection we did not see any patients accessing vasectomy services. We reviewed the patient feedback survey between April to May 2018 in which 100% were satisfied with the service overall and with the information they received.

Are termination of pregnancy services responsive?

Good 

We rated responsive as **good**.

Service delivery to meet the needs of local people

- The service was planned by the senior business development team and the seven clinical commissioning groups in the local area. This was in accordance with the RCOG guidance. However, there were variations of funding provided by commissioners for sexual health screening. The service had a clear

process to highlight which patients were funded for which sexually transmitted diseases. Any that were not funded the staff advised the women where to access screening.

- The centre was open six days a week, providing medical terminations Monday to Friday. Surgical terminations were undertaken every Thursday and every other Tuesday and a vasectomy list occurred monthly. In response to patient need the centre also provided a post-op consultation clinic on a Saturday.
- Different treatment options were available for termination of pregnancy dependant on gestation. Patients could book their appointment through the MSI UK One Call system. The booking system offered patients a choice of appointments or an alternative location to protect their privacy if required.
- Local service agreements were in place with the local acute NHS hospital to provide emergency advice and support and facilitate transfers when required.
- Pregnancy remains were disposed of sensitively complying with Human Tissue Authority Code of Practice (April 2017) Which included examining the remains, logging the tissue for traceability, correct storage and disposal and managing patient requests to arrange private burial if required. There was a leaflet which patients received to give them options about disposal of pregnancy remains.

Meeting people's individual needs

- The centre was a converted four storey building which was not fully accessible to people with physical disabilities. Patients with a physical disability who could not access stairs were referred to a different MSI centre.
- Staff undertaking assessments had a range of information that they could give to patients as required. This included advice on contraception, sexually transmitted infections, miscarriage and services to support patients who were victims of domestic abuse and how to access sexual health clinics.
- Staff told us that patients with learning disabilities could access the centre and staff would assess the patient and plan individualised care. This assessment began at the time of booking when the Right Care team at One Call clinically triaged the patients to the most appropriate centre.

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- The centre had hearing loops for patients who were hard of hearing (a special type of sound system for use by people with hearing aids).
- At the consultation with the patient, staff told us they provided patients with the opportunity to discuss disposal of pregnancy remains. We observed 10 treatment records and staff documented the discussion and patient's decision.
- All patients received a leaflet titled 'your treatment information' which outlined treatment options, what to expect, contact numbers and aftercare advice. This was revisited, and information reinforced throughout the patient's care pathway.
- Staff could use a telephone or face to face translation service if required for those patients whose first language was not English.
- The centre had a variety of information leaflets, such as information on domestic abuse, long acting reversible contraception and chlamydia. The leaflets were in English, although staff told us they could access patient information in other languages through an electronic system.
- Patients could choose a range of options for termination of pregnancy. If they were suitable for medical termination, from August 2017 the service provided simultaneous treatments, for gestation under nine weeks, which meant the patient could receive both medications at the same appointment.

Access and flow

- Patients could self-refer or have a GP referral to the centre. There was an option to pay privately, although this was rare.
- The Department of Health RSOP 11 states that patients should be offered an appointment within five working days of referral and they should be offered the termination of pregnancy treatment within five working days of the decision to proceed.
- Between August 2017 and July 2018, the average wait time for surgical termination of pregnancy before 14 weeks gestation was consistently 15.7 to 17 days which was above the target of 10 days. The average wait time for medical abortion was nine to 11 days which was near to MSI UK's target of 10 days.

- The did not attend rate for the centre was consistently below the target of 7% between August 2017 and July 2018. Staff did not routinely follow up patients that did not attend, however we were informed that contact would be made with other professionals, through the Right Care team, should there be a specific medical or safeguarding concern. Staff would make a safeguarding referral where appropriate.
- There was a board in the waiting area informing patients of any delays in clinic times.

Learning from complaints and concerns

- Patients were encouraged to raise a concern or make a complaint and staff were positive about learning from complaints. Complaints were monitored as part of the dashboard, which demonstrated that on average one informal complaint was raised per month between January and July 2018. The top three informal complaint trends were cancellations, attitudes and communications.
- The operational and clinical managers were responsible for the oversight of the management of complaints. We reviewed three complaint response and all were responded to in a timely manner within 30 days. The responses included an apology to the patient and thorough response to each area of concern, learning was identified and actions implemented were shared with the patient for example ensuring side effects were discussed and documented in full.
- Complaints were included as part of monthly team meetings. We reviewed the minutes from May to July 2018 and found that complaints were discussed and learnings identified. For example, one complaint related to a patient feeling overcrowded during the consultation. Staff were asked to be mindful of patients' feelings.
- Staff told us they would resolve any concerns raised immediately if they could otherwise they would advise the patient how to make a formal complaint.
- There were posters and leaflets on display in the waiting areas advising how to raise concerns and give feedback. The information clearly stated how feedback could be given and how concerns would be dealt with.

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Are termination of pregnancy services well-led?

Good 

We rated well led as **good**.

Leadership

- The leadership of the centre had improved since our last inspection. There were clearer lines of accountability the operations manager had overall responsibility for the centre, supported by the clinical lead, operational team leader, clinical team leader and the senior service manager who visited the centre weekly. The managers had developed a well-led framework to identify what the centre does well and improvements that need to be made.
- All staff we spoke with spoke highly of the clinical lead and the positive impact and support they provided to improving standards and care at the centre.
- The front of house staff were managed by the operational team leader. Staff told us that issues raised were addressed and that they were supportive.
- All staff we spoke with were positive about the culture in the service and in the management team; they provided examples of when they had received personal support from the management team and their colleagues.
- Previously the centre had not displayed their Department of Health certificate for approval (the licence for termination of pregnancy). This was now displayed at the front entrance of the centre.
- The management team of the service had good support and links to the area manager and the senior management team.

Vision and strategy

- Senior managers had a clearer vision and strategy for this centre. The managers we spoke with were knowledgeable about the corporate strategy and understood how this affected the local provision of services. They were committed to improving local leadership and we reviewed their well led framework

and the improvement action plan to continue to improve service provision at the centre. Within the document there were clear lines of responsibility with progress evident and deadlines for completion.

- Staff we spoke with were aware there was an organisational strategy but could not explain the values of the organisation to us, this had not improved since our last inspection.

Culture

- The culture within the service was caring and supportive. Staff were actively engaged in the running of the local service. Innovative ideas and approaches to care were encouraged and supported.
- All staff we spoke with were proud of their colleagues and the team they worked in. Staff spoke positively and passionately about their role in the clinic.
- Nursing staff, managers and doctors we spoke with all enjoyed working for the organisation we observed the culture as being patient centred, caring, compassionate and supportive of the development of staff. Medical staff told us that engagement with consultants had greatly improved and doctors forums were held regularly and organised with enough notice to allow doctors to arrange schedules to attend, which was an improvement.

Governance

- There was a governance system within the organisation. Senior staff explained this to us, which meetings were held and how feedback and information was shared up to board level and down to staff within the centre. The senior team felt that this process was more embedded within the centre since our last inspection.
- The centre had commenced a weekly Complaints, Litigation, Incident and Patient Safety (CLIP) group, where shared learning from all incidents across the MSI organisation were shared. We reviewed email feedback dated July 2018, and saw themes were shared and actions logged and followed up. For example, 100 boxes of a controlled drug had been ordered instead of 100 ampules. Following an investigation controls were put in place to prevent over order in the future. Staff were asked to be vigilant when ordering to prevent mistakes taking place.

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- The quality assurance meeting was held quarterly, this reported into the regional quality assurance meeting. Agenda items were categorised into the CQC five domains safe, effective, caring, responsive and well led. Topics discussed included safety incidents, risks, safeguarding concerns, audits, complaints, and patient feedback. There were allocated named actions with deadlines to complete.
- We reviewed minutes of local integrated governance meetings from March and May 2018. The governance groups monitored a dashboard of performance metrics against key risks quarterly. This enabled team locally to monitor their ongoing performance against key performance outcomes such as audits, complaints, and treatment failures. Identified concerns were monitored locally through the quality assurance meeting.
- The dashboard enabled management at a corporate level to benchmark the centre in comparison to other MSI centres however this could not be undertaken at a local level. Local assurance and exception reports were included in the south regional integrated governance meetings.
- Staff received a monthly regional clinical governance newsletter which included incidents, outcomes and lessons learnt. In the staff room area there was a file with updates for staff to read, that included the three top risks relating to the centre.
- The centre held monthly team meetings. We reviewed minutes from May, June, and July 2018. The meeting agenda began with celebrations and each member of staff was included. The meeting had a set agenda which clearly shared information and lessons learned from complaints and incidents, however there were no defined actions or a system to review that they were in progress or completed, which meant there was a potential for items to not be followed through.
- There was an audit compliance monitoring programme in place. We reviewed this and found that the informed consent audit was undertaken bi-monthly and the centre was 100% compliant in June 2018. Safeguarding quarterly audit showed 100% in July 2018. Medicines management was audited quarterly and was 93% compliant for July 2018 and controlled drugs audit was consistently 100% compliant.
- Whilst the governance systems had improved since the last inspection visit, we found several areas of duplication in the patient records. Where forms had been superseded previous versions remained in place such as equipment check sheets, simultaneous administration record sheet and contraception consent form. We found that there were gaps in checking of emergency equipment daily checklist, however when this was raised senior staff produced another form where the same checks had been recorded. Therefore, the checks had taken place but the two different forms meant an audit of the checks may not be reliable. This meant that we were not fully assured that oversight was fully effective and that governance systems needed further strengthening.
- The service submitted HSA4 forms to the Chief Medical Officer electronically as recommended by the Department of Health. We reviewed the corporate assurance flowchart and guidance for staff groups to ensure that the forms were completed correctly and submitted. In July 2018 the Department of Health communicated that the time limit for abortion under grounds C and D of the Abortion Act 1967 equates to a pregnancy not exceeding 23 weeks and 6 days as opposed to 24 weeks and 0 days. The medical director sent a communication update to all staff on the 23 July 2018 that confirmed HSA4 forms and other relevant information would be amended in line with this clarification.

Managing risks, issues and performance

- To ensure a consistent approach in the process of reviewing incidents (root cause analysis) managers attended a two day training course. All of the managers at the centre had attended this course.
- The centre had a local service agreement in place with the nearest NHS trust. We were able to review the contract for the provision of emergency transfer services 2017-2020. This meant if an emergency occurred patients could be transferred to access emergency treatment.
- The centre had responded to the fire and rescue service inspection completed in August 2017. We reviewed a detailed action plan and risk reduction strategies in response to the recommendations of the assessment. On inspection we reviewed the action plan and the

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management team had completed all of the actions required. We did not see any fire doors leading onto the stairwell wedged open, doors were now fire resistant compliant, and all exits had clear evacuation routes. The fire risk assessment report recommended the next review date was December 2018.

- If there was an uninterrupted power supply the centre had a backup generator. This meant vital equipment would continue to work in the event of a power cut. This was regularly maintained as part of the planned preventative maintenance programme.
- The risk register was held on the electronic system which was easily accessible. Managers could access other MSI centre risk registers and found this useful to compare if they had similar issues. There were 31 risks recorded on the risk register we reviewed. The senior team managed the risk register locally, the top four risks rated extreme were; staffing, emergency evacuation of patients, prescription delays and information loss. There was a risk management process whereby risks were discussed at the local integrated governance meetings and the risk register was updated accordingly as new risks were identified and previous risks were managed and reduced.
- Information regarding the recording and logging of pregnancy remains should they be required for private burial or further investigation was attached to the freezer where pregnancy remains were stored. However, this was out of date and staff could not describe the procedure to follow or where this information would be documented. When we raised this with senior staff we were informed that this had not been required in the last 12 months and they could only provide a blank template of the documentation log that would be used in these circumstances. We asked to see previous records however they could not be provided. Staff assured us that this would be investigated.

Managing information

- Staff told us that patients were made aware of the statutory requirements of the HSA4 forms during their initial consultation (a requirement to notify the Department of Health of an abortion) and were reassured that the data published by the Department of Health for statistical purposes was anonymised.

- The HSA4 forms were easily accessed on the electronic system for the medical staff to complete following the patients procedure. The Abortion Act 1967 clearly outlines that HSA4 notification must take place within 14 days of the termination taking place. We were informed that the current electronic system would not progress the patient to discharge until the HSA4 form had been uploaded and submitted to the Department of Health.
- Process flowcharts were in place to inform staff how to submit HSA4 forms to avoid completion errors and returned forms. The system was monitored centrally for rejected forms. Feedback would be provided to the doctor concerned when a form was rejected, amendments made and the form resubmitted. We were informed that a process for external and internal audit of HSA4 compliance to provide corporate assurance had been introduced and a status report would be included in the medical directors update to the quality subcommittee group.
- The service managed records appropriately in accordance with their Records Management and Retention Policy, termination of pregnancy records were kept for 20 years prior to disposal.
- Senior staff were aware that the IT system needed to be updated and this had been highlighted in previous inspections. Information provided post inspection detailed that the MSI board in July 2018 had approved a significant investment in a new IT and CRS system, this news had been shared with staff by way of the managing director update dated 11 July 2018.

Engagement

- Annual staff surveys were undertaken. This gave staff the opportunity to give feedback at a national level. The top percentages included 94% of staff confirming 'I feel data security and protection are important for MSUK', 91% said 'I understand the mission of MSUK and 'I would recommend the services of MSUK'. Lower percentages included 49% of staff said 'MSUK has effective communication throughout the organisation'. Results were shared with teams and they were asked to identify areas of importance that they could influence.

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- Staff we spoke with told us they had regular meetings and felt more involved in the development of the centre. Feedback from the national forums and meetings was shared with staff at their local team meetings. Urgent information was emailed or discussed directly with staff.
- Staff of all positions had recently been invited to the governance and CLIP meetings. One member of staff was planning a role play session to enhance knowledge of using the World Health Organisation (WHO) and five steps to safer surgery checklist.
- Staff encouraged patients to complete a feedback form about their experience. An independent organisation collected and analysed the forms, and produced a quarterly summary of results. If staff were named by a patient, managers would ensure the member of staff received individualised feedback. Red alerts were included in the survey. If a problem was identified the survey was red alerted and sent to the centre for investigation. We saw patient feedback survey results were discussed at the quality assurance meeting.

Learning, continuous improvement and innovation

- Staff told us that they were more confident since our last inspection that the service provided was improved and more established.
- All staff we spoke with were passionate and keen to improve services they provided for patients accessing the centre.
- The operations manager informed us that the centre planned to have coffee morning sessions to build relationships with other providers such as the genito-urinary clinic, commissioning groups and safeguarding teams.
- The managers were planning on sending staff for days at other services to network and build working relationships across the organisation.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that the waiting time for patients to access an appointment for a surgical termination is reduced in line with Royal College of Obstetricians and Gynaecologists (RCOG) guidance.
- The provider should ensure that improvements continue to enable patient's privacy and dignity throughout the centre to be maintained and that potential refurbishment options are explored.
- The provider should ensure that there is adequate storage for waste whilst awaiting collection and that waste is segregated appropriately according to national guidance.
- The provider should ensure governance processes are effective, including ensuring previous processes are discontinued when new systems are introduced.
- The provider should ensure that duplicated documentation is reviewed and assessed for purpose, in paper and electronic records and is minimised to prevent errors and provide assurance that data utilised for audit is accurate.
- The provider should review the use of schedule 2 registers for the use of controlled drugs.
- The provider should ensure that staff are aware of the process for recording and storing pregnancy remains should non standard disposal be required, such as private burial or criminal investigation, and that this is undertaken in line with local policy.