BPAS - Brierley Hill

Quality Report

Health and Social Care Centre
Venture Way
Brierley Hill
West Midlands
DY5 1RU
Tel: 03457 30 40 30
Website:www.bpas.org

Date of inspection visit: 16 June 2016
Date of publication: 10/07/2017

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

Summary of findings

Letter from the Chief Inspector of Hospitals

BPAS Brierley Hill is part of the national charitable organisation British Pregnancy Advisory Service (BPAS). BPAS provides medical and surgical termination of pregnancy services.

BPAS Brierley Hill provided a medical termination of pregnancy service in Brierley Hill West Midlands. BPAS Brierley Hill has contracts with clinical commissioning groups (CCGs) in the Black Country area to provide a termination of pregnancy service. Most patients are funded via the NHS, some patients choose to self-pay for services and the clinic offered services to paying overseas patients.

BPAS Brierley Hill provided support, information, treatment and aftercare for people seeking help with regulating their fertility and associated sexual health needs. Its main activity was termination of pregnancy.

We inspected but did not provide ratings for this service.

Are services safe at this service?

- Incidents and risks were reported and managed appropriately. Lessons learned and actions to be taken were cascaded to front line staff.
- Nursing and medical staffing numbers were sufficient and appropriate to meet the needs of patients in their care.
- Staff complied with best practice with regard to cleanliness and infection control. The clinic environment and equipment were clean and suitable for use; standards were monitored through audits and risk assessments such as health and safety risk assessments.
- Staff were aware of their safeguarding responsibilities, including to patients that were under the age of sixteen years old.
- Medicines were stored, prescribed and administered safely and in keeping with the Abortion Act 1967. Some aspects of audit arrangements for medication particularly those medicines used to bring about a termination of pregnancy were not consistently robust.

Are services effective at this service?

- Treatment was based on up to date good practice and staff followed policies and procedures.
- Patients were prescribed appropriate pain relief, preventative antibiotics and post termination of pregnancy contraceptives.
- There were processes in place for implementing and monitoring evidence based guidance.
- The clinic undertook audits recommended by Royal College of Obstetricians and Gynaecology (RCOG).
- Consent was gained in line with Department of Health guidelines for most patients. The provider had policies, procedures and guidelines for staff to support these. However protocols to assess capacity and support for patients who lack capacity to consent including those with a learning disability were not robust in practice. The risks involved in simultaneous administration of termination of pregnancy medication were not made sufficiently clear to patients. The provider informed us this was put right immediately after our inspection visit.
- Each patient had an ultrasound performed to confirm the pregnancy and gestation stage so that the correct treatment could be recommended.
- Pre and post termination of pregnancy counselling was offered and a telephone advice line for patients was available 24 hours a day.
- Nursing staff were trained and assessed as competent for general nursing practice and specific competencies pertaining to their roles.

Are services caring at this service?

Summary of findings

- Staff treated patients attending for consultation and termination of pregnancy with compassion, dignity and respect. There was a focus on the needs of patients.
- A 'client care coordinator' met with all patients on their own to establish that the patient was not being pressurised to make a decision. Patients' preferences for sharing information was established, respected and reviewed throughout their care.
- If patients needed time to make a decision, the staff supported this.
- All patients considering termination of pregnancy had access to counselling before and after procedures.

Are services responsive at this service?

- Pre and post-procedure checks and tests were carried out at the clinic to ensure continuity of care.
- Waiting times were within the guidelines set by the Department of Health and agreed by the local Clinical Commissioning Groups.
- Interpreting and counselling services were available to all patients and the clinic was accessible for those with disabilities.
- The service had good links with the sexual health service within which it was situated.
- Patients could be offered a provisional same day service, where they were booked on the same day for an appointment, assessment, ultrasound scan and received treatment.
- Complaints were responded to appropriately and within service agreed timescales.

Are services well led at this service?

- Senior managers had a clear vision and strategy for this service and staff were able to demonstrate the service's common aims to us.
- There was strong local leadership of the service and quality of care and patient experience was seen as the responsibility of all staff.
- Staff were proud of the service they provided and were aware of the requirements RCOG's clinical guidelines.
- Staff felt supported to carry out their roles and were confident to raise concerns with their managers.
- Patients were encouraged to provide feedback through a satisfaction survey, and the results were positive.
- There was a clear system of governance in place at national and regional levels and clinical governance was well managed to ensure service quality and performance was monitored and actions taken when needed. Governance forums were used to discuss quality and risk issues and monitor the service was adhering to legal requirements such as completion and submission of legal documentation (HSA1 and HSA4 forms).
- Comments, concerns and complaints were shared with staff.
- The provider had reviewed treatment programmes. When possible it had introduced new regimes to provide women with greater choice and flexibility.

.**We saw several areas of good practice including:**

- A sample of young people had been consulted in designing the safeguarding risk assessment. This improved the effectiveness of questions to identify young women who were isolated, at risk of abuse or exploitation.

However, there were also areas of where the provider needs to make improvements.

Importantly, the provider must:

- Put into practice protocols for all patients who may lack capacity to consent.
- Improve the audit arrangements in place for medication particularly abortifacient medicines.
- Improve practice in respect of the administration of an intramuscular medication
- Improve practice in respect of use of 'anti-d' (a blood product derivative drug used to prevent formation of antibodies).

In addition the provider should:

Summary of findings

- Consider developing a formal, local contingency plan for business continuity in the case of prolonged loss of premises due to major incident.
- Consider participating in relevant local or national audit programmes or peer review to bench mark outcomes against other similar services.
- Make clear on the consent form when simultaneous termination of pregnancy medication was administered the risks involved.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Termination of pregnancy		We have not provided ratings for this service. We have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities it provides. Staff reported incidents and incidents were logged, investigated and learned from. The manager who sent this information to senior managers and the clinical team which is then reported to the Board that ran the organisation checked the quality and safety of the services provided at the clinic regularly. Doctors, nurses and midwives followed recognised safe medical procedures. Staff followed procedures in place for good hygiene and control of infection, safeguarding children and vulnerable adults, assessing and responding to clinical risk for patients and record keeping. Some aspects of safe management of medication needed to be improved. Patients care and treatment was evidence-based and in line with good practice. Staff followed BPAS policies and procedures, developed to take account of national guidance including the Required Standard Operating Procedures (RSOP) from the Department of Health. The use of simultaneous administration of abortifacient drugs for early medical abortion (EMA) is outside of current Royal College of Obstetrician and Gynaecologist (RCOG) guidance and staff did not make sufficiently clear to patients when consenting to this method, it could increase the risk of failure. Managers regularly checked clinical practice to maintain good standards of patient care and continuously improve outcomes for patients. Staff employed at the clinic were competent, well trained and experienced. Staff gave patients good information on which to base their decisions and obtained informed consent, with the exception of the increased risks associated with simultaneous administration of abortifacient medication. The provider informed us it responded to our feedback and put this right immediately after our inspection visit. They spent time explaining options and procedures and giving advice

Summary of findings

on contraception. However, there was not a clear mental capacity assessment protocol in practice for women with learning disabilities or help to access an independent advocacy service.

All staff treated patients and those close to them with kindness and respect and put them at ease. Nurses asked about and respected patients' wishes around sharing information with a partner or family members or carers. Nurses checked along the way that patients were sure of their decision. A booklet called 'My BPAS Guide' was given to every BPAS patient and BPAS offered ongoing counselling support to all patients. Patients under 18 years old were counselled before treatment as a matter of policy.

The clinic opened three days each week including two evenings. Patients could book appointments through a national telephone service that ran a flexible appointment system to offer as much choice as possible to patients. Patients were generally offered an appointment within a few days and treatment within ten working days of access to the service. The clinic was in an accessible, modern building. Translation services were available. Counselling services were available for patients. However, support offered to patients with a learning disability to understand and give informed consent to procedures was limited.

The clinic was well run by a manager registered with the CQC and staff were all committed to the BPAS vision of women being in control of their fertility. The service was patient centred. BPAS had effective arrangements in place to manage quality and risk issues and monitor the service was adhering to legal requirements such as completion and submission of legal documentation (HSA1 and HSA4 forms). When possible it had introduced new regimes to provide women with greater choice and flexibility.

However we also found, it was not made sufficiently clear on the patient consent form, when simultaneous abortion medication was administered rather than having the medications with an interval of 24 hours or more between, that this method could increase the failure rate for a patient. The provider since assured us that the practice of nurses verbally communicating this information to patients was reinforced immediately after our inspection visit.

Start here...

Summary of findings

Contents

Location name here

Services we looked at
Termination of pregnancy

Summary of this inspection

Background to BPAS - Brierley Hill

BPAS is a national provider of medical and surgical termination of pregnancy services. BPAS Brierley Hill is part of the national charitable organisation British Pregnancy Advisory Service (BPAS). BPAS provides medical and surgical termination of pregnancy services.

BPAS Brierley Hill opened in 2013. The service was providing consultation and medical abortion treatments up to 10 weeks gestation. The clinic was nurse led. Patients travelled for treatment.

BPAS Brierley Hill had contracts with clinical commissioning groups (CCGs) in the Black Country area to provide a termination of pregnancy service. Most patients were funded via the NHS; some patients chose to self-pay for services.

BPAS Brierley Hill provided support, information, treatment and aftercare for people seeking help with regulating their fertility and associated sexual health needs. Its main activity was termination of pregnancy. The clinic ran in a suite of rooms on the first floor of a modern purpose built health and social care centre. The centre was also used by other services however; the BPAS clinic had its own waiting room.

The manager of the service was registered with the CQC and also managed a service in central Birmingham and in south Birmingham.

We inspected this service as part of our Comprehensive Inspection programme of acute medical services. We inspected termination of pregnancy services.

Our inspection team

Our inspection team comprised two CQC Inspectors and access by telephone to a Consultant Obstetrician and Gynaecologist.

How we carried out this inspection

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

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

Prior to our visit, we asked the provider organisation to send us information and data about the service covering the period for 2015. During our visit, we looked at data for 2016 and we also asked for some additional information after our visit.

We made an announced visit to the service on Thursday 16 June 2016. We spoke with two patients and followed their treatment pathway. We spoke with four staff that included nursing staff, the client care co-ordinator and the regional operations director

and registered manager for the service. We observed treatment and care, looked at records and looked around the environment of the clinic.

Summary of this inspection

Information about BPAS - Brierley Hill

The Brierley Hill clinic was a suite of rooms within the sexual health service of a purpose built health and social care centre in Brierley Hill. The clinic rooms including waiting room were solely occupied by BPAS when the clinic was running. It had one screening room, one consulting room and one waiting room. There were no overnight beds. The clinic was on the first floor and the building had a lift.

The clinic provided 387 medical terminations of pregnancy during 2015. This included three patients aged between 13 and 15 years.

Termination of pregnancy

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

The clinic, situated within a health and social care centre provided support, information, treatment and aftercare for people seeking help with regulating their fertility and associated sexual health needs. Its main activity was consultation and medical termination of pregnancy treatments up to 10 weeks gestation. It did not provide surgical or late gestation medical termination of pregnancy. The clinic was nurse led.

There was one screening room and one consultation room. These were on the first floor of the building and there was a lift.

The clinic conducted 387 medical terminations of pregnancy during 2015. This included three patients aged between 13 and 15 years.

The clinic opened on Tuesdays and Thursdays from 9am to 9pm and on Fridays from 9am to 3pm and the service employed one part time nurse. It was supported by three administration staff. No doctors worked on site but they were available remotely within the provider organisation.

BPAS offered patients an Aftercare Line which was accessible for 24-hours, seven days a week. Callers to the Aftercare Line would speak to registered nurses or midwives

Summary of findings

We have not provided ratings for this service. We have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities it provides.

Staff reported incidents and incidents were logged, investigated and learned from. The manager who sent this information to senior managers and the clinical team which is then reported to the Board that ran the organisation checked the quality and safety of the services provided at the clinic regularly. Doctors, nurses and midwives followed recognised safe medical procedures. Staff followed procedures in place for good hygiene and control of infection, safeguarding children and vulnerable adults, assessing and responding to clinical risk for patients and record keeping. Some aspects of safe management of medication needed to be improved.

Patients care and treatment was evidence-based and in line with good practice. Staff followed BPAS policies and procedures, developed to take account of national guidance including the Required Standard Operating Procedures (RSOP) from the Department of Health. The use of simultaneous administration of abortifacient drugs for early medical abortion (EMA) is outside of current Royal College of Obstetrician and Gynaecologist (RCOG) guidance and staff did not make sufficiently clear to patients when consenting to this method, it could increase the risk of failure.

Managers regularly checked clinical practice to maintain good standards of patient care and continuously improve outcomes for patients. Staff employed at the clinic were competent, well trained and experienced. Staff gave patients good information on which to base

their decisions and obtained informed consent, with the exception of the increased risks associated with simultaneous administration of abortifacient medication. The provider informed us it responded to our feedback and put this right immediately after our inspection visit. They spent time explaining options and procedures and giving advice on contraception. However, there was not a clear mental capacity assessment protocol in practice for women with learning disabilities or help to access an independent advocacy service.

All staff treated patients and those close to them with kindness and respect and put them at ease. Nurses asked about and respected patients' wishes around sharing information with a partner or family members or carers. Nurses checked along the way that patients were sure of their decision. A booklet called 'My BPAS Guide' was given to every BPAS patient and BPAS offered ongoing counselling support to all patients. Patients under 18 years old were counselled before treatment as a matter of policy.

The clinic opened three days each week including two evenings. Patients could book appointments through a national telephone service that ran a flexible appointment system to offer as much choice as possible to patients. Patients were generally offered an appointment within a few days and treatment within ten working days of access to the service. The clinic was in an accessible, modern building. Translation services were available. Counselling services were available for patients. However, support offered to patients with a learning disability to understand and give informed consent to procedures was limited.

The clinic was well run by a manager registered with the CQC and staff were all committed to the BPAS vision of women being in control of their fertility. The service was patient centred. BPAS had effective arrangements in place to manage quality and risk issues and monitor the service was adhering to legal requirements such as completion and submission of legal documentation (HSA1 and HSA4 forms). When possible it had introduced new regimes to provide women with greater choice and flexibility.

However we also found, it was not made sufficiently clear on the patient consent form, when simultaneous abortion medication was administered rather than having the medications with an interval of 24 hours or more between, that this method could increase the failure rate for a patient. The provider since assured us that the practice of nurses verbally communicating this information to patients was reinforced immediately after our inspection visit.

Termination of pregnancy

Are termination of pregnancy services safe?

- We saw the provider had a system in place for staff to report incidents and incidents were logged, investigated and learned from. A quality and safety dashboard completed by the clinic was in place and was submitted monthly through the provider's assurance system to the regional clinical lead.
- Staff followed procedures in place for good hygiene and control of infection safeguarding children and vulnerable adults, assessing and responding to clinical risk for patients and record keeping.
- Staff followed recognised safe medical procedures including assessment of risks and observation and monitoring of patients. The clinic had arrangements in place to transfer patients to local NHS hospitals in any emergency.
- There were sufficient nurses on site and doctors available to treat patients.

However we also found:

- Some aspects of safe management of medication needed to be improved.
- Staff did not always follow the patient group directive in respect of giving patients information that 'anti-d' (a drug used to prevent formation of antibodies) is a blood product (in case they had an ethical or religious objection to its use).

Incidents

- The provider reported no never events, 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. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.
- The clinic reported incidents when they occurred. This included one serious incident (SI) in respect of an ectopic pregnancy, which had occurred within the twelve months before our inspection.
- We saw the provider had a system in place for staff to report incidents through their line manager. The registered manager for the service was responsible for ensuring reported incidents were investigated and learned from. Staff used a paper-based incident reporting form and the forms were scanned and sent to the regional clinical lead for review. .
- Staff we spoke with had a good understanding of the incident reporting system and they received feedback when they raised concerns. They confirmed feedback was received individually by email and in team meetings.
- We 'tracked' the serious incident reported in 2015 and noted from a range of records the incident was investigated, lessons learned and discussed at regional quality, assessment and improvement forum (RQuAIF) level and local team level.
- Actions were identified and planned with timescales for achieving improved practice including reviewing the ectopic pregnancy guidelines and providing refresher training for clinicians. These actions were audited for effectiveness. Staff confirmed they had received feedback and training and their practice had changed.
- The manager told us on occasion the organisation's clinical leads may decide to send a serious incident investigation team to the clinic. They would discuss learning individually with clinicians.
- We saw a quality and safety dashboard was in place that was completed by the manager and submitted monthly through the provider's assurance system to the regional clinical lead.
- We noted details of all serious incidents from across the organisation were sent to local clinics. This included the details of the serious incident, the investigation and the learning outcomes. Each member of staff was expected to read the incident report and sign to confirm receiving the information. The signed sheet was then returned to the head office to be logged centrally with the provider.
- The provider had put in place a 'red top' bulletin page. This brought to staff attention immediate changes that needed to take place after an incident or complaint within the organisation, with links to policies and procedures, while the full governance process went on.
- Each member of staff was expected to read the red top alert and then the subsequent incident report and sign to confirm receiving the information. The signed sheet was then sent back to the head office to be logged centrally with the provider.
- The manager told us there had been a delay in the incident review process for the SI we tracked because of

confusion over who should report it. Overload of work for regional and administration staff were raised as reasons in the review report. However, we noted these were not factored in to the root cause analysis (RCA) therefore not addressed in the outcome.

- We raised this with the manager who assured us that different RCA models had been put in place since that time and were more effective.
- Doctors were sent three monthly reports indicating the number of procedures undertaken, complaints and complications. Outliers were identified in this way and were reviewed by the medical director.
- All nurses and midwives we spoke with were aware of their duty of candour. The manager described to us the system in place to respond to this regulation including sharing outcomes from the investigation with the patient and offering an apology. The provider confirmed managers had training in this area as they dealt directly with compliments, feedback, complaints and incidents
- The manager told us the provider's duty of candour procedure sat within its complaints procedure and was operated through managers; staff operated openness and reporting without the duty of candour label, although training was now included in staff induction. It was addressed in the provider's core briefing that went to staff three times each year.

Cleanliness, infection control and hygiene

- The provider had a hygiene and control of infection policy and procedures in place in line with the Health and Social Care Act (2008) code of practice on the prevention and control of infections and related guidance. We observed staff followed these procedures.
- For example, clinical staff used personal protective equipment appropriately. Nurses changed aprons and gloves between patients. There were posters on display to prompt staff with steps to correct method of washing displayed and the handwashing we observed was satisfactory.
- We noted the environment was visibly clean; floors in consulting, procedure and waiting rooms were vinyl and so could be effectively cleaned. All seating and couch arrangements were wipe clean.
- The manager told us the clinic was cleaned through an NHS contract for the whole community building. Staff confirmed the cleaning crew had recently responded to an overflowing toilet very quickly.
- Clinical waste was separated appropriately and bins were not overfilled. Arrangements for sharps were appropriate, wall mounted bins were not overfilled, labelled correctly and not out of date.

Environment and equipment

- The clinic ran in rooms on the first floor of a modern purpose built health centre. The environment was light and airy. The waiting room was spacious with plenty of seating.
- There were emergency buzzers in rooms for patients and staff to summon help if necessary
- We noted arrangements were in place to manage equipment for example, electrical equipment was regularly tested, clean and ready to use. The checklist for the crash trolley was fully completed however; this did not include the use of a list of items that should be on the trolley.
- Emergency equipment was cleaned and checked and ready for use.

Medicines

- The provider had policies and procedures in place for the safe management of medication and compliance with the Abortion Act 1967 and Royal College of Obstetricians and Gynaecologists (GCOG) guidelines.
- We checked the storage arrangements for medication in the clinic and found they were appropriate. Including those stored in the fridge. However, we noted the stock check for some stored drugs did not correlate to the numbers of drugs present in storage. The two items that were not correctly accounted for were the two abortion medications, mifepristone and misoprostol.
- We discussed this with the manager who explained they were aware of the stock discrepancy and were investigating it. They believed the error was due to temporary staff not correctly filling in the stock balance sheet.
- We asked the provider to send us the outcome of the investigation into the stock discrepancy. This concluded, 'It was identified that during the period due to staff sickness absence, the entry that had been recorded was the number of clients treated and not the number of tablets dispensed. Once this error was discovered a check clarified that there were no missing Misoprostol drugs and stock balance was correct.' The

manager submitted an incident report to the regional clinical team and concluded, 'this issue identified that the system used for medicine management needed to be modified to prevent this error recurring'.

- We noted the quality dashboard April 2016 monthly submission form the provider sent to us prior to our visit showed 'achieved' for medicines management at this clinic. After our inspection, we asked for the May 2016 submission. This showed no entry for medicines management.
- During our visit, we observed nurses administering medication to two patients. We noted patient group directive (PGD) permitting the supply of prescription-only medicines to groups of patients, without individual prescriptions, were appropriate and contained adequate information to guide nurses.
- We noted the nurses confirmed patient details with the patient, checked allergies and indicated correctly on the prescription chart. Registered medical practitioners had prescribed all medications correctly and signed for them with a clearly printed name and signature as required by the Abortion Act 1967 and 1991 Regulations, following the signing of the HSA1 form.
- We observed the administration of an intramuscular medication into an incorrect injection site. Although this would not have caused any patient harm, absorption of the drug may be reduced. The policy and PGD for this drug indicated the correct site and we noted the nurse had signed to confirm they had read this policy. We raised this with the manager and regional operations director who told us they would follow this up.
- We noted the PGD made clear that 'anti-d' (a drug used to prevent formation of antibodies) is a blood product and that this should be discussed with patients in case they have an ethical or religious objection to its use.
- However, we observed that nurses did not discuss with the patient that 'anti d' was manufactured from a blood product. Neither did the BPAS information leaflet disclose this information to the patient. We raised this with manager who agreed to raise it for discussion through governance structures.
- We heard nurses give clear explanations to patients about how to take the medication and the expected side effects.

Records

- We looked at 10 sets of patient records and noted they were complete, legible, and up to date. For example, we saw in all notes integrated care pathways. Clinical staff had recorded consent and discussion regarding choices and information about continuing the pregnancy.
- We saw the notification of termination of pregnancy form HSA1 in patient's files. Each had the patient's details the signatures of two registered medical practitioners.
- Administrative staff explained all patient information was uploaded onto a patient information system. Medication prescription charts were generated electronically. These were then printed at the clinic and secured into patient notes.

Safeguarding

- The provider had a range of policies and procedures in place including: safeguarding and management of clients aged under 18; protection of vulnerable adults and domestic abuse.
- The registered manager was responsible for the sharing of necessary information with external safeguarding/ child protection agencies in a timely manner. They were also responsible for the development and regular review of their local adult and child protection procedures, ensuring these were in line with BPAS procedures and with any additional guidance from the local safeguarding children board.
- Records showed all staff were trained to level three safeguarding for adults and children. Staff we spoke with confirmed their training was up to date and regularly refreshed.
- Individuals under 18 were highlighted on the booking system and appropriate pathways then put into place to support their needs. We noted the consent form prompted clinical staff to assess the young patient for Gillick competence (a term used to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge), and Fraser guidelines in respect of future contraception.
- Patients identified as at safeguarding risk for example, less than 18 years of age underwent a safeguarding risk assessment. We noted the assessment was thorough and included questions aimed to identify individuals who were isolated, at risk of abuse or exploitation.
- If the doctor assessed a patient of 14 years or younger to be at low risk of exploitation they proceeded with the

treatment. If the assessment indicated other than low risk the patient was treated after assessment with the involvement of the provider's safeguarding lead that assessed whether to involve social services or the police. Staff told us the local police attended whenever BPAS reported an underage pregnancy.

- The provider organisation had consulted a sample of young people in designing the safeguarding risk assessment. This improved the ability of questions to identify young women who were isolated, at risk of abuse or exploitation. The manager told us nurses checked during assessment if young patients were known to other agencies.
- Staff we spoke with were aware of female genital mutilation (FGM) and the pathway they would follow if they came across a patient with FGM.
- All staff were aware of their responsibility under the Fraser guidelines in relation to gaining consent from underage patients.

Mandatory training

- All staff we spoke with at the clinic confirmed they had updated mandatory training. The training matrix we saw for the clinic supported this.
- Mandatory topics for staff in all roles included, life support at levels identified for job roles; defibrillator and CPR; safeguarding vulnerable groups and child protection (level three); fire training; infection control and information governance. Other topics were role specific such as moving and handling.

Assessing and responding to patient risk

- We saw nurses documented clinical observations of patients prior to administration of medication, including identification of allergies and for post procedure reviews.
- During the clinic appointment booking interview, staff undertook a risk assessment of the patient. We saw from notes this included taking a detailed medical and social history. We saw these on each patient's file we looked at.
- At this point, a patient could be referred to other termination of pregnancy service providers. For example if it was a high risk or 'complex' termination, the patient would be referred to an appropriate NHS acute trust service locally. BPAS was able to offer patients a termination up to the legal limit and did not need to refer to an acute trust for treatment. A specialist team was able to provide support to patients requiring a termination who had complex health needs to access treatment in an NHS hospital.
- We noted the clinic did not use a system of early warning score (EWS); observations were noted on patient records documented prior to the administration of medication for medical termination of pregnancy. We saw Venous Thrombo Embolism (VTE) risk assessment and also a bleeding risk assessment within the patient's medical history.
- The clinic had an agreed protocol in place to transfer a patient to a local NHS Hospital in an emergency.
- A training matrix showed all clinic staff had updated basic life support training in April 2016. The lead nurse and nurse practitioner who had immediate life support training (ILS) training were based within the cluster of provider services. The Resuscitation Council (UK) training guideline advise that anaphylaxis training is part of this course.

Nursing staffing

- The clinic was nurse led. The provider employed one nurse on a part time basis. We noted this was sufficient to support the appointments made.
- However, the provider's local audit return for May 2016 showed 'not achieved' for safe staffing levels; 'due to staff sickness the clinic was closed for two sessions, alternative cover since arranged. Clients have been offered alternative appointments at units within the cluster'.

Medical staffing

- No doctors worked on the premises. Medical staff were available to the clinic nurse remotely for advice and to electronically view patient's notes, sign the HSA1 forms and prescribe the medication.

Major incident awareness and training

- The manager told us the service had no major incident plans or strategies. There was a written emergency contingency plan in place specific to the clinic and this covered failure of supply such as gas, water and electricity. There was no formal, local contingency plan for business continuity in the case of prolonged loss of premises due to major incident.

Termination of pregnancy

Are termination of pregnancy services effective?

- Staff provided care in line with national best practice guidelines with the exception of the use of simultaneous administration of abortifacient drugs for early medical abortion (EMA), which is outside of current Royal College of Obstetrician and Gynaecologist (RCOG) guidance. The organisation was monitoring outcomes from this treatment
- There were systems in place to regularly audit clinical practice and new approaches to treatment.
- Staff employed at the clinic were competent, well trained and experienced. They had access to good information systems and worked well together, and with staff in local acute hospitals for the benefit of patients.
- Staff gave patients good information on which to base their decisions and obtained informed consent and spent time explaining options and procedures and giving advice on contraception.

However we also found:

- The use of simultaneous administration of abortifacient drugs for early medical abortion (EMA) is outside of current Royal College of Obstetrician and Gynaecologist (RCOG) guidance and staff did not make sufficiently clear to patients when simultaneous abortion medication was administered rather than having the medications with an interval of 24 hours or more between, that this method could increase the failure rate for a patient.
- There was not a clear capacity assessment protocol in practice for women with learning disabilities or signposting to an independent advocacy service.
- The service did not participate in any relevant regional or national audit programme or peer review to bench mark its outcomes against other similar provider services. The provider informed us, in a competitive commissioning market it did as much as was reasonable to benchmark its service.

Evidence-based care and treatment

- We found for the most part, policies were framed and treatment was offered in line with the Royal College of Obstetrician and Gynaecologists guidelines as required by required standard operating procedure (RSOP) 10. However, an exception was the use of simultaneous administration of abortifacient drugs for early medical abortion (EMA), which is outside of current Royal College of Obstetrician and Gynaecologists guidelines.
- We followed the care and treatment pathway with two patients. We noted staff discussed all choices concerning the pregnancy, methods of termination of pregnancy and all methods of future contraception with each patient.
- Sexually transmitted infection (STI) screening was offered, contraception including long-acting reversible contraception (LARC) and GP follow up was offered. All patients were discharged with a pack of two condoms; all methods of contraception were available. We saw administration of the contraceptive pill. Contraception was recorded in patient notes along with appropriate consent and risk/benefits discussion.
- Staff gave information at discharge on signs and symptoms to be aware of and those which would be concerning. These also featured in the provider patient information booklet.

Pain relief

- We observed staff discuss pain relief options with patients prior to the administration of the termination of pregnancy medication. This included discussion of signs of abnormal pain. Staff offered patients suitable pain relief to take home.

Patient outcomes

- The provider had put in place systems to regularly audit clinical practice. We were told BPAS had a planned programme of audit and monitoring including the patient helpline service, patient satisfaction and contraception uptake.
- Audit outcomes and service reviews were reported to governance committees. Registered Managers were expected to complete action plans for areas of non-compliance which were then reviewed by the BPAS clinical department and regional quality, assessment and improvement forum (RQuAIF).
- We saw the clinic manager completed an outcomes audit each month and a clinical dashboard which was sent to the regional clinical director. This included for example, infection control practices and we noted for the May 2016 audit the clinic was rated as 'achieved'. These audit results were displayed in the clinic waiting room and reported the clinic as 100% compliant.

- The manager also audited the patient journey monthly by following through the experience of a sample of a standard percentage of patients. Staff undertook ultrasound scan audits and sent them to the lead sonographer for review. The provider collected data that compared the outcomes of the two different regimens offered by the clinic for medical termination treatment.
- The manager told us a 'following the patient pathway' audit in early June 2016 established a need for improvement in providing patients with the opportunity of making informed choice about the disposal of pregnancy remains. An action plan was produced to address this and it was included in clinical supervision discussion.
- The clinic was offering simultaneous administration of abortifacient drugs to patients. We noted it monitored the outcomes of and reported this to the BPAS clinical governance committee.
- Minutes of the provider's clinical governance committee meeting in June 2015 acknowledged the increase risk and continued to monitor client outcomes. Minutes from a regional management meeting in October 2015 showed that the reported complications were within the 2% predicted.
- However, minutes of the clinical governance committee meeting in November 2015 stated there was a 'large increase (of complications) driven by EMA [early medical abortions] with simultaneous administration of mifepristone and misoprostol'.
- We noted at this stage, the provider gave consideration to altering the regimen of later medical abortion to try and improve outcomes. During the clinical governance committee meeting in February 2016, it was reported that 'although overall complications with simultaneous EMA are consistent with the BPAS pilot, analysis by gestational age suggests there is a higher risk of failure as gestational age advances, particularly at 57-63 days. A comparative analysis of continuing pregnancies over the entire period during which simultaneous EMA has been provided will be undertaken and client materials changed if needed'.
- The manager told us the service did not participate in any relevant national or regional audit programme to bench mark its outcomes against other similar provider services. The provider informed us following the inspection that in a competitive commissioning market where data was hard to come by, it did as much as was reasonable to benchmark its service and welcomed peer review with its NHS colleagues at every opportunity that was offered to it.
- The provider offered post termination of pregnancy support. A helpline was available and staff discussed this with patients at discharge and details were also in the provider's patient information booklet.

Competent staff

- We noted from records nurses on duty on the day of our visit had up to date professional registration.
- Nurses were clinical nurse specialists and they told us they had adequate time for supervision and the provider was supporting them with the revalidation process. The provider reported 100% of nursing and administration staff had an annual appraisal during 2015/16. All staff completed a corporate induction programme.
- We observed nurses on duty had ultrasound competency and they confirmed the provider offered a good ongoing education programme with supervision. Nursing staff confirmed they felt confident about making referrals to the BPAS Birmingham Central clinic if they were unsure of an ultrasound finding and to an early pregnancy advice unit (EPAU) at a local acute hospital if they had any concerns over ectopic pregnancy.
- 'Client care coordinators' who saw patients before the clinician's consultation told us they were trained in counselling.

Multidisciplinary working (related to this core service)

- We observed good multidisciplinary working **(**MDT) between the nurse and 'client care coordinator' in the clinic.
- On discharge, staff gave patients a letter providing sufficient information about the procedure to enable other practitioners to manage complications if required. If patients agreed, staff sent a copy of the letter to the patient's GP.
- Staff reported a good relationship between the clinic and the NHS sexual health services team based at the same building. The provider had a service level

agreement with a local acute NHS hospital for early pregnancy assessment unit (EPAU) referrals or emergency transfers or for complex termination of pregnancy services.

Seven-day services

- The clinic did not provide a seven-day service. It opened on Tuesdays and Thursdays from 9am to 9pm and on Fridays from 9am to 3pm. The provider organisation ran a telephone helpline that was available 24-hrs seven days each week.

Access to information

- Nurses confirmed they had access to patient's records that were securely stored at the clinic for a specific time period only. They could easily access the provider's policies and procedures and national clinical guidelines via the intranet.
- We saw patient notes were made electronically accessible to nurses and doctors including registered medical practitioners working at the provider's other locations and clinics.
- Records were regularly audited by the registered manager. The provider's lead sonographer checked the quality of ultrasound scanning.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We noted nurses sought patient's consent to care and treatment.
- It was the provider's policy that nurses or 'client care co coordinators' consult initially with all patients on their own, regardless of their age to ensure that all women and young people seeking termination of pregnancy were doing so voluntarily. Arrangements were in place to support translation via Language Line telephone services.
- We observed both patients whose care and treatment pathway we followed, confirming their consent before the procedure. We saw in all 10 sets of patient notes we looked at, staff recorded consent as given following discussion about possible complications and patients confirmed they understood the implications.
- Staff completed consent prior to administration of medication.
- However, we noted consent for simultaneous administration of medication for a medical termination of pregnancy was not clearly indicated on the patient consent to treatment document patients were asked to sign. The provider was aware of increased risk of failure with this method and nurses did not discuss this with patients. Staff did not make sufficiently clear to patients, when simultaneous abortion medication was administered rather than having the medications with an interval of 24 hours or more between, that this method could increase the failure rate for a patient. The provider since assured us that the practice of nurses verbally communicating this information to patients was reinforced immediately after our inspection visit. This also demonstrates that the process of sharing our concerns during the inspection drives improvement.
- For patients less than 18 years of age staff completed a Gillick competency assessment and followed Fraser guidelines, (it is lawful for doctors and nurses to provide contraceptive advice and treatment without parental consent providing certain criteria are met), for contraceptive advice.
- We discussed with the manager the clinic's practice around gaining consent. They told us the provider policies were available to staff on the intranet. The clinic had good multidisciplinary contacts and arrangements within the local authority and the police for safeguarding children.
- However, we found from discussion with staff and the registered manager there was not a clear capacity assessment protocol in practice, in keeping with required standard operating procedure (RSOP) 8 for women with learning disabilities. Nor was there signposting to an independent advocacy service. Staff were not clear about capacity assessment processes for patients with learning disabilities; their understanding was it was not necessary to trigger a capacity assessment if a patient had someone accompanying them such as a supportive parent or care worker.

Are termination of pregnancy services caring?

Summary

- Staff in all roles treated patients and those close to them with kindness and respect and put them at ease.
- Nurses asked about and respected patients' wishes about sharing information with a partner or family members or carers.

- Nurses checked along the way that patients were sure of their decision. Patients were given opportunities to express their feelings. Additional information and counselling could be offered or the procedure postponed if they were unsure.
- Every BPAS patient was given a booklet called 'My BPAS Guide' which provided written information about the patient's post treatment care. The guide had a section dedicated to recovery, which detailed what would normally be expected following treatment.
- BPAS offered ongoing counselling support to all patients and patients under 18 years old were counselled prior to treatment as a matter of policy.

Compassionate care

- We observed clinical and other staff behaving in a non-judgmental manner, going beyond requirement to help patients feel at ease. Staff spoke with patients in a warm, patient and friendly way and respected their dignity at all times.
- Although the building was shared by other services, BPAS did not share its waiting room and consulting room doors were identified only by number. Staff respected patients right to confidentially and privacy. For example, they established patient's wishes to share information with a partner, family member or carers and these were respected.
- We spoke with two patients during our visit and they told us, "They have made me feel welcome at ease"; "really supportive and kind."

Understanding and involvement of patients and those close to them

- Patients were then then seen at the appropriate clinic and staff there discussed options, benefits and risks with them. We observed this with one patient during our visit and saw notes of this process in 10 sets of patient's records.
- The provider offered post procedure care complications support following termination of pregnancy.

Emotional support

- We noted counselling support from the client care co-ordinator was offered to all patients and we observed patients under 18 years old were counselled prior to treatment as a matter of policy.
- We noted the nurse checklist included question prompts to establish if the patient had anxieties and that they were sure of their decision. Additional information and counselling could then be offered or the procedure postponed if necessary.
- The clinic staff offered the provider's counselling service at the consultation and on the day of the procedure (if different). The counselling service was available indefinitely to BPAS patients.

Are termination of pregnancy services responsive?

Summary

- The clinic was located within a sexual health service in a health centre and opened three days each week.
- Patients could book appointments through a national telephone service that ran a flexible appointment system to offer as much choice as possible to patients.
- Patients were generally offered an appointment within seven days of contact with the service. Patients could be offered consultation and treatment all in one day if required. Most patients had their procedure within 10 working days of access to the service.
- Translation services and counselling service were available for every part of the pathway
- The clinic encouraged patients to give feedback on the service including making a complaint and the provider used this to improve the service.

However we also found:

- There were limited effective means in practice to support patients with a learning disability to understand and give informed consent to procedures or benefit from best interest decision making on their behalf.

Service planning and delivery to meet the needs of local people

- The clinic was located in a sexual health clinic and was well served by public transport. It opened on Tuesdays and Thursdays from 9am to 9pm and on Fridays from 9am to 3pm for early medical termination of pregnancy.
- The provider had a system in place for making appointments at its clinics through a national contact centre phone line service.
- Staff at the provider's national telephone contact centre which was a 24/7 telephone booking and information

service made the appointments and could offer patients appointments at other times in clinics within the region. If patients required surgical termination of pregnancy, they would be referred to a local BPAS clinic that provided surgical options.
- Patients could self-refer to the services as well as through traditional referral routes. Patients were offered appointments to suit their needs, there were enough appointments available to suit the need for treatment and patients we spoke with confirmed this.
- BPAS offered patients an Aftercare Line which was accessible for 24 hours, seven days a week. Post termination of pregnancy counselling was a free service to all BPAS clients, and could be accessed any time after their procedure, whether this was the same day or many years later.
- If patients were assessed as needing a complex termination of pregnancy pathway for example, for late gestation the provider had service level agreements in place to refer patients to other providers including NHS acute services.
- The clinic has dedicated staff; including a 'client care co-ordinator' who was counselling trained and supported the service to meet the national guidelines relating to the 'Care of Women Requesting Induced Abortion (2011)'.

Access and flow

- The clinic conducted 387 medical terminations of pregnancy during 2015. This included three patients aged between 13 and 15 years and no patients under 13 years old.
- A centralised electronic triage booking system offered patients a choice of dates, times and locations. This ensured women were able to access the most suitable appointment for their needs and access treatment as early as possible.
- Women were able to choose their preferred treatment option and location, subject to their gestation time and a medical assessment and patients we spoke with confirmed this. The provider also had access to specialist late gestation termination of pregnancy services.
- The manager told us the provider's business development managers were responsible for overseeing capacity management and clinic managers amended their appointment templates, adding additional appointments when necessary.
- The provider had systems in place to ensure as far as possible the total time from access to procedure was not more than 10 working days in line with RSOP 11.
- The system recorded what appointments were available within a 30-mile radius of the patient's home address at the point of booking. This enabled the provider to analyse waiting times and evidence patient choice.
- The provider shared data with us for across the local clinical commissioning group (CCG) for example, for the period October to December 2015. This showed the proportion of patients who had their treatment within seven calendar days of deciding to proceed was 75%. The proportion of patients who could have had their treatment within seven calendar days was 100%.
- The provider reported an improving picture of patients treated below 10 weeks gestation. For 2014 it was 80% of patients and thus far in 2015/16 it was over 85.5% of patients. We noted this was above the average of 69% for 2015 in England and Wales.
- Forty-four (11%) of the provider's patients waited longer than 10 working days from first appointment to termination of pregnancy during 2015. The manager told us the clinic had improved this performance, had no waiting list at the time of our inspection and all patients were seen within one calendar week of their first contact with the service.

Meeting people's individual needs

- The service operated on the first floor of an accessible, modern purpose built health centre. There was a lift and car parking at the rear.
- Policies were in place to aid translation via Language Line telephone services. Staff had access to translation services over the 'phone or if necessary face to face. The provider had a contract with a translation service that patients could use to access the national contact centre to make an appointment at a clinic.
- There were systems in place for obtaining consent and pathways and support for patients under 18 years.
- However, we noted there were no specific means of supporting patients with a learning disability to

understand and weigh up the issues involved, as is required by RSOP 8. For example, the 'My BPAS guide' booklet had no easy read page or accompanying leaflet to signpost a patient through its contents.

- Staff told us they relied on the input of support workers or parents to facilitate the patients' understanding of the procedures and the options and consent.
- The manager had established from the 'following the patient pathway' audit in early June 2016 that staff needed more support to improve their confidence in providing patients with the opportunity of making an informed choice about the disposal of pregnancy remains.
- Contraception and STI information was discussed at discharge and was in the patient information booklet form

Learning from complaints and concerns

- The provider reported it had received no complaints about services at the Brierley Hill clinic in the 12 months preceding our inspection.
- We noted a system in place for patients to raise concerns, make a complaint or just provide feedback and we observed it in action.
- For example, all patients were given a client survey/ comment form entitled 'Your Opinion Counts' and there were boxes available at the clinic for patients to leave their forms or post directly to the providers head office. We noted a poster and leaflets on display encouraging and guiding patients to make a complaint or give feedback.
- The manager told us completed forms left at the clinic were initially reviewed by the clinic manager and then sent to the head office for collation and reporting. This meant the manager could begin to immediately address any adverse comments.
- The provider's client engagement manager produced satisfaction survey reports which were collated by clinic. The provider's regional quality, assessment and improvement forum (RQuAIF) and clinical governance committee reviewed a report of all complaints and a summary of service user feedback (including return rates and scores). Survey results were shared with the clinic.
- The patient booklet 'My BPAS Guide' also included a section on how to give feedback and how to complain, as did the provider's website.

Are termination of pregnancy services well-led?

Summary

- Staff were all committed to the BPAS vision of women being in control of their fertility. The service was patient centred and caring.
- There was a clear system of governance in place at national and regional levels and clinical governance was well managed to ensure service quality and performance was monitored and actions taken when needed.
- Governance forums were used to discuss quality and risk issues and monitor the service was adhering to legal requirements such as completion and submission of legal documentation (HSA1 and HSA4 forms).
- The clinic was well run by a manager registered with the CQC and staff felt confident about speaking up, learning from incidents and trying out new ways to improve the service.
- Staff encouraged patients to give feedback about the service they received and contribute to improving the service in a range of ways including through social media.
- The provider had reviewed treatment programmes. When possible it had introduced new regimes to provide women with greater choice and flexibility.

Leadership / culture of service

- A manager registered with the CQC oversaw the clinic. She told us she was available to staff everyday via telephone if not on site. She planned her week to cover all three clinics she managed and varied her time to ensure contact with all staff. Clinical and administrative staff we spoke with confirmed this.
- Staff we spoke with in all roles reported that the organisational culture was open and honest. They felt confident to approach the registered manager at any time with concerns or questions and said regional operations directors and directors were accessible to them to approach.
- Staff we spoke with about learning from incidents told us they did not feel victimised when they made mistakes and they were encouraged to be involved in sharing learning from incidents.

Vision and strategy for this this core service

- All staff we spoke with were aware of and personally committed to the provider's vision of enabling women to control their own fertility in safety.
- We saw posters and publications available to patients communicating the provider's vision and purpose.
- We noted the provider displayed the documentation of approval (the license issued by the department of health to carry out terminations of pregnancy) in a prominent position in the clinic waiting room.

Governance, risk management and quality measurement for this core service

- We saw the provider had prominently displayed its department of health operating licence for termination of pregnancy, as it is required by law. The CQC registration documentation was also displayed.
- The provider had a system of governance in place at national and regional levels. It comprised of a board of trustees, a clinical governance committee, research and ethics committee, infection control committee, information governance committee and regional quality, assessment and improvement forum (RQuAIF)
- The provider had recently created a new position of risk manager within the organisation. The regional clinical lead told us this signalled a sharper focus on risk management, for example they had changed route cause analysis (RCA) models for incident investigation.
- We noted the provider had robust arrangements in place for risk management and quality assurance. The manager followed those and reported up through the organisation within effective governance structures.
- For example, we saw measures had been put in place in the clinic to mitigate the risk in an area of practice that had generated a serious incident during 2015.
- However, we also noted that the issue over reconciliation of drugs stock we found had not been identified by the service in a timely and effective way.
- Clinical governance was well managed to ensure service quality and performance was monitored and actions taken when needed. Four-monthly national clinical governance meetings and regional quality and managers meetings took place. These forums were used to discuss quality and risk issues and monitor the service was adhering to legal requirements such as completion and submission of legal documentation (HSA1 and HSA4 forms).
- Each clinic maintained high-risk incident logs including Brierley Hill. Risks identified and rated covered a wide range of issues and areas from political and ethical to clinical in categories. These risks appeared standardised across the organisation.
- Risks for Brierley Hill were largely rated as low 'green' with serious clinical incidents, accident/clinical events rated as 'pink', high risk. These risks had control measures identified and the chief executive officer and or the clinical director were accountable for monitoring them. We noted however, the risk register did not indicate any date for review of these risks.
- The manager and clinicians told us the RQuAIF were embedded on a good and effective cycle for checking and monitoring quality from local audit and providing feedback on incidents and complaints to clinics regionally.
- The provider showed us routinely collected data from each clinic on clinical complications and year on year comparisons. This included data comparison for simultaneous and 48 hour gap administration of abortifacient (drugs used to bring about a termination of pregnancy) medication for termination of pregnancy.
- The assessment process for termination of pregnancy legally requires that two doctors agree with the reason for the termination and sign a form to indicate their agreement (HSA1 form), in line with the requirements of the 1967 Abortion Act. Legislation requires that for an abortion to be legal, two doctors must each independently reach an opinion in good faith as to whether one or more of the legal grounds for a termination is met. They must be in agreement that at least one and the same ground is met for the termination to be lawful.
- We saw documentations for termination of pregnancy (HSA1 forms) were present in each set of patient notes and signed prescription charts where appropriate.
- As required the clinic submitted HSA4 forms to the Department of Health. These were sent electronically. The doctor who terminated the pregnancy signed these within 14 days of the completion of the termination of pregnancy. The provider's on-line completion and submission process for HSA4 forms, within which was its 'booking information system', linked directly with the department of health computer.

Public and staff engagement

Termination of pregnancy

- We observed staff encouraged patients to give feedback about the service they received in a range of ways including through social media. The patient engagement manager confirmed to us they reviewed any comments left about the service on the NHS Choices website.
- The provider had consulted and involved young patients in the content of and questions in the safeguarding assessment form.
- Staff told us they felt part of the organisation and were proud to demonstrate a commitment to their patients.

Innovation, improvement and sustainability

- The provider told us it has been involved in providing advice and guidance to the Human Tissue Authority (HTA) on production of its document, 'Guidance on the Disposal of Pregnancy Remains Following Pregnancy Loss or Termination', and was part of the team updating the Royal College of Nursing's guidance document, 'Sensitive Disposal of all Foetal Remains'.

Outstanding practice and areas for improvement

Outstanding practice

The provider organisation had consulted a sample of young people in designing the safeguarding risk assessment. This improved the effectiveness of questions to identify young women who were isolated, at risk of abuse or exploitation.

Areas for improvement

Action the provider MUST take to improve

- Ensure that protocols are put into practice for assessing consent and obtaining best interest decisions where appropriate, and support for all patients who lack capacity to consent.
- Improve the audit arrangements in place for medication particularly abortifacient medicines.
- Improve practise in respect of the administration of an intramuscular medication
- Improve practice in respect of use of 'anti-d' (a blood product derivative drug used to prevent formation of antibodies) to better inform patients so they could consider their preference.

Action the provider SHOULD take to improve

- Consider developing a formal, local contingency plan for business continuity in the case of prolonged loss of premises due to major incident.
- Ensure that when patient's consent to simultaneous administration of abortion medication for medical abortions they are clearly informed this method, rather than having the medications with an interval of 24 hours or more between, could increase the risk of failure.
- Consider participating in relevant local or national audit programmes or peer review to bench mark outcomes against other similar provider services.

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 9 HSCA (RA) Regulations 2014 Person-centred care 1. The care and treatment of service users must- (c) reflect their preferences The provider was not meeting this Regulation because: Nurses were not informing patients 'anti-d' (used to prevent formation of antibodies) was a blood product derivative drug, so they could better consider their preference.

Regulated activity	Regulation
Termination of pregnancies	Regulation 11 HSCA (RA) Regulations 2014 Need for consent (1) Care and treatment of service users must only be provided with the consent of the relevant person. (2) Paragraph (1) is subject to paragraphs (3) and (4). (3) If the service user is 16 or over and is unable to give such consent because they lack capacity to do so, the registered person must act in accordance with the 2005 Act. (4) But if Part 4 or 4A of the 1983 Act applies to a service user, the registered person must act in accordance with the provisions of that Act. (5) Nothing in this regulation affects the operation of section 5 of the 2005 Act, as read with section 6 of that Act (acts in connection with care or treatment).

This section is primarily information for the provider

Requirement notices

The provider was not meeting this Regulation because:

The provider did not have effective protocols in practice for all patients including those who may lack capacity to, consent.

Regulated activity	Regulation
Termination of pregnancies	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment (1) Care and treatment must be provided in a safe way for service users. (2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include- (g) the proper and safe management of medicines; The provider was not meeting this Regulation because: Audit arrangements in place for medication particularly abortifacient medicines were not consistently robust. Nurses administered an intramuscular medication into an incorrect injection site. Nurses did not discuss with patients that 'anti d' (a blood product derivative drug used to prevent formation of antibodies) was manufactured from a blood product. The BPAS information leaflet did not disclose this information to the patient.