Marie Stopes International South London 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

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out this comprehensive inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned as part of our scheduled inspection programme.

Marie Stopes International (MSI) is part of the Marie Stopes International UK founded in 1976 to make family planning services available to women and men around the world. Marie Stopes is a specialist reproductive healthcare organisation and registered charity.

MSI South London provided medical and surgical termination of pregnancy services, screening for sexually transmitted diseases, contraception advice and counselling. The service was providing early surgical terminations between five and 14 weeks gestation and late surgical terminations between 19 and 23 weeks, plus six days. Medical abortions were undertaken up to nine weeks plus four days gestations. The service treated NHS and private patients.

We visited by announcement on 4 May 2016 and undertook an unannounced visit on13 May 2016. We also visited by announcement two early medical units (satellite) locations in Guildford and Waterloo on the 18 and 19 May respectively.

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, which it provides.

We report on whether the services are safe, effective, caring, responsive to people's needs, and well-led. We have highlight areas of good practice and areas for improvement.

Due to the number of concerns arising from the inspection of this and other MSI locations, we inspected the governance systems at the MSI corporate (provider) level in late July and August 2016. We identified serious concerns and MSI undertook the immediate voluntary suspension of the following services as of 19 August 2016 across its locations, where applicable:

- Suspension of the termination of pregnancy for children and young people aged under 18 and those aged 18 and over who are vulnerable, to include those with a learning disability
- Suspension of all terminations using general anaesthesia or conscious sedation
- Suspension of all surgical terminations at the Norwich Centre

MSI responded to the most serious patient safety concerns we raised and was able to lift the restrictions on the provision of its termination of pregnancy services at this location on 7 October 2016.

CQC also issued warning notices for breaches of the following regulations, which are relevant to this location:

Regulation 12 Care and treatment must be provided in a safe way for service users.

Regulation 20 A health service body must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity.

CQC is actively monitoring compliance with the above warning notices in order to ensure that services are operated in a manner which protects patients from abuse and avoidable harm.

Are services safe at this service

Improvements were required to ensure a safe service was consistently delivered.

- A formal incident reporting process was used by staff, which included investigation by designated staff external to the location. Learning from the investigation of adverse events, near misses and complaints was not evident. Staff could not provide any significant examples of such learning or changes in practices.

Summary of findings

- People who may have been affected by incidents were not always informed of this or provided with information related to the investigation or actions taken. The duty of candour regulations were not embedded in practice.
- Staff we spoke with understood their responsibilities for safeguarding children and adults. However, corporate safeguarding guidance was not sufficiently up to date, and did not reflect the latest requirements, and published guidance. This included the new Care and Support Guidance published in March 2016, chapter 14 of which replaces the 'No secrets' guidance.
- Clinical staff were not required to undertake the recommended level of safeguarding training, which did not reflect statutory guidance; 'Working Together to Safeguard Children. (2015). This references the intercollegiate document 2014, Safeguarding Children and Young People: Roles and Competences for Health Care Staff. Level 3 training is required of clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns.
- An adapted version of The World Health Organisation (WHO) 'five steps to safer surgery' was used in the operating department. However, a pre-operative briefing and post-operative de-brief was not always carried out.
- Expired and unused medicines were not disposed of correctly. The service did not provide staff with the correct disposal bins for expired and unused medicines. Medicines top up arrangements at satellite locations did not follow the corporate medicines management policy.
- Patients attending the service were assessed for suitability for treatment, and were monitored following surgical procedures.
- There were suitable transfer agreements with the local NHS to ensure patients who required higher levels of medical treatment had their needs met.

Are services effective at this service

The services provided at the location were not effective.

- Whilst most Required Operating Standards (RSOP) were generally followed, RSOP 14 and Royal College of Obstetricians and Gynaecologists guidelines related to consent were not sufficient. Adult and child consent for treatment was devolved to nurses and healthcare assistants, training of which was provided corporately. Questions raised by patients during the consent process could not always be answered due to a lack of knowledge. Further, this devolved responsibility meant the medical practitioners were not following the General medical Council (GMC) guidance with respect to deciding whether a young person was able to understand the nature, purpose and possible consequences of investigations or proposed treatments, as well as the consequences of not having treatment.
- Staff could access policies and procedures; however, they had not always been updated to reflect changes in national guidelines.
- Staff were encouraged to gain competencies in key skills through training. However, Mental Capacity Act (2005) training was not provided to staff, and some staff did not have a full understanding of this area.
- Revalidation and practising privileges were managed corporately, which meant the registered manager did not oversight of the medical personnel working at the service.
- The service provided good sexually transmitted infection (STI) screening and patients received comprehensive contraception advice. The service participated in regular monitoring to monitor patient outcomes such as individuals who did not proceed with treatment.
- Staff were able to explain fully the choices patients could make with termination decisions.

Summary of findings

- Patient outcomes were monitored, and benchmarked within the national group.
- Local audits contributed to the broader organisational monitoring of the quality and effectiveness of services.

Are services caring at this service

- Staff provided a good standard of treatment and care, and we observed staff presenting a kind, compassionate, and caring manner when responding to the needs of people using the service.
- Information was provided to individuals using the service in a range of formats, which enabled them to make informed choices.
- People were encouraged to feedback on their experience, and information was compared with other locations within the organisation. Results showed patients were happy with the service provided. Emotional support, including counselling was available to everyone.

Are services responsive at this service

We found the services available were not always responsive to the individual needs of people who sought treatment and care. This was because:

- Patients were not offered information about disposal of fetal remains, despite the Human Tissue Authority published guidance of March 2015, and the Royal College of Nursing guidelines, which state that, patients should be provided with options before their treatment.
- People experienced long waits on arrival for appointments and occasionally, several patients were booked for the same appointment times.
- Privacy was not always assured at satellite sites and waiting areas did not always have sufficient seating.
- The service was open between specific hours, and arrangements could be made to attend alternative locations outside of these hours.
- There were supportive systems available, including interpreters, and printed literature provided additional detailed information. Advice and counselling was part of the service.
- Complaints were acknowledged, investigated, and responded to within a specified time. Information arising from complaints was communicated to staff, although they could not provide any examples of learning from such feedback.

Are services well led at this service

Overall, the service was not well led but there were limitations to decision-making and local governance.

- The corporate vision and strategy underpinned the delivery of services, but not all staff were aware of the corporate goals.
- There was a corporate governance approach to leadership, which was hierarchical, and as a result, limited the decision-making processes at location level. Further, there lacked a degree of responsibility for managing risks, or for overseeing and challenging practices where these did not meet professional standards.
- Although there was a local risk register in place, which included some risks and mitigations, identification of actual and potential risk was not sufficiently robust. Therefore risk management was not actively addressed.
- There was low attendance from consultants at team meetings, which meant multidisciplinary involvement was limited.
- Staff felt proud to work for MSI and there was a positive culture of continuous professional development.

Summary of findings

- The Client Feedback Questionnaires produced good results and gave the company constructive feedback from those that had used their services.
- HSA4 forms were submitted and authorised within the Department of Health required time of 14 days following abortion.

Our key findings were as follows:

- Actions were required to ensure people using the service were informed where incidents that may have affected them were identified. The responsibilities of senior staff under the duty of candour regulation needed to be understood and acted upon.
- The overarching governance arrangements were insufficient. This had resulted in a lack of effective risk management, and the ability oversee required standards, or to challenge practices. This included compliance with the requirements of The Health and Social Care Act 2008, Code of Practice on the prevention and control of infections and related guidance or associated national guidelines.
- The limitations of training provided to staff meant consent procedures were not robust, and staff did not always have the required competencies for their roles and responsibilities. Further, staff had not completed level three safeguarding training, as outlined in statutory guidance; 'Working Together to Safeguard Children (2015), and the intercollegiate document 2014, Safeguarding Children and Young People: Roles and Competences for Health Care Staff.
- Staffing levels were appropriate for the level of activity. Where agency staff were used, they were subject to assurance checks and local induction.

We saw areas of good practice including:

- Staff we observed were kind, caring, and non-judgemental.
- The service had a good service level agreement with the local hospital and were able to transfer patients who required additional help.
- Patient's privacy was respected. They received a private consultation without anyone present, which afforded them the opportunity to talk through any issues in a safe environment.

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

Importantly, the provider must:

- Ensure an open and transparent approach to investigating adverse events and reporting on the findings includes individuals who may have been at risk. Correspondence must include a formal written apology.
- Address infection prevention control measures in line with national guidelines, so a consistent approach is adopted amongst all staff.
- Ensure theatres are treated and managed as a sterile environment by staff, and appropriate dress code is adhered to.
- Ensure safeguarding policies are updated to reflect current recommendations and professional guidance.
- Ensure safeguarding level three training is provided in accordance with professional guidance.
- Review and deliver comprehensive training on patient consent and ensure competency is assessed before delegating such responsibilities to nursing and healthcare assistants.
- Ensure the WHO safety checks include pre-operative briefing and post-operative debrief.

Summary of findings

- Ensure advanced life support training is provided to nursing staff.

In addition the provider should:

- Consider including anaesthetic risk assessments within pre-surgical reviews.
- Review records auditing to facilitate monitoring of compliance with consent processes.
- Provide information about fetal disposal to patients.
- Inform patients of the completion of HSA forms and what these records are used for.
- Enable registered managers to oversee the complaints process at location level in order that timely investigation and feedback can be cascaded to staff.
- Encourage consultant surgeons and anaesthetists to participate in location meetings, with a view to identifying and monitoring the quality of services delivered.
- Review the policy on disposal of pregnancy remains, to allow clients the choice of disposal, in line with the Human Tissue Authority's 'Guidance on the disposal of pregnancy remains following pregnancy loss or termination' March 2015.
- Review staffing at satellite clinics to ensure the safety of staff covering such clinics, and encourage the registered manager to undertake regular visits to such locations.
- Review adherence to the medicines management policy, with regard to the delivery of top up medicines to satellite locations.
- Provide a consistent approach to the offering and provision of counselling to all patients at consultation stage.
- The duty of candour and Mental Capacity Act (2005) should be embedded in the culture and training for staff.
- Allow local operation managers more empowerment to make decisions at their centres.
- Provide registered managers are provided with updated information to assure them of medical staff's fitness to practice, training, and re-validation.
- Review appointment-booking systems to avoid patients arriving at the same-booked time, and provide patients with information about waiting times.
- Review privacy arrangements, so that patients are not having their treatment in front of other clients.
- Consider how the waiting areas can be improved to accommodate expected numbers of attendees.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Overall summary

Overall, we found this was not a well-led service and improvements were needed to ensure a safe, effective, and response service. However, staff provided a good standard of care. This was because:

- The staff we spoke with understood how to report adverse incidents, errors, or near misses. They were aware that such matters would be investigated. However, actions required of staff to minimise risks to patients were not always addressed promptly.

Summary of findings

- Patients were not always informed where an incident occurred, which may have affected them. They did not always receive information about this or the outcome, including any actions taken. The reporting of serious incidents was not always made to the CQC.
- The duty of candour regulation was not embedded in the culture of the service. Staff were not sufficiently aware of the regulatory requirements, especially providing a written apology.
- Learning from the investigation of adverse events, near misses and complaints was not evident. Staff could not provide any significant examples of such learning or changes in practices.
- Staff did not undertake a pre-surgical brief or de-briefing following surgery. These practices are recommended as part of the World Health Organisation (WHO) 'five steps to safer surgery'.
- Infection prevention control (IPC) procedures did not adhere to The Health and Social Care Act 2008, Code of Practice on the prevention and control of infections and related guidance or associated national guidelines. Systems to manage and monitor the prevention and control of infection were not fully implemented and acted upon. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them. Further, systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection were not sufficiently robust. Staff did not follow correct IPC practices in the operating theatre with regard to dress code and use of personal protective equipment.
- Policies were accessible to staff but these did not always reflect the most recent professional guidance.
- Safeguarding policies were not up to date and did not include the latest requirements, and published guidance. This included the new Care and Support Guidance published in March 2016, chapter 14 of which replaces the 'No secrets' guidance. Additional guidance within the aforementioned document includes for example, coercion in domestic abuse, safeguarding adults training, and the Modern Slavery Act 2015.
- Although staff had completed the corporate mandatory required safeguarding training, they had not completed level three safeguarding training, in regard to statutory guidance; 'Working Together to Safeguard Children. (2015). This references the intercollegiate document 2014, Safeguarding Children and Young People: Roles and Competences for Health Care Staff. Level 3 training is required of clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns.
- Throughout the patient's pathway of care, they were not given information for the disposal of human remains, in line with the Human Tissue Authority guidelines March 2015. There was no evidence that discussions took place and staff told us they did not provide this option for patients, unless they raised the matter.
- There was no local pharmacist input into monitoring medicines optimisation or audit processes. Expired and unused medicines were not disposed of correctly, and there was no auditing check compliance with the required practice. Medicine top up arrangements at satellite locations did not follow the corporate medicines management policy in full.
- Staff were given induction training and additional training to specialise in areas of treatment, such as undertaking scans and providing contraception. However, staff did not receive training in the Mental Capacity Act (2005), and as a result had limited knowledge with regard to this matter.
- Required Operating Standards (RSOP)14 and Royal College of Obstreticians and Gynaecologists guidelines related to consent were not sufficient. Adult and child consent for treatment had been devolved to nurses and healthcare assistants. Questions raised by patients during the consent process could not always be answered due to a lack

of knowledge, which indicated training had not been sufficiently detailed. Further, this devolved responsibility meant the medical practitioners were not following the General medical Council (GMC) guidance with respect to deciding whether a young person was able to understand the nature, purpose and possible consequences of investigations or proposed treatments, as well as the consequences of not having treatment.

- With the exception of anaesthetic risk assessments, patients received nursing assessment of risks prior to procedures and following treatment.
- There was a corporate vision and strategy; however, staff were not fully aware of what this was and the part their role-played in the company's success.
- There was a lack of oversight of local professional practices, staffs adherence with professional guidance and monitoring of standards. Further, the location manager was not empowered to make decisions on behalf of the centre. Therefore, it was difficult for staff to be innovative and inspired.
- Lone workers at satellite sites often felt vulnerable when dealing with difficult situations. Staff were able to tell us of incidents where their safety was compromised.
- Appointments times were sometimes booked for several people. Waiting rooms were not always large enough to accommodate all attendees, and there were lengthy waits for planned appointments.

However positive findings included:

- Sufficient staff were available to support patients using the service. There was minimal use of bank and agency staff. Staff were able to work at different locations when demand was high, which allowed flexibility for staffing cover.
- An early warning score system was used to assess patients. Procedures were set up to transfer women to a local NHS hospital, should they deteriorate.
- Other Required Operating Standardswere generally followed by the staff, although such standards were not explicitly stated in the information we reviewed. Accessibility, gestational limits and treatment options, patient confidentiality, maintenance of equipment, counselling, and information provision broadly met the RSOP. The service also participated in regular monitoring to monitor patient outcomes such as individuals who did not proceed with treatment, failed abortion rates, and infections.
- Staff showed compassionate and kind care and treated clients with dignity and respect. Patients told us staff were understanding and non-judgemental.
- Staff generally respected the privacy of patients during their treatment and gave them time to make informed decisions. Patients were not pressurised and were given time to consider before consent was taken.
- Staff were mostly knowledgeable about medical and surgical treatment options, and were able to provide patients with the appropriate information. They had a comprehensive understanding of contraception and were able to offer choices and support patients with their decisions.
- Staff monitored individuals for pain and offered the appropriate pain relief when required. Staff would seek the advice of senior staff if they felt patients were becoming distressed.
- Staff told us they enjoyed working for Marie Stopes International. They liked working in different locations and felt they had the chance to develop their skills.
- The centre operated a six-day week service. Patients were offered a selection of appointment times to suit their needs. Flexible, alternative arrangements at other centres were available to accommodate their requirements. There were good arrangements in place for out of hour's access, with a 24-hour contact line available for individuals to use.
- A selection of information was available to patients, in the form of leaflets, booklets, the company's website, and face-to-face discussions with staff. Such advice included abortion treatment, the different types of contraception available, and support groups.
- People who used the service had the opportunity to provide feedback and offer suggestions for improvement.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Termination of pregnancy		Inspected but not rated. We have not provided the 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 which it provides. Although we do not currently have the powers to rate these services, we report on whether they are safe, effective, caring, responsive to people's needs, and well-led. We have highlight areas of good practice and areas for improvement.

Summary of findings

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Marie Stopes International South London

Services we looked at:
Termination of pregnancy

Summary of this inspection

Background to Marie Stopes International South London Centre

Termination of pregnancy (TOP) refers to the treatment of termination of pregnancy, by surgical or medical methods. Marie Stopes International (MSI) South London Centre is part of the provider group Marie Stopes International, a not for profit organisation that was founded in 1976.

The service was registered as a single speciality service for termination of pregnancy and was registered for the following regulated activities:

- Diagnostic & Screening Procedures
- Family Planning Services
- Treatment of Disease, Disorder and/or Injury
- Termination of Pregnancy
- Surgical Procedures

The services provided under these activities were:

- Pregnancy Testing
- Unplanned Pregnancy Counselling/Consultation
- Medical Abortion
- Surgical Abortion under Local or General Anaesthetic/Conscious Sedation
- Abortion Aftercare
- Miscarriage Management
- Sexually Transmitted Infection Testing and Treatment
- Contraceptive Advice
- Contraception Supply

We carried out this announced inspection as part of our inspection programme.

The Registered Manager for the location has been in post since 3 December 2015.

Our inspection team

Our inspection team was led by Stella Franklin, Inspection Manager, Care Quality Commission.

The team included a CQC inspector trained to carry out the inspection of termination of pregnancy services.

Why we carried out this inspection

We carried out this announced inspection as part of our inspection programme.

How we carried out this inspection

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

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

We have not provided the 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 which it provides

Summary of this inspection

Although we do not currently have the powers to rate these services, we report on whether they are safe, effective, caring, responsive to people's needs and well-led. We have highlight areas of good practice and areas for improvement.

Prior to the inspection, we requested a provider information report, the information submitted to the commission was analysed and considered both in the planning and as part of the evidence gathering process.

We visited by announcement on 4 May 2016 and undertook an unannounced visit on13 May 2016. We also visited by announcement two satellite locations, Guildford and Waterloo on the 18 and 19 May respectively.

During the initial visit we talked to three patients using the service, 15 clinical staff, including doctors, nurses, and health care assistants. We also spoke with administrative staff. We spoke with three staff during our other visits.

We made observation of the environment, checked equipment, and practices related to the delivery of services. This included reviewing documentation, computer records, and information displayed. We observed the interactions of staff with one another and the people who were receiving treatment and care. In addition, we reviewed 25 responses made via feedback cards left in the waiting area prior to and after our inspection visit.

Information about Marie Stopes International South London Centre

This location is registered with the Care Quality Commission as a provider of termination of pregnancy services. Registration began on 19 June 1989. The centre currently operates six days per week (Monday to Saturday).

The service prescribes and administers abortifacient medication for early-medical abortion, that is where a pregnancy is up to nine weeks and four days gestation. They also provided early surgical abortion, between five and 14 weeks gestation, using local or general anaesthesia and or conscious sedation. Surgical abortions were undertaken under general anaesthetic where the gestation was between five and 24 weeks. Late surgical abortions were performed from between 19 and 23 weeks, plus six days.

Surgical terminations under general anaesthesia or conscious sedation are performed Monday to Thursday and Saturday (late gestation lists Tuesdays and Saturdays). The service also offers contraception, screening for sexually transmitted infections and counselling for TOP clients.

Five early medical units (EMUs) known as satellite sites are linked to the Brixton location. These are located in Guildford, Greenwich, Lewisham, Croydon, and Waterloo. Medical termination and consultations in the early stages of pregnancy are provided at these satellite sites. All locations hold a licence from the Department of Health (DH) to undertake termination of pregnancy services in accordance with The Abortion Act 1967. Services are provided to both NHS and privately funded clients.

Patients of all ages except those of 12 and under are treated at all locations. The service was accessed by 12,114 patients between February 2015 and January 2016. Of the services provided, early medical abortion accounted for 2557 (22%) of activity, surgical abortion 9262 (78%) and there were 295 (2%) abortions after 20 weeks gestation.

Summary of this inspection

What people who use the service say

The three patients who spoke with us commented on the caring approach of staff. We were told how "nice" staff were, and of them being non-judgemental. One patient told us they had "definitely been treated with dignity and respect."

Patients told us they were provided with a good level of information to help them understand the choices available, and about the procedures. Where questions arose, staff responded to these.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found improvements were needed to ensure a safe service was consistently provided. This was because:

- Staff did not have access to the electronic database to report incidents and relied on the Operations Manager to take forward any reported incidents for investigation. Incidents were managed centrally rather than locally, which meant feedback was not timely.
- Although incidents were investigated, the reporting, sharing and learning of outcomes was not fully embedded in practice.
- There was a limited understanding with regard to being open and honest where mistakes happened. Patients involved in incidents were not always made aware of this, and as a result were not fully informed or provided with a written apology.
- Infection control procedures did not adhere to national guidelines. Theatre staff we observed did not wear the appropriate personal protective equipment during surgical procedures, and failed to follow their own theatre dress code policy. Staff did not always wear gloves or wash their hands when providing ultrasound scans to patients.
- Safeguarding policies were not up to date and did not include the latest requirements, and published guidance. This included the new Care and Support Guidance published in March 2016, chapter 14 of which replaces the 'No secrets' guidance. Additional guidance within the aforementioned document includes for example, coercion in domestic abuse, safeguarding adults training, and the Modern Slavery Act 2015.
- Although staff had completed the mandatory required safeguarding training, they had not completed level three safeguarding training, in regard for statutory guidance; 'Working Together to Safeguard Children,(2015). This references the intercollegiate document 2014, Safeguarding Children and Young People: Roles and Competences for Health Care Staff. Level 3 training is required of clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns.

Summary of this inspection

- An adapted version of The World Health Organisation (WHO) 'five steps to safer surgery' was used in the operating department. However, a pre-operative briefing and post-operative de-brief was not always carried out.
- Expired and unused medicines were not disposed of correctly. The service did not provide staff with the correct disposal bins for expired and unused medicines. Medicines top up arrangements at satellite locations did not follow the corporate medicines management policy.

However;

- Staff completed individuals records correctly and stored them safely in accordance to the Data Protection Act 1998.
- There was good understanding of safeguarding issues and staff knew who the safeguarding lead was.
- There was a good escalation process for the urgent transfer to an NHS trust.
- The environment was clean and clutter free and up to date checks had been made on all equipment.

Are services effective?

We found an effective service was not always provided. This was because:

- Whilst most Required Operating Standards (RSOP) were followed, RSOP 14 and Royal College of Obstetricians and Gynaecologists guidelines related to consent were not sufficient. Adult and child consent for treatment was devolved to nurses and healthcare assistants, training of which was provided corporately. Questions raised by patients during the consent process could not always be answered due to a lack of knowledge. Further, this devolved responsibility meant the medical practitioners were not following the General medical Council (GMC) guidance with respect to deciding whether a young person was able to understand the nature, purpose and possible consequences of investigations or proposed treatments, as well as the consequences of not having treatment.
- Whilst staff could access policies and procedures, they had not always been updated to reflect changes in national guidelines.
- Staff did not have a full understanding of the Mental Capacity Act (2005) and what it entailed. Although small booklets were available to staff, they did not receive training from the company.
- Staff were not provided with advanced paediatric life support.

We found however;

Summary of this inspection

- The service provided good sexually transmitted infection (STI) screening and patients received comprehensive contraception advice. The service participated in regular monitoring to monitor patient outcomes such as individuals who did not proceed with treatment.
- Staff were given induction training and additional training to specialise in areas of treatment, such as undertaking scans and providing contraception. Their development was encouraged.

Are services caring?

We found staff provided a caring service. This was because:

- Staff were caring, compassionate, and treated patients with dignity.
- Staff were non-judgmental and respected patients' decisions.
- Patients who attended the centre told us staff were understanding and kind.
- Counselling services were offered to individuals and brochures were available for patients to contact other supports groups.

Are services responsive?

We found staff needed to make improvements in order to provide a fully responsive service. This was because:

- Patients were not offered information about disposal of fetal remains, despite The Human Tissue Authority published guidance of March 2015 and the Royal College of Nursing guidelines, which states that patients should be provided with options before their treatment.
- People experienced long waits on arrival for appointments and occasionally, several patients were booked for the same appointment times.
- Privacy was not always assured at satellite sites.
- The waiting areas did not always have sufficient seating.

However;

- The service operated six days a week and patients were able to make contact 24 hours a day.
- Patients were provided with choice and flexibility with their appointments times. They could be seen at the location of their choice, usually at a suitable time.
- Translation services were available when required and an interpreter would be present through the patient's pathway.

Summary of this inspection

- Although complaints were not managed locally, they were managed well and issues were resolved as quickly as possible. Staff did not provide us with any information to indicate how they learnt from complaints, and we did not see any formal evidence to demonstrate learning from complaints.

Are services well-led?

We found the service was not well led.

- In particular, we had concerns about the lack of oversight of local professional practices, staffs adherence with professional guidance and monitoring of standards. The registered manager had a degree of reliance on assurance of standards through perceived staff competence, rather than reliable performance indicators.
- The governance arrangements was very organisational based and hierarchical. Local managers were well supported but were limited in the decisions they could make.
- Risk management arrangements were not sufficiently robust, and as a result, some risks were not identified or acted upon.
- There was lack of attendance from consultants at team meetings, which meant multidisciplinary involvement was limited.
- Although there was clear corporate vision and strategy, not all staff were aware of the corporate goals

However;

- Staff felt proud to work for MSI. There was a good culture of continuous professional development.
- Staff enjoyed the company's regional conference. They felt they were able to share their work experiences with other staff members and discuss ways of making improvements.
- The Client Feedback Questionnaires produced good results and gave the company constructive feedback from those that had used their services.

Termination of pregnancy

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

The service provided arrangements for consultations, screening, surgical procedures, and aftercare.

The day ward has three-day care beds, used for patients attending for treatment at a later gestation period. There are 10 reclining chairs available in the day ward, one operating theatre, with adjoining recovery area, and four rooms used for consultations and screening. There was a nurse discharge room within the ward.

There were six consultants covering the main premises in South London. Ten registered nurses were employed at the service and satellite centres. Seven staff provided administrative support.

The service was supported by satellite centres, which provided patients with access to nurse-led consultation and treatment rooms. Separate waiting areas were available at the locations visited. Surgery was not available at satellite locations.

The location was previously inspected under our former methodology on 12 March 2013, where it was found to be meeting all the required regulations.

Summary of findings

Overall, we found this was not a well-led service and improvements were needed to ensure a safe, effective, and response service. However, staff provided a good standard of care. This was because:

- The staff we spoke with understood how to report adverse incidents, errors, or near misses. They were aware that such matters would be investigated. However, actions required of staff to minimise risks to patients were not always addressed promptly.
- Patients were not always informed where an incident occurred, which may have affected them. They did not always receive information about this or the outcome, including any actions taken. The reporting of serious incidents was not always made to the CQC.
- The duty of candour regulation was not embedded in the culture of the service. Staff were not sufficiently aware of the regulatory requirements, especially providing a written apology.
- Learning from the investigation of adverse events, near misses and complaints was not evident. Staff could not provide any significant examples of such learning or changes in practices.
- Staff did not undertake a pre-surgical brief or de-briefing following surgery. These practices are recommended as part of the World Health Organisation (WHO) 'five steps to safer surgery'.
- Infection prevention control (IPC) procedures did not adhere to The Health and Social Care Act 2008, Code of Practice on the prevention and control of infections and related guidance or associated national guidelines. Systems to manage and monitor the prevention and control of infection were not fully

implemented and acted upon. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them. Further, systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection were not sufficiently robust. Staff did not follow correct IPC practices in the operating theatre with regard to dress code and use of personal protective equipment.

- Policies were accessible to staff but these did not always reflect the most recent professional guidance.
- Safeguarding policies were not up to date and did not include the latest requirements, and published guidance. This included the new Care and Support Guidance published in March 2016, chapter 14 of which replaces the 'No secrets' guidance. Additional guidance within the aforementioned document includes for example, coercion in domestic abuse, safeguarding adults training, and the Modern Slavery Act 2015.
- Although staff had completed the corporate mandatory required safeguarding training, they had not completed level three safeguarding training, in regard to statutory guidance; 'Working Together to Safeguard Children. (2015). This references the intercollegiate document 2014, Safeguarding Children and Young People: Roles and Competences for Health Care Staff. Level 3 training is required of clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns.
- Throughout the patient's pathway of care, they were not given information for the disposal of human remains, in line with the Human Tissue Authority guidelines March 2015. There was no evidence that discussions took place and staff told us they did not provide this option for patients, unless they raised the matter.
- There was no local pharmacist input into monitoring medicines optimisation or audit processes. Expired and unused medicines were not disposed of correctly, and there was no auditing check compliance with the required practice. Medicine top up arrangements at satellite locations did not follow the corporate medicines management policy in full.
- Staff were given induction training and additional training to specialise in areas of treatment, such as undertaking scans and providing contraception. However, staff were not provided with training in the Mental Capacity Act (2005), and as a result had limited knowledge with regard to this matter.
- Required Operating Standards (RSOP)14 and Royal College of Obstreticians and Gynaecologists guidelines related to consent were not sufficient. Adult and child consent for treatment had been devolved to nurses and healthcare assistants. Questions raised by patients during the consent process could not always be answered due to a lack of knowledge, which indicated training had not been sufficiently detailed. Further, this devolved responsibility meant the medical practitioners were not following the General medical Council (GMC) guidance with respect to deciding whether a young person was able to understand the nature, purpose and possible consequences of investigations or proposed treatments, as well as the consequences of not having treatment.
- With the exception of anaesthetic risk assessments, patients received nursing assessment of risks prior to procedures and following treatment.
- There was a corporate vision and strategy; however, staff were not fully aware of what this was and the part their role-played in the company's success.
- There was a lack of oversight of local professional practices, staffs adherence with professional guidance and monitoring of standards. Further, the location manager was not empowered to make decisions on behalf of the centre. Therefore, it was difficult for staff to be innovative and inspired.

Termination of pregnancy

- Lone workers at satellite sites often felt vulnerable when dealing with difficult situations. Staff were able to tell us of incidents where their safety was compromised.
- Appointments times were sometimes booked for several people. Waiting rooms were not always large enough to accommodate all attendees, and there were lengthy waits for planned appointments.

However positive findings included:

- Sufficient staff were available to support patients using the service. There was minimal use of bank and agency staff. Staff were able to work at different locations when demand was high, which allowed flexibility for staffing cover.
- An early warning score system was used to assess patients. Procedures were set up to transfer women to a local NHS hospital, should they deteriorate.
- Other Required Operating Standardswere generally followed by the staff, although such standards were not explicitly stated in the information we reviewed. Accessibility, gestational limits and treatment options, patient confidentiality, maintenance of equipment, counselling, and information provision broadly met the RSOP. The service also participated in regular monitoring to monitor patient outcomes such as individuals who did not proceed with treatment, failed abortion rates, and infections.
- Staff showed compassionate and kind care and treated clients with dignity and respect. Patients told us staff were understanding and non-judgemental.
- Staff generally respected the privacy of patients during their treatment and gave them time to make informed decisions. Patients were not pressurised and were given time to consider before consent was taken.
- Staff were mostly knowledgeable about medical and surgical treatment options, and were able to provide patients with the appropriate information. They had a comprehensive understanding of contraception and were able to offer choices and support patients with their decisions.
- Staff monitored individuals for pain and offered the appropriate pain relief when required. Staff would seek the advice of senior staff if they felt patients were becoming distressed.
- Staff told us they enjoyed working for Marie Stopes International. They liked working in different locations and felt they had the chance to develop their skills.
- The centre operated a six-day week service. Patients were offered a selection of appointment times to suit their needs. Flexible, alternative arrangements at other centres were available to accommodate their requirements. There were good arrangements in place for out of hour's access, with a 24-hour contact line available for individuals to use.
- A selection of information was available to patients, in the form of leaflets, booklets, the company's website, and face-to-face discussions with staff. Such advice included abortion treatment, the different types of contraception available, and support groups.
- People who used the service had the opportunity to provide feedback and offer suggestions for improvement.

Termination of pregnancy

Are termination of pregnancy services safe?

We found improvements were needed to ensure a safe service was consistently provided. This was because:

- Staff did not have access to the electronic database to report incidents and relied on the Clinical Operations Manager to take forward any reported incidents for investigation. Incidents were managed centrally rather than locally, which meant feedback was not timely.
- Although incidents were investigated, the reporting, sharing and learning of outcomes was not fully embedded in practice.
- There was a limited understanding with regard to being open and honest where mistakes happened. Patients involved in incidents were not always made aware of this, and as a result were not fully informed or provided with a written apology.
- Infection control procedures did not adhere to national guidelines. Theatre staff we observed did not wear the appropriate personal protective equipment during surgical procedures, and failed to follow their own theatre dress code policy. Staff did not always wear gloves or wash their hands when providing ultrasound scans to patients.
- Safeguarding policies were not up to date and did not include the latest requirements, and published guidance. This included the new Care and Support Guidance published in March 2016, chapter 14 of which replaces the 'No secrets' guidance. Additional guidance within the aforementioned document includes for example, coercion in domestic abuse, safeguarding adults training, and the Modern Slavery Act 2015.
- Although staff had completed the mandatory required safeguarding training, they had not completed level three safeguarding training, in regard for statutory guidance; 'Working Together to Safeguard Children,(2015). This references the intercollegiate document 2014, Safeguarding Children and Young People: Roles and Competences for Health Care Staff. Level 3 training is required of clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns.
- An adapted version of The World Health Organisation (WHO) 'five steps to safer surgery' was used in the operating department. However, a pre-operative briefing and post-operative de-brief was not always carried out.
- Expired and unused medicines were not disposed of correctly. The service did not provide staff with the correct disposal bins for expired and unused medicines. Medicines top up arrangements at satellite locations did not follow the corporate medicines management policy.

However;

- Staff completed individuals records correctly and stored them safely in accordance to the Data Protection Act 1998.
- There was good understanding of safeguarding issues and staff knew who the safeguarding lead was.
- There was a good escalation process for the urgent transfer to an NHS trust.
- The environment was clean and clutter free and up to date checks had been made on all equipment.

Incidents

- There were no Never Events reported at this service. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- The corporate Serious Incident Management Policy sets out the procedure for reporting and responding to incidents, categorising them and investigative process. It also indicated that team members who were involved in or carried out part of the investigation process must have documented evidence of their attendance at root cause analysis (RCA) training. The registered manager advised they had not had any RCA training but they had received low-level investigations training.

Termination of pregnancy

- Serious incidents were reported and investigated centrally, rather than at clinic level. This meant the review of incidents and cascade of learning and required actions might not always be as prompt as expected.
- There was one serious incident reported and requiring investigation during the period February 2015 and January 2016. This related to the unofficial supply and use of an item of non-sterilised surgical instrumentation. These individual instruments were used in 15 separate procedures, which became known when a member of nursing staff and the procurement officer noted an equipment issue. Subsequently it was identified one patient had been admitted to a local hospital with post procedure bleeding, (recognised as a possible complication of a Termination of Pregnancy procedure). We found the incident had been investigated and actions taken to avoid further occurrences. However, we found the investigative process had not included formal notification to all the individuals who were exposed to the potential risks associated with the use of non-sterilised instrumentation. Because individuals had not been made aware of the incident, the service could not be certain that none of these patients had been adversely affected.
- Staff who spoke with us explained how they completed a paper record for incidents and this was then sent to the manager, who uploaded the information to the electronic incident database, prior to investigation.
- We noted the incident form provided staff sections covering date, time and location and by type. Staff were required to describe the incident and any immediate actions taken. For example, we saw in information provided to us there were 20 clinical complicated incidents out of 769 post-operative patients for the period April 2015 to the end of April 2016. Such clinical complications included adverse response to medication, fainting, and prolonged pain. In addition, incidents included patients who did not have their procedure completed, or where an unplanned return to theatre occurred.
- We asked staff working in theatres how they learned from incidents, near misses and never events. They were not familiar with the term never event but indicated learning took place through regular monthly team meetings.
- Staff working at the satellite services we visited told us they received information via email and directly from managers where learning from adverse events or changes in practice was required. We were given an example of recent changes in the provision of simultaneous dosing of medicines used for early medical abortion.
- In response to examples of action taken because of learning from an incident or near miss, the consultant surgeon indicated more thorough checking had been introduced when calling individuals forward for treatment. This had been done because of the wrong woman responding to a name call, although this was identified before any treatment took place.

Duty of Candour

- The registered manager told us there had been discussion about the duty of candour at team meetings and the head of health and safety had delivered a session on this subject.
- Staff did not follow the statutory duty of candour requirements. For example, individuals were not always made aware when errors occurred, or about the outcome of investigation. They did not receive a written apology with information to indicate the actions taken by the service.
- Nursing staff in theatres were not aware when asked what the duty of candour was, despite the registered manager indicating they would have awareness. There was however, a degree of understanding about being open and honest when an error occurred, but nursing staff were not aware of the finer details, such as formally apologising in writing.
- The consultant surgeon explained how they would apologise directly as soon as an issue was identified. They added a report would be made via the electronic system and someone from head office would investigate the matter, although the investigation may include statements from staff.

Termination of pregnancy

Cleanliness, infection control and hygiene

- A director of infection prevention and control (DIPC), based at Marie Stopes head office was responsible for leading the organisation's infection prevention team.
- We looked at the formal Infection Prevention and Control (IPC) Strategy during our visit. This was for the period 2014/16, and it set out the roles and responsibilities, the arrangements for the IPC committee, monitoring of the strategy and reporting to the board.
- The location did not have any IPC link nurse at the time of our visit. IPC link nurses were said to be responsible for promoting good infection control practice in their work area with their colleagues, patients, and relatives. They were also responsible for undertaking infection control audits where required within their work area, for disseminating new infection control information to colleagues and act as a role model. Staff told us the Clinical Operations Manager handled all infection control issues.
- Infection prevention control (IPC) procedures did not adhere to The Health and Social Care Act 2008, Code of Practice on the prevention and control of infections and related guidance or associated national guidelines. Systems to risk assess, manage, and monitor the prevention and control of infection were not fully implemented and acted upon in the operating theatre.
- We found systems to ensure all care workers (including contractors and volunteers) were aware of and discharge their responsibilities in the process of preventing and controlling infection were not sufficiently robust. We observed staff working in the operating theatres were not following standard infection prevention and control precautions related to personal protective equipment. Theatre staff did not use an apron to protect their theatre clothing from potential contamination during procedures. We noted in the infection control committee meeting, 10 March 2016 minutes the entry 'staff must wear aprons and gloves' for invasive procedures.
- Nursing staff in theatres were seen to follow good hand hygiene practices, wearing gloves for procedures and hand washing between patients and nursing activities. However, nurses in consultation rooms did not wear gloves or wash their hands when giving clients ultrasounds. Gloves were provided to nurses on the wards but there was no provision of aprons.
- The Health and Social Care Act 2008, Code of Practice on the prevention and control of infections indicates uniform and work wear policies must ensure that clothing worn by staff when carrying out their duties is clean and fit for purpose. Particular consideration should be given to items of attire that may inadvertently come into contact with the person being cared for.
- Uniform and dress code policies should specifically support good hand hygiene. Theatre staff were not following recommended dress code practices, as outlined by The Association for Perioperative Practice. Whilst staff wore theatre clothing and shoes, they did not have their hair covered and staff were seen with long hair tied back and trailing down their back. It is best practice to have head and facial hair covered completely by a head cover/cap, as surgical site infections have been traced to organisms isolated from the hair and scalp. Although surgical terminations are not a sterile procedure, it would be an expectation that those undertaking the surgery should wear a hat. Headwear should be donned prior to surgery as this eliminates any possibility of hair or dandruff being shed onto theatre attire. Other staff should have their hair tied up.
- When theatre staff left the environment, they did not cover their theatre uniform with a clean over jacket or change into daywear.
- Non-theatre staff accessed the operating theatre to provide information to theatre staff but did not cover up their outdoor shoes. All staff who enter the restricted area of the theatre should wear the expected scrubs intended for the surgical area. If staff are required to leave the theatre without changing, fully fastened over jackets may be worn. However if this is accepted and authorised practice, then there must be arrangements made to ensure clean over gowns are available.
- We reviewed the dress code policy and noted it did not make specific requirement for staff to follow best practice guidance. However, we did note reference was made to non-clinical staff not entering the department when operational, unless wearing theatre attire, and visitors should have scrub clothing and clogs on.

- Although Infection control audits had been undertaken, we were concerned these audits did not identify the lack of proper dress code and use of personal protective equipment. We reviewed the audit results dated 27 April 2016, which indicated an overall score of 94%. The infection control audits included safe handling and disposal of sharps, use of personal protective equipment, gloves observed being worn and the environment. The associated action plan included the setting up of a clog cleaning station but did not refer to identifying staff not covering their hair or other concerns we identified.
- There was an onsite maintenance facilitator. They checked all equipment was functioning correctly and dealt with environment and equipment issues. For example, they checked the water systems were compatible to Health Technical Memorandum (HTM) 04-01 'the control of Legionella'. An outside company later tested this.
- All areas of the main premises we inspected were noted to be visibly clean. Cleaning instructions for the operating theatre were displayed. Staff confirmed they had responsibility for cleaning the theatre at the end of the day, and for ensuring technical equipment was cleaned. The recovery ward displayed hand hygiene instructions above the washbasin.
- Staff told us the owner of the building cleaned the satellite service at Guildford. The facilities were generally clean, although there were some splash stains on the wall, and dust on weighing scales. These were brought to the attention of the staff, who addressed the matter whilst we were on site. Staff told us cleaning of the services of the satellite site at Waterloo was arranged by the owner of the building. The environment and facilities there were clean and clutter free.
- The practice said they had an agreement with a contracted cleaning company but we did not see the agreement. We were told the logs for checks on cleaning were kept with the cleaning contractor and not with the practice. The cleaning company came once a day in the morning to clean the service and a deep clean of theatres was completed every three months. Service level agreements had been set up with external cleaning companies. Housekeeping supervisors and staff were responsible for ensuring cleaning was maintained to the required standard.
- There was appropriate segregation of clean and dirty waste, and safe disposal of clinical waste including sharp instruments and objects in all locations we visited. An external contract was set up for the collection of clinical waste. However, we did observe a sharps bin on the floor of a consultation room. It is best practice to have sharps bins wall mounted to prevent accidents and sharps injuries especially with young children.
- There was good access to hand washing facilities and hand decontamination products in all areas we visited. We saw hand hygiene notices displayed above the washbasins. NHS Infection Control guidance recommends that liquid soap dispensers should be wall mounted. In the recovery ward, we saw there were two above the sink; however, one of these was empty. Three refillable dispensers were not wall mounted.

Environment and equipment

- The operating theatre environment was suitably laid out, with separate areas for preparation of clean surgical items and a dirty utility room. The theatre was adjoined by a recovery area, with access to a lift. There were no separate anaesthetic room or scrub facilities.
- As standard, the theatre was equipped with oxygen and suction. Suction liners, suckers, and tubing for suction were disposable. Staff logged and made regular routine checks of this equipment.
- Equipment checked by us in theatres indicated the most recent service date and next date for safety checks.
- Staff working in the theatre took responsibility for checking equipment and we observed this taking place in practise, as well as records, which indicated checking processes had taken place regularly. The anaesthetist also undertook safety checks on the anaesthetic machine and associated equipment.
- Resuscitation equipment was accessible and had been checked by staff at the main location weekly. Resuscitation at the Guildford satellite location included suction and oxygen. There was no defibrillator on site. Resuscitation equipment was available at the Waterloo satellite site.
- We noted there was access to other emergency equipment, including post-operative haemorrhage kits, defibrillators, oxygen and general emergency equipment. In theatres, there was an airway emergency trolley, with a basic airway and advanced airway sections. Staff made routine daily checks of this

equipment and we viewed the records they kept of the checks. We noted that the laryngoscope blades were not single use. They were clean and packaged in sterile pouches.

- All equipment and environment checks were logged in a folder. A Clinical Operations Manager was responsible for ensuring the premises, environment and equipment were maintained and repaired to required standards in order to promote good infection control practice and ensure easy cleaning of clinical areas. They liaised with facilities personnel as required and external companies, ensuring the provision of hygienic and safe premises for team members and clients.
- The registered manager told us there was a service level agreement with an external provider for sterile surgical equipment. The service they provided was said to be generally good, although at times staff were inconvenienced when some items were not returned. We were advised no patients had been cancelled because of this.
- The main location had an on-site maintenance person, who was responsible for portable appliance safety testing, fire safety checks and technical equipment. They also undertook safety checks of equipment at the satellite sites.
- There were external arrangements for Legionella water testing and fire certification and we saw the paperwork that showed testing had taken place.

Medicines

- We were told by the registered manager medicines were obtained via the company procurement arrangements. A designated registered nurse was responsible for stock checks and for ordering top up supplies. These were seen by the registered manager, (who was aware of the required levels) before approval.
- Nursing staff told us medicines at the Guildford satellite site were re-stocked on a Friday, with a delivery from the main Brixton centre. These were said to be delivered in a secure container by administrative staff, although we were not able to witness this. However, we did note, the Medicines Management Policy, issued March 2013 indicated, all medicine were to be delivered in sealed containers, indicating the destination of the delivery and any hazardous warnings relevant to the medicines being conveyed. This delivery was to be carried out by the approved suppliers.
- A corporate service level agreement, dated 4 April 2016, was in use for the supply of prescription-only medicines, with appropriate dispensing labels.
- We saw medicines safety alerts were sent to all centres by MSI central office.
- There was no local pharmacist input into monitoring medicines optimisation or audit processes. However, we saw the audit results for February 2016 and noted 96.1% compliance had been achieved against a target of 100%. Areas requiring action had been identified, and included inconsistent temperature recording of the medicines storage room. The action plan indicated delegation of responsibility for this to the maintenance staff member. However, there was no indication as to who would cover this role in their absence.
- Medicines in the theatre department were stored safely within locked secured cupboards. Keys to these cupboards were only accessible via a secure coded storage container, secured to an internal wall.
- A stock of pain relief, contraception, anti-sickness, antibiotics, and abortifacient was held at the satellite sites we visited. These were stored safely and managed in appropriate stock rotation. However, such medication when needed was dispensed by the nurse.
- The minimum and maximum temperature of fridges used to store medicines were monitored and recorded to ensure medicines were kept at the required temperature. This practice happened at each location we visited. We did not see if there was a proforma available in the event of out of range recordings, although guidance with respect to this was included in the Medicines Management Policy, issued March 2013.
- Staff were observed undertaking stock checks of medicines, including two registered nurse checks with respect to the schedule 5-controlled drug, oramorph. This was stored in a controlled drug cabinet.
- Doctors using a secure electronic prescribing system prescribed medicines remotely. We saw details of the prescribed medicine and were informed of the procedures followed before administration. We were

told medicines used in the treatment of abortion were only prescribed and administered once the legal requirements for obtaining the opinions of two doctors that the abortion could go ahead were met.

- Staff told us they made sure patients whilst in their presence took prescribed abortifacient medicines.
- There was one medication prescribing error reported in February 2016. This related to a patient not being given an Anti-D injection. (This is given to a patient with RH D-negative blood following a termination of pregnancy).
- Health Technical Memorandum 07-01: Safe Management of Health Care waste requires colour coded sharps bins are used to dispose of out of date or unused medicines. Expired or unused medicines were not correctly disposed of, as they were disposed of in sharps bins designed for clinical or highly infectious waste, not the bins designed specifically for disposal of medicines. There was no evidence of any auditing of compliance with the required practice. This meant that there was a risk that medicines might be accidentally diverted or intentionally misused.
- The Medicines Management Policy, issues March 2013 states medicines will routinely be administered against a patient specific direction on the computer records system (CRS) or a PGD. Nursing staff at the Guildford satellite service told us they did not use any patient group directives and all medicines were prescribed by the remote doctor.

Records

- We reviewed both electronic and paper records during our inspection. The electronic records were comprehensive and used for every patient. Information included, initial consultation discussions, medical details, risk assessments, doctors input and patients consent and discharge information. The paper records were used for those patients who had surgical treatment. They provided details of pain medication and observational charts for the patient to be monitored. This information was also recorded electronically.
- Patient records and consent did not provide information on the disposal of fetal remains.
- Records completion audit had been carried out in January 2016, with a compliance score of 94.9% for the 30 sets of records reviewed. Areas that contributed to the deficit related to on-call booking, record of marital status, ethnicity, and language, which had not been recorded in any of the 30 records.

Safeguarding

- There were two safeguarding policies available to staff, including, The Safeguarding Children, Young People and Adults at Risk policy dated July 2104, for review July 2016, and Safeguarding Adults at Risk Policy, review date December 2016. Both policies referred to adults, children and young people, rather than having a separate policy for each patient group. Separate policies would have enabled specific and appropriate information to be included for each patient group. For example, information from Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children March 2015 provides specific guidance around a child centred approach of safeguarding children.
- Safeguarding policies had not been updated to reflect reference to the new Care and Support Guidance published in March 2016, chapter 14 of which replaces the 'No secrets' guidance. Additional guidance within the aforementioned document includes for example, coercion in domestic abuse, safeguarding adults training, and the Modern Slavery Act 2015.
- The policy in use at the time of our inspection did not make it clear about learning disability procedures, with reference to the named person and their contact numbers for raising concerns about an adult.
- Reference was made within the safeguarding policies to 'Working Together to Safeguard Children (DH 2010 and 2012)', both of which were out of date when the policy was created. Other elements of the policy did not set out the detailed requirements. For example, 'The Care Quality Commission must also be notified of all allegations and investigations against an employee of Marie Stopes International'. This should include notifications for example of abuse that are reported to the Local Authority in line with our regulations.
- There was an incorrect reference to training in the policy: 'In line with requirements from the CQC (2010) and the working documentation (Working Together to

Safeguard Children 2010, No Secrets 2000), all members of staff working for Marie Stopes International (UK base), will have a basic awareness, concerning the abuse of children and adults.

- Required Operating Standard (RSOP) 7 sets out a responsibility to have regard for statutory guidance; 'Working Together to Safeguard Children. (2015). This references the intercollegiate document 2014, Safeguarding Children and Young People: Roles and Competences for Health Care Staff. This sets out a competency framework, which includes a set of abilities that enable staff to effectively safeguard, protect, and promote the welfare of children and young people. Level 3 training is required of clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns.
- We were told by the registered manager the location had three nominated staff who acted as safeguarding leads. These included the registered manager, a healthcare assistant (HCA) and member of administrative staff.
- The registered manager told us the three lead staff had undertaken level 3 safeguarding training. In addition, we saw in the training matrix provided 15 staff had received safeguarding training at level 2. We were told the safeguarding level 2 training was the minimum level required for staff who had contact with children, young people, adults and parents or carers and who were in a position to identify concerns of maltreatment. Staff had to show they were able to act on concerns and contribute to MSI local and national policies, legislation, and procedures. The training was said to be delivered by an appointed trainer or safeguarding lead via a classroom setting.
- Staff told us safeguarding training covered both adults and children. In line with the corporate policy for safeguarding vulnerable children, young people and adults, training was said to have included child sexual exploitation and female genital mutilation (FGM), including recognising this. We did not see the content of the training programme to corroborate this.
- Staff had a good understanding of the identification of potential safeguarding concerns and for reporting this through the managerial line.
- We were told by staff they had received recent training related to Female Genital Mutilation (FGM) and they knew they had to report such issues to the police, where an individual was under 18, as well as raising safeguarding concerns.
- We noted from information provided, nine FGM notifications had been reported between October 2015, and the end of March 2016.
- Staff confirmed they had received training with respect to recognising and responding to female genital mutilation (FGM). They were able to explain how they would notify relevant people and agencies of this and the process for recording such matters.

Mandatory training

- Staff told us they were required to complete mandatory safety training in a range of subjects. This included manual handling, infection prevention and control, health and safety, fire, information governance and resuscitation.
- The registered manager told us the unit closed four times per year and on such days; staff were expected to complete training, such as basic and immediate life support.
- Training data provided for us indicated the majority of safety subjects had been completed by 100% of staff. There was one area where three staff (20%) required an update in basic or immediate life support (ILS).
- We were provided with information informing us all nurses were ILS trained, and the HCA's were BLS trained. We were told there would always be an ILS trained nurse within the satellite sites.
- We did not see any evidence of staff, including anaesthetists having advanced life support skills.

Assessing and responding to patient risk

- During consultation visits, patients were assessed for risks before any surgical activity. Patients were asked questions regarding heart conditions, diabetes, and asthma, history of thrombosis, epilepsy, and allergies.

The person's height and weight was taken as well as their blood pressure. If the BMI was above 35, patients were referred to the anaesthetist for further risk assessments.

- An ultrasound was undertaken for confirmation of gestation dates.
- The surgeon or anaesthetist did not see individuals pre-operatively, unless a request was made to do so by the nurse. For example, if a patient had a cold or was unsure of proceeding.
- Fitness assessments for anaesthetics were not routinely completed on all patients prior to general anaesthetic. The Association of Anaesthetists of Great Britain and Ireland (2010) safety guideline - 'Pre-operative Assessment and Patient Preparation The Role of the Anaesthetist' states 'Pre-operative anaesthetic assessment is an integral part of the surgical process.' Its purpose is to minimise risk for all patients, as well as identify patients at particularly high risk.
- With the agreement of patients, we observed and heard the completion of pre-operative checklist with the patient in the waiting area, prior to going into theatre. This was completed by the non-clinical co-ordinator and then by the theatre nurse checking the patient in. Checks included when the person last ate and drank, any allergies, the completion of a consent form and the type of anaesthetic they were to have.
- We asked staff what the arrangements were for following the World Health Organisations (WHO) Surgical Safety Checklist. This is a core set of safety checks, identified for improving performance at safety critical time points within the patient's intra-operative care pathway. There are three steps to this, including sign in, time out, and sign out. Two additional elements of safety include pre-operative briefing and debrief. The two members of theatre staff we spoke with had a clear understanding of the three steps, but did not know what the two additional steps were. Our observations in the theatre department indicated there was no pre-operative briefing or debrief taking place. We did not see any record of this either electronically or in paper form. However, we saw results of the records audit, which indicated 100% compliance with the safety checks, defined by the location as WHO surgical safety checklist.
- With regard to reducing potential of infection, we were told prophylactic antibiotics were used to cover uterine infection and chlamydia.
- Patients attending the service were encouraged to have screening for chlamydia as part of their treatment, but had the choice to decline this. Where such screening took place, staff told us negative results were sent to the patient by text message. Positive results were managed by phoning the person directly. They were asked at this point if they had taken the prophylactic antibiotics and advised their partner would need to be screened and treated before they resumed sexual activity. All staff we observed during consultations offered this choice to the patient.
- RCOG guidance for women seeking an abortion sets out in standard 6.0 that a risk assessment should be undertaken with respect to venous thromboembolism (VTE). The service reported 100% for VTE risk assessing patients who attended for a surgical abortion. We noted the VTE assessment was not included on the pre-operative checklist. However, we were told there was a separate form for recording the VTE assessment, although we did not see these during the review of patient records.
- Staff told us prophylactic (in case) medicines were not given to patients who were at risk after having the VTE assessment. At consultation, staff would ask patients' medical questions. The computer system would indicate a medical risk and the staff member would then contact a senior staff member, doctor, or anaesthetist for further instructions.
- Patients who had a surgical procedure were monitored in the immediate post-operative period by nursing staff to assess their recovery and fitness for discharge.
- We asked staff if there was a formal process used to monitor for signs of deterioration in patients who had surgery. The surgeon told us the ward staff monitored the patient blood pressure and used an early warning system for individuals who had their procedure at a later stage of pregnancy.
- The registered manager told us the staff used an adapted early warning score system. Staff increased

their observations of individuals where a change was noted. The decision to transfer a deteriorating woman was made early. The patient records we viewed showed the observational checks made by staff.

- We were told and saw evidence to support the information provided that a formal arrangement had been established for transferring deteriorating patients to a local hospital. There was a clear referral pathway to follow. Formal meetings took place between the location and the trust providing the service yearly, the most recent of which took place in April 2016. During the meetings, the transfers were reviewed for appropriateness.
- Nursing staff working at the Guildford and Waterloo satellite locations were trained immediate life support. The HCA had basic life support training.

Nursing and Health Care staffing

- The registered manager told us staffing arrangements for clinical services were based on activity, with flexibility in the workforce to rotate staff into consultation or theatre areas. We reviewed a range of duty rosters and noted staffing levels reflected the needs associated with increased theatre activity and in particular, where later gestation terminations were taking place.
- Staffing arrangements included cover for satellite services and we observed staff rotated into these areas.
- Working hours at the main Brixton centre were in the main 8am to 4pm, with some staff starting at 7.30am and finishing at 3.30pm or 8.30am until 4.30pm, depending on service needs. Staff confirmed they stayed later if there was a need to keep someone on the day unit, pending fitness for discharge.
- A registered nurse and healthcare assistant (HCA) covered the Guildford satellite services. A registered nurse covered the Waterloo service.
- The total number of shifts where agency cover was provided by registered nurses for the period November 2015 to January 2016 was 21. The last use of agency recorded on the duty roster was in February 2016.

Medical staffing

- Appropriate medical practitioners were available for the type of treatments being provided. The doctors were employed by the organisation, and were subject to professional checks at a corporate level. We did not see any evidence to substantiate this, as information about doctors was not held at local level.

Major incident awareness and training

- The registered manager advised there was an emergency backup generator, which was tested weekly, although we did not see the logged checks that were made.

Are termination of pregnancy services effective?

We found an effective service was not always provided. This was because:

- Whilst most Required Operating Standards (RSOP) were followed, RSOP 14 and Royal College of Obstetricians and Gynaecologists guidelines related to consent were not sufficient. Adult and child consent for treatment was devolved to nurses and healthcare assistants, training of which was provided corporately. Questions raised by patients during the consent process could not always be answered due to a lack of knowledge. Further, this devolved responsibility meant the medical practitioners were not following the General medical Council (GMC) guidance with respect to deciding whether a young person was able to understand the nature, purpose and possible consequences of investigations or proposed treatments, as well as the consequences of not having treatment.
- Whilst staff could access policies and procedures, they had not always been updated to reflect changes in national guidelines.
- Staff did not have a full understanding of the Mental Capacity Act (2005) and what it entailed. Although small booklets were available to staff, they did not receive training from the company.

We found however;

- The service provided good sexually transmitted infection (STI) screening and patients received comprehensive contraception advice. The service participated in regular monitoring to monitor patient outcomes such as individuals who did not proceed with treatment.

- Staff were given induction training and additional training to specialise in areas of treatment, such as undertaking scans and providing contraception. Their development was encouraged.

Evidence-based care and treatment

- We reviewed a range of policies and procedures, and spoke with staff in order to evaluate how the service ensured treatment was based on professional evidence.
- Required Operating Standard (RSOP) 9 relates to the gestational limits with respect to termination. We were told the maximum gestational age accepted for termination was 23 weeks and six days. The service prescribed and administered abortifacient medication for early-medical abortion, that is where a pregnancy is up to nine weeks and four days gestation. They also provided early surgical abortion, between five and 14 weeks gestation, using local anaesthesia and or conscious sedation, and general anaesthesia. Surgical abortions were undertaken under general anaesthetic where the gestation was between five and 23 weeks and five days. Late surgical abortions were performed from between 19 and 23 weeks and six days. The registered manager told us they did not do feticide, which is best practice for late surgical terminations. Late medical abortions were not undertaken. Professional guidance indicates two main surgical methods for TOP, which includes; vacuum aspiration, recommended at up to 15 weeks gestation and dilatation and evacuation (D&E), which is recommended where gestation is greater than 15 weeks.
- RSOP 2 relates to medical terminations including early medical abortion (EMA), delegation of duties and protocols. The provision of terminations at different gestation including early medical abortion (EMA). We were told different methods were available to terminate a pregnancy, depending on the pregnancy gestation. The medical method involved the use of the abortifacient drug Mifegyne (mifepristone, also known as RU486). Nurses were administering the drugs used for medical abortions, once these had been prescribed by a doctor. This was in accordance with the Abortion Act, which requires that only a registered medical practitioner (RMP) may carry out an abortion. However, provided the RMP personally decides upon, initiates, and takes responsibility throughout the process, the protection provided by the Act will apply to the RMP and to any other person participating in the termination under his or her authority.
- Staff told us all women underwent an ultra sound scan at the treatment unit to determine gestation of the pregnancy. However, this is outside the guidance issued by the RCOG, which states the use of routine pre-abortion ultrasound scanning is unnecessary (The Care of Clients Requesting Induced Abortion; Nov 2011).
- Blood was tested at the initial assessment to determine Rhesus factor and Anti-D immunoglobulin administered to clients who were found to be rhesus negative. This was in accordance with RCOG guidance 6.7
- RCOG guidance and RSOP 12: Contraception and Sexually Transmitted Infection (STI) Screening suggest information about the prevention of sexually transmitted infections (STI) should be made available and all methods of contraception should be discussed with women at the initial assessment, and a plan should be agreed for contraception after the abortion. The staff we observed offered all patients testing for chlamydia and other STI's. We saw staff take the appropriate tests with the clients consent. Staff discussed with patients the different methods of contraception available, and there was supporting literature available.
- Contraceptive options included Long Acting Reversible methods (LARC), which are considered to be the most effective, and are suggested by the National Collaborating Treatment unit for Women's and Children's Health.
- The organisation set key performance indicators (KPI) for individual staff to meet targets for patient uptake of contraception. Individual monthly results were displayed for staff to see. For example, we saw the target of 50% was not 39% in January 2016, down on the 43% achieved in January 2015. Certain staff told us they felt pressurised to meet these targets and did not like that information was displayed.
- We were informed the location monitored the efficiency of the service and other targets to ensure the service were sustainable and cost effective. Monitoring included adverse outcomes, such as infection and failed treatment to ensure these were in line with national statistics. We saw information, which indicated there

had been 10 transfers out because of complications, such as post-operative pain, and bleeding post operatively. We noted within Integrated Governance meeting minutes and team meeting training, discussion around performance, such as testing for sexually transmitted infections and procedures for doing so were covered.

- Staff told us and we saw that they adhered to The Royal College of Obstetricians and Gynaecologists (RCOG) guidelines for the treatment of women with specific conditions, such as ectopic pregnancy. The centre had a service level agreement with Kings College Hospital and patients with specific conditions were transferred to their care. We spoke with a member of staff at Kings College London who confirmed, they were satisfied with the transfer arrangements, and that Marie Stopes followed the correct procedures when transferring a patient. Marie Stopes' staff had been to the hospital for meetings and training.
- Discharge support was provided to all patients in the form of a 24-hour helpline should they feel the need to contact the service. We were told this service was maned by a registered nurse, provided corporately.

Pain relief

- RCOG 7. 14 states services should be able to provide surgical abortions without resort to general anaesthesia**.** Where general anaesthesia is not used conscious sedation should be available. (RCOG 7.15), and be undertaken by a trained practitioner. We observed both types of procedure were available. A designated anaesthetist was on duty and took responsibility for the management of patients care whilst having either method. We were unable to check out their professional qualifications, as records were not held on site.
- We asked the consultant anaesthetist about pain relief. They advised patients were offered paracetamol and a non-steroidal anti-inflammatory. They added paracetamol was sometimes given intravenously during the operation.
- The registered manager told us the most common form of pain relief provided was anti-inflammatory administered as suppository. Paracetamol was used a secondary choice and codeine phosphate where additional pain relief required. Pre-operative pain relief was said to be given to some women. In the wards staff were given instructions by the anaesthetists as to what type of pain killer patients were given and when.
- Staff observed patients hourly following their procedure to ensure they were pain free, and recorded a pain score on their paper records.
- We observed nursing staff asking patients about pain.

Patient outcomes

- The Required Standard Operating Procedure (RSOP) 16 relates to performance standards and audit. These should include rates of complications, prevention of infective complications and failure rates. We were told data on failed procedures was continually collected and analysed using a web based management system.
- On a quarterly basis, clinical reports were produced. We observed information, such as failure rate for surgery and medical treatments, infections, transfers out, and the reasons for doing so was included. These numbers were also converted into rates, which allowed the service to trend against previous results.
- In the previous 12 months, we noted from the data provided there had been 20 clinical complications out of 769 post-operative patients. This included four patients who fainted, three patients with prolonged pain, five adverse responses to medicine, and a number of unable to complete the procedure. There were two unplanned returns to theatre.
- Did not proceed rates for the first three months of 2016 ranged from 69% in January, 16% in February, and 20% in March. Between April 2015 and April 2016, 88 medical assisted and surgical TOP failed during this period, with retained products of conception or continuing pregnancy accounting for these.
- Following medical abortion patients were asked to ensure a pregnancy test was completed four to five weeks after their treatment to ensure that it had been successful. Patients were provided with two pregnancy tests and the date for when they should be taken was recorded on these. Staff told us it was the responsibility of the individual to take the test. If the test was positive, they were told to contact the one call centre number provided.

Competent staff

- We reviewed information on-site, which demonstrated new staff undertook a formal induction programme,

which included competency assessments, such as scanning and contraceptive implants. They also received and were tested in relation to service specific terminology, such as consent. Recently appointed nursing staff also confirmed the arrangements around their induction and training.

- We reviewed the doctor's induction file, which contained information related to the service, required forms, safeguarding and consent. We were not able to review any medical personnel records or evidence of their training, re-validation, or fitness to practice, as this was not held on site.
- Nursing staff told us they had been able to access additional training related to their roles. For example, a health care assistant had undertaken training in abdominal and transvaginal scanning. A member of nursing staff told us they were to have training in ultrasound dating and contraceptive implants.
- We were told but did not see any evidence that staff undertook training and assessment of competence in ultrasound scanning. For accreditation of first trimester scans under 13 weeks of pregnancy, staff were required to undertake 100 abdominal, 25 transvaginal scans and 15 abdominal scans over 13 weeks gestation. Staff told us for second trimester accreditation (from 13 to 27 weeks of pregnancy), they were required to undertake 50 scans of the baby's head and five scans of the placental site. A nurse who had recently completed their probationary period told us they had completed more than 100 abdominal scans and at least 25 transvaginal scans. They told us the training had been provided by Birmingham University, and they were mentored and assessed by the 'head of scanning'. We did not see any formal evidence to corroborate this.
- The RSOP 14: Counselling sets out that all the staff involved in pre assessment counselling should be trained to diploma level in counselling. Although we did not see any certificates to support this, we were told counsellors were diploma trained to level four and five in professional counselling. We were also told counsellors were members of the British Association for counselling and Psychotherapy and renewed their memberships annually.
- The service reported that all staff across grades and roles had received an annual performance review between the period of February 2015 and February 2016, and we saw records to corroborate this. We reviewed evidence of this process recorded on the electronic database. The appraisal process was noted to be based on corporate targets and values, with employees able to add in personal objectives and actions.
- Nurse revalidation requirements had been discussed with staff at the London team meeting and training delivered on the 8 April 2016. We noted from the minutes a message was conveyed of MSI supporting staff with revalidation but the ultimate responsibility was down to each registered nurse.

Multidisciplinary working

- Clinical and administrative staff worked well together as a team. There were clear lines of accountability set out in job descriptions, which contributed to the effective planning and delivery of care.
- There were established arrangements with the local trust for supporting the service where a patient required transfer. Annual meetings took place to review this and to discuss appropriateness of transfers.
- The service had links with the police, local safeguarding authority and GP to ensure appropriate support was available to patients who used the service.

Seven-day services

- RSOP 11 relates to having access to timely abortion services. We were told the Brixton centre operated six days per week (Monday to Saturday). Surgical terminations were performed Monday to Thursday and on a Saturday, (late gestation lists were held on Tuesdays and Saturdays). Medical terminations were offered six days per week.
- EMU, satellite services were accessible at the following locations: Marie Stopes International - Croydon Early Medical Unit, was open Monday, Wednesday, Friday- offering medical TOPs and consultations.
- Marie Stopes UK – Greenwich Early Medical Unit, opened Monday, Wednesday, alternate Fridays - offering medical TOPs and consultations.
- Marie Stopes UK Guildford, open Wednesday, and Friday- offering medical TOPs and consultations.
- Marie Stopes International - Lewisham Early Medical Unit, open Tuesday and Thursday- offering medical TOPs and consultations.

Termination of pregnancy

- Marie Stopes International – Waterloo Early Medical Unit, open Tuesday, Thursday, alternate Fridays (depending on demand) - offering medical TOPs and consultations.
- Contraception, screening for sexually transmitted infections and early medical abortion was available at the two satellite services we visited.
- RSOP 3: Post Procedure sets out that clients should have access to a 24-hour advice line, which specialises in post-abortion support and care. Women who used the service were provided with a 24-hour aftercare phone number. We were told this was serviced by registered nurses trained to assess clients over the phone and give advice.

Access to information

- Staff had access to a range of corporate policies and procedures, although these had not always been updated to reflect revised guidance or professional practices. Resource files were available at satellite sites visited.
- There was access to medicines formulary information.
- Patient records were accessible to staff.
- RSOP 3: Post Procedure recommends that wherever possible the woman's GP should be informed about treatment. Patients attending the service were asked if they wanted their GP to be informed by letter about the care and treatment they received. Their decisions were recorded and their wishes were respected.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- RSOP 8 relates to consent, including adults and individuals under the age of 16 years. Staff told us nurses and HCAs were able to obtain consent. We were told they attended formal training provided by head office and a paralegal presenter delivered this. We were told doctors signed off individual staff competence to understand and obtain the consent process.
- We saw information, which indicated an e-learning module related to consent had to achieve a 90% pass mark. Where an individual did not achieve this, they could re-take the test and if necessary received additional training.
- A range of consent forms were available, such as for Depo-Provera injection and medical treatment for early termination.
- The consent process involved providing patients with information as to the range of treatment options, failure rates, and possible complications. However, we were concerned when witnessing a HCA undertaking the consent process they were unable to answer one of the questions and had to leave the room. There was a potential risk of nursing or HCA not being able to respond to questions raised during the consent process.
- Staff explained how they used an under 16 years of age proforma framework to determine if the individual was Gillick competent, this took into account Fraser guidelines.
- Where a younger person under 16, attended a satellite service and they had not received face to face counselling, staff told us they could not proceed until they had this. Staff told us where an individual had learning disabilities, they would check out their ability to understand and make informed consent decisions. If they were not deemed able to do so they were informed that, they could not proceed and would be referred back to the main centre.
- We saw the nurses completed a checklist to assess whether a child under 16 was competent to give consent. The General medical Council (GMC) guidance is that the medical practitioner must decide whether a young person is able to understand the nature, purpose and possible consequences of investigations or treatments you propose, as well as the consequences of not having treatment. Only if they are able to understand, retain, use, and weigh this information, and communicate their decision to others can they consent to that investigation or treatment. That means the practitioner must make sure all relevant information has been provided and thoroughly discussed before deciding whether a child or young person has the capacity to consent.
- We heard staff obtaining verbal consent for carrying out ultrasound scans and transvaginal scanning. Consent was also heard being obtained for administration of medicines via the rectum.
- Although a medical records audit was undertaken, there was no separate audit of the completion of consent. The

registered manager told us the medical records audit would identify if there were issues related to consent. We saw results of the records audit for January 2016 showed a compliance rate of 95% and for March 2016, 98%.

- We were told the monitoring of consent processes was also taking place through the informal supervision processes. This involved spending time with individual staff and observing practice, as well as checking staff competence.

Are termination of pregnancy services caring?

We found staff provided a caring service. This was because:

- Staff were caring, compassionate, and treated patients with dignity.
- Staff were non-judgmental and respected patients' decisions.
- Patients who attended the centre told us staff were understanding and kind.
- Counselling services were offered to individuals and brochures were available for patients to contact other supports groups.

Compassionate care

- We observed nursing staff acting with kindness and compassionate in their interactions with patients in the operating theatre area. Attention was paid by staff to ensure each patient understood what was to take place and information and reassurance was offered. Nursing staff were seen to support each patient throughout the procedure, providing physical contact and appropriate use of verbal interaction.
- The nurse working at the Guildford satellite site demonstrated compassion and empathy when dealing with a distressed individual. Time was taken to ensure decisions were not made at a time when their emotions were in conflict. The nurse made sure they discussed the importance of having a referral for face-to-face counselling, and this was arranged at the time, with the agreement of the individual.
- The three patients who spoke with us commented on the caring approach of staff, how "nice" staff were and of being non-judgemental. One patient told us they had "definitely been treated with dignity and respect."
- Feedback through a patient satisfaction survey, (January – March 2016) for the Croydon and Guildford satellite services indicated 100% of respondents felt they were treated with dignity and respect. The response rates, however were low with 52 (30%) of patients providing feedback for Croydon and 13 (18%) of patients providing feedback for Guildford. The survey results for the period January – March 2016 for South London Brixton centre indicated 95% for this element of service with a response rate of 962 patients (39%).
- Prior to our inspection patient comment cards were provided for feedback. We received 25 patient feedback cards. Comments were positive regarding the care and information they received.

Understanding and involvement of patients and those close to them

- We were told by the three patients who spoke with us during the visit the staff had provided a good level of information to help them understand the choices available and the procedures. All aspects had been explained in detail and staff had checked individuals understanding. Where questions arose, staff responded to these.
- Staff interactions at each stage of the pathway indicated to us how they continued to check each patient's understanding and provided opportunities for questions or clarification.
- Patients were not informed of the statutory requirements of the HSA4 forms and where they were sent.

Emotional support

- Emotional support was offered by staff within the process of assessment and discussing their pathways.
- Counselling services were available to patients using the service and were offered to all individuals' pre and post treatment. Where a child was aged under, 16 they were required to have a counselling appointment on a day prior to their treatment.

- We heard staff offering counselling during the consultation with healthcare assistant. One of the patients who spoke with us confirmed they had been told there was access to a counsellor, should they wish to have this.

Are termination of pregnancy services responsive?

We found staff needed to make improvements in order to provide a fully responsive service. This was because:

- Patients were not offered information about disposal of fetal remains, despite The Human Tissue Authority published guidance of March 2015 and the Royal College of Nursing guidelines, which states that patients should be provided with options before their treatment.
- People experienced long waits on arrival for appointments and occasionally, several patients were booked for the same appointment times.
- Privacy was not always assured at satellite sites.
- The waiting areas did not always have sufficient seating.

However;

- The service operated six days a week and patients were able to make contact 24 hours a day.
- Patients were provided with choice and flexibility with their appointments times. They could be seen at the location of their choice, usually at a suitable time.
- Translation services were available when required and an interpreter would be present through the patient's pathway.
- Although complaints were not managed locally, they were managed well and issues were resolved as quickly as possible. Staff did not provide us with any information to indicate how they learnt from complaints, and we did not see any formal evidence to demonstrate learning from complaints.

Service planning and delivery to meet the needs of local people

- The services were operational six days per week, Monday to Saturday inclusive and were accessible to the local population and those from further afield. Patients could be self-referred or referred via the clinical commissioning groups, as an NHS patient.
- The service provided treatment options, which included, prescribing and administering abortifacient medication for early-medical abortion, that is where a pregnancy is up to nine weeks and four days gestation. They also provided early surgical abortion, for patients with a pregnancy gestation between five and 14 weeks. This was carried out using local anaesthesia and or conscious sedation. Late surgical abortions were performed from between 19 and 23 weeks and six days.
- Contraception, including long-acting reversible contraception (LARC) and sexually transmitted infection (STI) screening was available.
- Satellite locations provided services more locally for patients who met the criteria for early medical abortion and contraception.
- Local clinical commissioning groups (CCG) worked with the location in order to ensure NHS patients had access to the services.

Access and flow

- The service could be accessed via a 0345 telephone number, which was included in free call packages from landline and mobiles. Patients could also access the service by email, text, and website enquiry form. Appointment were designed to ensure short wait times and speedy access to the full range of services. A network of clinicians enabled the flexibility to re-arrange appointments at very short notice.
- RSOP 11: Access to Timely Abortion Services states, women should be offered an appointment within five working days of referral and they should be offered the abortion treatment within five working days of the decision to proceed. The service monitored its performance against the waiting time guidelines set by the Department of Health. The registered manager told us they received emails three times per week with information on the current wait times. Where the target was not achieved, the service was required to respond to the clinical operations manager with an action to address the delay, such as increasing clinics or theatre

sessions. We were told wait times would very rarely exceed three days. We were provided with an example of a report, which showed no patients had waited above the three-day target.

- There was a team of administrative staff who monitored and managed capacity on a daily basis. The service had a target to provide an appointment within three working days and they met this target. This meant patients were seen very quickly. Regular email information was communicated to the manager regarding appointments and it was rare for this time target to be exceeded, unless by the choice of the individual.
- First contact with the service included security questions and the allocation of an individual PIN number. Patients were then offered a telephone or face-to-face consultation in order to obtain a detailed medical and obstetric history.
- We reviewed formal guidance, which was followed by staff at the South London centre to determine eligibility for treatment. This was known as the 'Pre-existing Conditions' (PEC). Where additional information was required or a patient was not suitable for treatment, staff liaised with the respective GP with the patients consent.
- Capacity information was collected as part of the locations key performance indicators (KPI). We reviewed capacity reports for January to March 2016. With respect to access the location was expected to be accessible to people 95% of the time and achieved an opening time rate of 94% for January, 100% for February and 99% during March.
- Patient flow was a KPI with a target of 115 minutes per patient, from admission to discharge. The information we reviewed indicated efficiency in flow at the south London centre was achieved in January and February 2016, with an average of 109, and 113 minutes per patient respectively. The average for each patient was 126 minutes for March 2016.
- The number of pre-booked patients who did not attend the location in January was 60 (8%), February 54, (8%) and for March 52 (9%).
- Between 13 April and 28 October 2015, there were 17 occasions where the service was disrupted. Reasons included staff sickness, training, broken equipment and low uptake of patients.
- Staff told us that at busy times patients were often left sitting on the waiting room floor, due to lack of space.
- Patients were not always told that they would have to wait, sometimes up to two hours for authorisation for treatment.

Meeting people's individual needs

- The registered manager had undertaken a disability provision survey in September 2015, which considered the working environment for staff and accessibility for people wishing to use the service. We noted from this some actions had been identified; however, others, such as the provision of easy to read or different versions of documents for people had not been listed as something to be addressed.
- Staff told us they arranged face to face or telephone translation services when required. The former was said to be arranged when identified either through the GP referral or at the initial appointment arrangements. Theatre staff told us a translator would be able to stay for each part of the pathway, in order to ensure full understanding and to facilitate effective communication.
- Abortifacient medicines were administered using different timing options. Although they can be administered simultaneously over a six, 24, 48 and 72 hour period, at the time of the inspection they were either administered over 24, 48 or a 72 hour period, returning to a treatment centre to take the second abortifacient medication. Staff were heard to provide women with a choice and indicated the success rate with all methods.
- The Human Tissue Authority published guidance about the sensitive handling of pregnancy remains following pregnancy loss or termination in England, Wales, and Northern Ireland in March 2015. Royal College of Nursing Guidance was also available for staff to follow where the pregnancy, including medically or surgically induced termination of pregnancy ended before the 24th week of gestation. Guidance included the recommendation

that nursing staff ensure the patient knows, before the procedure, what her options are with regard to disposal of the pregnancy remains, and that her choice will be supported and respected.

- The guidance indicates that where a patient prefers not to make a decision about disposal, she should be informed what method of disposal will be used. Where an individual does not want to engage in any discussion about disposal, their position should be respected but they should be made aware that information is available to access, should she so wish.
- The service had a Management of Fetal Tissue Policy, which reflected some aspects of the RSOP 15, disposal of fetal tissue guidance, including storage and disposal of fetal tissue, and with respect to individuals who requested to view the fetal tissue. However, we found staff did not provide people with any information about disposal of fetal remains or burial of the fetus or fetal remains. Staff told us this area was not discussed with patients, unless they raised the subject themselves. There was no literature visibly available to patients to provide information about this area. Further, there was no awareness within the service of the Human Tissue Authority guidance on the importance of considering the needs and wishes of individuals
- Information provided to us in advance of the inspection indicated patients were informed of the options for fetal disposal on request but very few requested the information. A patient information leaflet was said to be provided, with details of the options available. The information also indicated patients were advised what documentation was required in order to procure a cremation or burial. Where possible (and with the clients permission), staff would also liaise with the funeral directors to facilitate as smooth a process as possible to alleviate stress.
- Fetal remains were stored in a container in line with guidance from The Human Tissue Authority.
- A 'Your treatment information' booklet was provided to women. This included details to inform them what to expect after the treatment, and included a 24-hour telephone number of where clients could seek advice if they were worried, and post-abortion counselling. There was no information about fetal disposal.
- Verbal information was provided by nursing staff regarding what to expect following treatment, the warning signs they needed to be aware of and when to contact the service urgently.
- Patients had access to a 24-hour aftercare telephone line that was covered by registered nurses. We were told nurses were trained to assess and provide advice over the telephone. Individuals could be booked back into our centres for further assessment if required.
- A range of leaflets were available, covering such topics as sexual transmitted infection, contraception and the Anti-D prophylaxis.
- There was information for support, in the form of leaflets for patients who were victims of domestic violence. Access to information about sexual health clinics was supplied in leaflet and booklet form, available in the reception and waiting areas.
- Patient appointment times were always accommodated. If a particular appointment was not available, an alternative at another centre was offered. However, feedback from comment cards indicated long waiting times.
- One feedback card mentioned a lack of privacy at the Croydon satellite and how they were made to take their tablets in front of other people in the waiting area. They said there were six other women with the same appointment time.

Learning from complaints and concerns

- RSOP 17 pertains to complaints and feedback. The service, including its satellite locations reported that 15 complaints had been received during the period April to December 2015. We noted from the information provided the majority of these were not upheld. One complaint indicated that it had not yet been processed. When we followed up on this, we were told and saw confirming evidence; the complainant had not provided the required information deemed necessary for investigating. This included their personal PIN number, which they were supplied with when they made contact with the service. We were told that without the PIN number, staff could not proceed with any investigation.
- The registered manager did not manage complaints at a local level. We reviewed the process for responding to these and the resulting information provided to complainants. Each complaint was acknowledged and

dealt with by a designated member of corporate staff. The response to individuals detailed each element of the complaint and provided direct information according to the patient treatment and care record. Where relevant reference was made to recorded discussion through the call centre. Each response contained a formal apology, in line with the duty of candour. Where necessary, the action taken to avoid similar concerns arising for others was included.

- Staff did not provide us with any information to indicate they learned from complaints and we did not see any formal evidence to suggest this either.

Are termination of pregnancy services well-led?

We found the service was not well led.

- In particular, we had concerns about the lack of oversight of local professional practices, staffs adherence with professional guidance and monitoring of standards. The registered manager had a degree of reliance on assurance of standards through perceived staff competence, rather than reliable performance indicators.
- The governance arrangements was very organisational based and hierarchical. Local managers were well supported but were limited in the decisions they could make.
- Risk management arrangements were not sufficiently robust, and as a result, some risks were not identified or acted upon.
- There was lack of attendance from consultants at team meetings, which meant multidisciplinary involvement was limited.
- Although there was clear corporate vision and strategy, not all staff were aware of the corporate goals

However;

- Staff felt proud to work for MSI. There was a good culture of continuous professional development.
- Staff enjoyed the company's regional conference. They felt they were able to share their work experiences with other staff members and discuss ways of making improvements.
- The Client Feedback Questionnaires produced good results and gave the company constructive feedback from those that had used their services.

Vision and strategy for this this core service

- Marie Stopes International (MSI) had a vision, core values, and strategy to deliver high quality care to promote good outcomes for clients and encompass key elements such as compassion, dignity, and equality. We found some staff were aware of the company's strategy while others were not. Staff told us regular newsletters, such as 'press in the news' and 'one' staff magazine provided updates on corporate goals, and we saw the vision of Marie Stopes displayed on posters throughout the centre.
- The registered manager advised us there was no local service related vision or formal strategy, but stated there was healthy competition between different locations with regard to the key performance indicators and financial targets.

Governance, risk management and quality measurement for this core service

- Legislation and regulations require that in non-NHS places, the place where termination of pregnancy is carried out must display a certificate of approval issued by the Department of Health. We observed the certificate of approval (issued by the Department of Health) was on display in the main reception area and the waiting room for theatre.
- We asked what the governance arrangements were and were told, MSI provided the centre with an integrated governance framework in line with the NHS governance agenda, and the CQC Essential Standards of Quality and Safety.
- The local governance arrangements were described by the registered manager. They included having a designated governance assistant who covered the location and that of central London. Their responsibilities included keeping polices up to date and keeping the 'Red' alerts, (feedback from clients) up to date. In addition, they oversaw the evidence folders related to complaints.
- We were told the corporate Integrated Governance Committee (IGC) met three times a year and reported

directly to the MSI Board. On a quarterly basis, the MSI UK Governance Support Team produced national clinical governance reports, which were shared with the location.

- Information provided in advance of the inspection indicated the 'Local IGCs' met four times a year. All local managers and nurses attended this meeting. However, there was a conflict in the information provided to us pre-inspection and that shared with us by the registered manager. We were told the governance meetings had changed in the past year from the previously held quarterly IGCs meetings to team meetings. We were told the team meetings included elements taken from the governance framework, such as complaints and incidents. Because the meetings were, only one and a half hours it was not possible to cover the whole framework, and therefore only certain sections were covered. They added teaching or updates with respect to policies or procedures may also be addressed at these meetings.
- We saw team meeting minutes, which showed various points of discussion were covered, ranging from contraception through to nurse revalidation, clinical waste and HSA forms. Other team meeting minutes reviewed indicated they were part of the integrated governance process. Agenda items included incident reports, feedback from people who used the centre and satellites, and infection control. We saw discussion took place as relevant around medicines and risk management.
- Monthly meetings were attended by all staff who were not working in the EMU. We asked if the consultants were attending these meetings and were told they were invited but not many attended. The consultant surgeon and anaesthetist on duty during the day of our visit confirmed there were local governance meetings. The surgeon advised they had not attended these. Both consultants told us there was no formal medical advisory committee but there was a doctors meeting, which took place at quarterly intervals, attended by two senior managers. They felt they had a voice and were listened to.
- We asked the registered manager how they were assured the staff were undertaking their duties and responsibilities in accordance with professional practices and local protocols. They told us they were assured by having confidence in the other staff running the service in their absence. For example, the lead nurse running a shift and supporting the non-clinical person in charge. They added there was a degree of reliance on staff alerting them of problems.
- We found there was a lack of oversight of adherence with some protocols. For example, how medicines top up to satellite sites was not carried out as per the corporate guidance.
- We asked if there were monitoring processes, which enabled them to measure risks and quality of the service. Information was said to be collected in a number of ways. This was said to include the 'did not proceed' report, incident reporting, and trending, which took place at corporate level. This would include for example, surgical complications, failed medical abortions. At a local level, they also identified certain outcomes. An example of which included three recent molar pregnancies. (This is an unsuccessful pregnancy, where the placenta and foetus do not form properly).
- A local clinical risk register was provided to us. There were no high risks listed. The centre had three medium risks identified with actions plans in place, but no dates as to when the actions would start or would be reviewed. The risk register recognised a need for policies to be updated, which we identified during our inspection. The risk register mentioned a need for a duty manager to be placed on the rota, so staff knew whom to contact in the absence of the registered manager. During our unannounced inspection, staff we spoke with knew who the duty manager was and how to contact them.
- Risks were not always discussed at the local Information Governance Meetings. Of the four sets of minutes we viewed from November 2015 to March 2016, risks were only discussed once. Further, risk management processes failed to identify potential and actual risks associated with staffs' failure to follow professional practices.
- RSOP 1 reflects the law for all TOP provision, and The Abortion Act 1967 regulates the provision of abortion services in England, Wales, and Scotland. If an abortion

is performed, which does not comply with the terms of the Act then an offence will have been committed under the Offences Against the Person Act 1861 and /or the Infant Life (Preservation) Act 1929.

- Legislation requires that for an abortion to be legal, two doctors must agree in good faith, the grounds for abortion in the Abortion Act are met and documented in a certificate of opinion. Arrangements were seen, which indicated certificate(s) of opinion known as HSA1 forms were signed by two medical practitioners in line with the requirements of the Abortion Act 1967 and Abortion Regulations 1991. The forms were signed and uploaded onto the electronic database.
- We observed in theatres the certificate(s) of opinion HSA1 were prepared with the stamped details of the consultant surgeon and anaesthetist. These were then signed by the two of them and indicated they had not seen the patient in advance of doing so. This was in line with the requirements of the Abortion Act 1967 and Abortion Regulations 1991.
- During our visit to the Waterloo satellite site, we saw the nurse obtain the HSA1 form for the patient, which had two separate doctors' signatures on it.
- The patient medical records audit process evaluated compliance with the arrangements to ensure the certificate(s) of opinion HSA1 were signed by two medical practitioners, in line with the requirements of the Abortion Act 1967 and Abortion Regulations 1991 and the subsequent arrangements for submission of HSA4 forms. The medical records audit for January 2016 indicated 100% compliance with HSA1 form completion.

Leadership

- The registered manager explained how aspects of leadership were managed at a corporate level through business support. This included doctor's rotas, checks with the General Medical Council, insurance, doctors training, appraisals, and revalidation. Information was communicated to the registered manager with respect to those who could prescribe and their induction.
- Staff working at the Guildford satellite site told us the registered manager did not visit the location on a routine basis. They said they were autonomous but were expecting to have greater links with a recently appointed district team lead. Support was available from the main centre and they received information regularly via emails, and by attending meetings, which included input from the registered manager.

Culture

- Staff displayed a compassionate and caring manner to the people using the service. They recognised it was a difficult decision for women to seek and undergo a termination of pregnancy.
- We were told by staff it was nice to work for MSI and the organisation was understanding and accommodating but expected a lot of staff. Staff working at the satellite site said they enjoyed coming into work and they felt proud to work there. They were passionate about the support they offered to women and the non-judgemental approach they took.
- Staff felt recognised and valued. They told us it was, the "little things" which made a difference, and managers were good at thanking them. There was a 'STAR' award, where nominations could be made or were received. A staff member from the Brixton location had been nominated.
- There was a culture of continuous professional development. Staff told us they had been able to discuss their ongoing aspirations and development and were supported to achieve these. Staff who we spoke with told us they felt confident to discuss service issues with the registered manager.

Public and staff engagement

- An external company was used to receive and interpret feedback from members of the public who had used the location. Anonymised Client Feedback Questionnaires (CFQ) with postage paid was given to each person who attended the service. These were either sent directly to the external organisation or left within the centre to be sent on for analysis.
- Completed CFQs were sent daily to the external company for analysis and urgent issues reported to the Governance team and Regional Manager within 24 hours. Reports were generated quarterly and the findings were discussed in team meetings.
- We reviewed feedback received from the main location and satellite services obtained between January and

March 2016. Overall care at the Croydon satellite site was rated as very good or excellent in 98% of responses. At the Guildford satellite service, the score for this was 100%, which compares to 95% nationally.

- An employee engagement survey had been conducted in 2016. This obtained the feedback from 17 staff working at the location for a range of questions. We noted 17.6% of staff had worked for the service for more than 10 years; almost 6% had worked in excess of 20 years. Just fewer than 60% of staff were satisfied with MSI UK and 17.6% were strongly satisfied. More than 40% of staff indicated either they strongly agreed or agreed they were proud to work for MSI UK. 64.7% of respondents strongly agreed they were committed to MSI UK goals.
- A regional conference was held in December 2015 where staff met with colleagues from other MSI UK centres. They were given the opportunity to engage and feedback on practices. A member of staff who had attended found the event was very useful and they had a clear vision of what was expected of them and was able to participate in team discussions.

Innovation, improvement and sustainability

- There were no examples provided by staff indicating innovative practices or improvements. Staff were focused on providing an accessible service, which recognised the needs of women and younger females.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The service must ensure an open and transparent approach to investigating adverse events and reporting on the findings includes individuals who may have been at risk. Correspondence must include a formal written apology.
- Ensure local management provide full oversite of the systems and processes to be adhered to by staff, and monitoring of required practices is undertaken.
- Ensure all risks are identified and mitigation of these risks are made clear, with target dates for review or resolution.
- Address infection prevention control measures in line with national guidelines, so a consistent approach is adopted amongst all staff.
- Ensure theatres are treated and managed as a sterile environment by staff, and appropriate dress code is adhered to.
- Ensure safeguarding policies are updated to reflect current recommendations and professional guidance.
- Ensure safeguarding level three training is provided in accordance with professional guidance.
- Review and deliver comprehensive training on patient consent and ensure competency is assessed before delegating such responsibilities to nursing and healthcare assistants.
- Ensure the WHO safety checks include pre-operative briefing and post-operative debrief.

Action the provider SHOULD take to improve

- Consider including anaesthetic risk assessments within pre-surgical reviews.
- Review records auditing to facilitate monitoring of compliance with consent processes.
- Provide information about fetal disposal to patients.
- Inform patients of the completion of HSA forms and what these records are used for.
- Enable registered managers to oversee the complaints process at location level in order that timely investigation, and feedback can be cascaded to staff.
- Encourage consultant surgeons and anaesthetists to participate in location meetings, with a view to identifying and monitoring the quality of services delivered.
- Review the policy on disposal of pregnancy remains, to allow clients the choice of disposal, in line with the Human Tissue Authority's 'Guidance on the disposal of pregnancy remains following pregnancy loss or termination' March 2015.
- Review staffing at satellite clinics to ensure the safety of staff covering such clinics, and encourage the registered manager to undertake regular visits to such locations.
- Review adherence to the medicines management policy, with regard to the delivery of top up medicines to satellite locations.
- Provide a consistent approach to the offering and provision of counselling to all patients at consultation stage.
- The duty of candour and Mental Capacity Act (2005) should be embedded in the culture and training for staff.
- Allow local operation managers more empowerment to make decisions at their centres.
- Provide registered managers with updated information to assure them of medical staff's fitness to practice, training, and re-validation.
- Review appointment-booking systems to avoid patients arriving at the same-booked time, and provide patients with information about waiting times.
- Review privacy arrangements, so that patients are not having their treatment in front of other clients.
- Consider how the waiting areas can be improved to accommodate expected numbers of attendees.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control • Staff working in the operating theatres were not following recommended dress code practices, as outlined by The Association for Perioperative Practice. Hair was not always covered or sufficiently secured when long. • When theatre staff left the environment they did not cover their theatre uniform with a clean over jacket or change into day wear. • Theatre staff did not use an apron to protect their theatre clothing from potential contamination during procedures. • Non-theatre staff accessed the operating room to provide information to theatre staff but did not cover up their outdoor clothes or shoes, as per the local policy. • The scrub sink facilities in the theatre were not appropriate. The hand wash basin was not located away from the area containing laid-up instrument trolleys in order to prevent water contamination.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour • Patients who may have been harmed as a result of an adverse incident were not contacted and made aware of this. They were not informed of the investigation, the findings of this, and any actions taken to prevent similar occurrences. Patients did not receive a written letter containing an apology.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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