Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

The Bridge Centre

1 St Thomas Street, London Bridge, London, SE1 9RY

Tel: 02070891431

Date of Inspection: 26 November 2012

Date of Publication: January 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Management of medicines	✓ Met this standard
Staffing	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	The Bridge Centre Limited
Registered Managers	Mr. Mohamed Menabawey Ms. Deidre Myburgh
Overview of the service	The Bridge Centre provides in vitro fertilisation (IVF) and other fertility treatments. In January 2012 The Bridge Centre entered into a management agreement with JD Healthcare Limited. The Centre is licensed by the Human Fertilisation and Embryology Authority (HFEA), the independent regulator of treatment using eggs and sperm, and of treatment and research involving human embryos. .
Type of service	Acute services without overnight beds / listed acute services with or without overnight beds
Regulated activities	Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

	Page
Summary of this inspection:	
Why we carried out this inspection	4
How we carried out this inspection	4
What people told us and what we found	4
More information about the provider	5
Our judgements for each standard inspected:	
Consent to care and treatment	6
Care and welfare of people who use services	7
Management of medicines	9
Staffing	10
Assessing and monitoring the quality of service provision	11
About CQC Inspections	12
How we define our judgements	13
Glossary of terms we use in this report	15
Contact us	17

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, reviewed information sent to us by other organisations, carried out a visit on 26 November 2012 and talked with people who use the service. We talked with staff and talked with stakeholders.

What people told us and what we found

We looked at the Human Fertilisation and Embryology Authority (HFEA) report of their April 2012 inspection of the Bridge Centre before our visit to the Centre and discussed the findings with the HFEA inspector. Our inspection focused on the procedures, such as egg collection, which were undertaken in the day centre unit.

We selected three sets of records on the day of our inspection, which the woman, and their partner when appropriate, had given consent to share. We spoke with one woman who had undergone a procedure.

The woman told us the nurse and the doctor involved in her care discussed the procedure so that they were able to give informed consent. She appreciated this thorough approach and said that it meant there were "no questions unanswered".

People's medical history was obtained before any treatment was given and more information was obtained when health issues were identified. There were checks before, during and after the procedure, recorded in a patient care plan, to protect people from unsafe or inappropriate care.

Anaesthetic drugs were recorded appropriately and stored safely.

There were systems in place to check that staff were appropriately skilled and that there were rotas for different groups of staff to make sure there were sufficient numbers on duty.

We found evidence that complaints and incidents were discussed and these were taken into account to improve the service.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

Reasons for our judgement

People undergoing treatment had a consultation with a doctor, and information sessions with a nurse before they signed a consent form. A woman who had undergone a procedure told us the nurse and the doctor involved in her care discussed the procedure so that they were able to give informed consent. She appreciated this thorough approach and said that it meant there were 'no questions unanswered.'

The records we looked at contained consent forms signed by the woman, and her partner when appropriate.

The evidence we collected corroborated the views of people using the service given at the HFEA inspection. People considered that they were given sufficient time to discuss their proposed treatment plan prior to giving consent.

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

Care and treatment were planned and carried out in a way that was intended to ensure people's safety and welfare.

The person's medical history was obtained before any treatment was given and more information was obtained when health issues were identified. There was evidence in the records of these checks. The Consultant Gynaecologist we spoke with said the Centre contacted the woman's GP and/or specialist if the woman had a health condition to make sure the condition was well controlled before treatment began. Some women with health problems were advised to go for treatment in a hospital setting and women with high BMI were not treated. There was a multi-disciplinary meeting every week at which there was an opportunity to discuss complex cases and reach a collective decision about treatment.

The provider had processes in place to protect patients from inappropriate or unsafe care and treatment when they underwent procedures, such as egg collection, in the day centre unit. There were checks before, during and after the procedure, recorded in a patient care plan.

Nursing staff described the pre-operative checks, such as weight, blood pressure, identification of any allergies, medical problems, anaesthetic problems, and any medication, alcoholic drinks and food taken within the last 24 hours. An agency anaesthetist who regularly worked at the Centre described how he checked the patient was fit for anaesthesia and decided on the most suitable drug and technique for sedation before the procedure. He checked the theatre equipment and made sure that the appropriate drugs to counteract the effect of sedation were available if needed. The Consultant Gynaecologist saw the patient before the procedure began.

Nursing staff also made a record of the procedure, including the names of staff attending and the anaesthetic equipment used. There was a count of swabs, needles and blades used during the procedure and a signature was required to say the count at the end of the procedure had been checked and was correct.

The provider might find it useful to note that these checks did not include all those included on the World Health Organisation (WHO) surgical safety checklist, an internationally recognised process for optimising the safety of surgical procedures. For example, we were told there was routine antibiotic prophylaxis given prior to procedures, but there was

no check that this had been administered. In addition, there was no "time out" at the point the patient was taken into theatre during which all members of the multi-disciplinary team had the opportunity to share information and discuss any anticipated problems.

Post-operative checks were undertaken by the nurse to ensure that the patient was stable during recovery, and clear information was provided to the patient to ensure self-assessment of recovery once discharged.

People's care and treatment was planned and delivered in a way that protected them from unlawful discrimination. Information in the records and from discussions with staff corroborated the HFEA findings on their inspection that care and treatment was provided in a non-discriminatory manner.

There were arrangements in place to deal with foreseeable emergencies in the day centre unit. There was emergency resuscitation equipment and there was evidence that these were regularly checked. There was regular training in life support for all clinical staff. Anaesthetists had access to emergency airway equipment if required during the procedure. There were also arrangements to transfer people to a nearby acute hospital if they became unwell.

Management of medicines ✓ Met this standard

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with anaesthetic drugs during procedures because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

There were arrangements in place for recording of drugs used in the day centre unit. A new batch of the controlled drugs used for sedation during procedures was only ordered when supplies were needed, and the delivery was recorded, with a running total, and signed for by two nurses. There was also evidence of frequent reconciliation of the controlled drugs in stock, undertaken by two nurses. There were regular audits of the records of controlled drugs.

There were monthly stock takes of all other drugs, including those in the emergency resuscitation equipment bag. Those which were out of date were disposed of appropriately.

Medicines in the day centre unit were kept safely in a separate lockable room. Controlled drugs were locked in a separate cabinet in the room.

There was evidence in the recording book for controlled drugs of difficulties with supply in the past. We were told that the nurse responsible for checking stocks now contacted the central purchasing department to order drugs. A nurse manager had been given responsibility for ensuring that drug supplies were adequate. There had also been a decision to no longer store a sedative associated with risks of breathing problems following an adverse incident when this drug was used.

Staffing ✓ Met this standard

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

There were appropriate systems in place to ensure that there was adequate staffing and that staff were appropriately skilled.

There had been changes to the medical staff in the last year, and most consultant gynaecologists were now employed directly by the Centre. The person responsible for the rota for the consultants told us how she worked with the medical staff to ensure that all aspects of care and treatment were covered every day. The lead clinician for the Centre had responsibility for ensuring all medical staff completed the General Medical Council revalidation process.

The nurse co-managers were responsible for organising the rota for nursing staff. There was a nursing competence assessment framework, and there was evidence in staff files that the managers used a competency list to check that nurses were appropriately skilled. The nursing staff files we reviewed contained details of the induction programme for new staff and annual appraisals. Nursing staff were able to access courses for their professional development.

Anaesthetists were generally supplied by an agency. There was a rota so the Centre knew in advance which anaesthetist would attend each day, and we saw from the month's rota that most of these attended regularly. We were informed that there had been changes to the agreement with the agency to make sure there were no last minute changes and that anaesthetists arrived on time.

There had been occasions when an anaesthetic nurse practitioner took part in procedures and administered sedation. We were told there was a job description for this post and that there were clear protocols for when the nurse was allowed to work alone without supervision by an anaesthetist.

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service and others.

Reasons for our judgement

The Quality Assurance Coordinator for the JD Healthcare group described the improvements to systems for assuring the health, safety and welfare of people using the service in recent months. There were clear lines of accountability for quality assurance. Each department at the Centre, such as nursing and the laboratory, had regular meetings and reported to the quality management group. This group reported to the clinical governance committee of JD Healthcare.

There was a weekly complaints review meeting and the time of response to complaints, which had been high in 2011, had reduced in recent months. There was the expectation that the Centre would take account of complaints and comments to improve the service and actions were noted in the notes of meetings. People using the service were asked to complete questionnaires on their experience of using the service.

There was evidence of improved understanding of the importance of reporting and learning from incidents. There was now centralised oversight of incidents and the expectation that investigations carried out locally should identify corrective action and preventative action (CAPA). We were given an example of sharing CAPA across the fertility centres run by the group.

Decisions about care and treatment were made by the appropriate staff at the appropriate level. The organisational chart showed the accountability structure for all staff groups. We were told the clinical lead was reinforcing the Consultant Gynaecologists' responsibility for treatment decisions, including the procedures undertaken at the day centre unit.

The audits provided by the Centre to the HFEA documented findings and corrective actions if needed. The HFEA found at their inspection of April 2012 that the centre has made significant progress since the previous inspection. The centre's licence had been renewed for a period of four years without additional conditions. Further evidence of action taken to address areas identified for improvement had been provided to the HFEA in October 2012.

The centre had an ISO Quality Management System (QMS) certification and an audit of the QMS in November 2012 found there were no areas of non conformity.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk