Hull University Teaching Hospitals NHS Trust

Hull Royal Infirmary

Inspection Report

Anlaby suite,
Hull Royal Infirmary,
Anlaby Road,
Hull,
HU3 2J2.

Date of inspection visit: Desk top inspection 26 May 2020
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Overall summary

We carried out a focused desktop inspection on the Child Sexual Assault Assessment Service provided by Hull University Teaching Hospitals NHS Trust at the Hull Royal Infirmary in May 2020. Under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions.

We carried out this inspection to follow up on the S29a Warning Notice issued following our inspection in January 2020

We do not currently rate services provided in sexual assault referral centres.

Background

Hull University Teaching Hospitals NHS Trust (HUTHT) is commissioned by NHS England, to provide a Child Sexual Assault Assessment Service (CSAAS) for the Humberside Police area in East Yorkshire, Hull, North Lincolnshire and North East Lincolnshire, for children aged 16 and under and for 17 to 18-year old young people with vulnerabilities. The CSAAS is known as the Anlaby Suite. The CSAAS covers core hours, outside of these hours, the service is provided by other organisations.

The service provides medical and forensic assessment of children and young people who have experienced sexual abuse at the request of Humberside Police and Local Authorities' Children's Services. The holistic medical examination includes sexual health assessment, contraception if required, sexual health screening and treatment where clinically indicated.

The service is delivered from within a standalone building in the grounds of Hull Royal Infirmary. The building is accessible for children and young people with disabilities. The accommodation includes one forensic suite, with an adjoining shower room and waiting room. In addition, there are more comfortable interview rooms and a children's play room.

The team includes a service manager, a clinical lead nurse, two full time registered nurses, four doctors and one administrator.

We last inspected the service in January 2020 when we judged the trust needed to make significant improvements regarding the quality of healthcare. We issued a S29a Warning Notice.

The report on the comprehensive January 2020 inspection can be found on our website at:https://www.cqc.org.uk/location/RWA01

This desk-based inspection was conducted by one CQC health and justice inspector and included a review of evidence and a teleconference with the service manager and lead nurse.

Documents we reviewed included:

- The trust's action plan in response to our Warning Notice
- Temperature logs for where medicines were stored
- Standard Operating Procedures for forensic cleaning and medicine stock

Summary of findings

- Photographs of the examination suite, equipment, toys and rooms following forensic cleaning
- A sample of log books for monitoring the forensic cleaning
- Leaflets and information available to children and young people

We did not visit the service to carry out an inspection due to the COVID -19 pandemic. However, we were able to gain sufficient assurance through the documentary evidence provided by the trust.

The inspection focused on the areas set out in the S29a Warning Notice issued to the trust on 14 February 2020.

At this inspection we found the following improvements:

- A service specific self-harm and suicide risk assessment had been developed for the premises
- Managers had implemented a standard operating procedure and staff guidance for forensic cleaning
- There was an effective system to monitor and maintain appropriate room temperatures in areas where medicines were stored
- Managers ensured staff carried out effective decontamination procedures and checked their effectiveness
- Arrangements to support the communication needs of all children had improved
- Staff demonstrated that children and young people could be examined by a male or female physician and that a choice was given.
- A service specific competency programme enabled managers to assess staff.

Summary of findings

The five questions we ask about services and what we found

We asked the following question(s).

Are services safe?
We found that this service was providing safe care in accordance with the relevant regulations.

Are services effective?
We found that this service was providing effective care in accordance with the relevant regulations.

Are services caring?
We found that this service was providing caring services in accordance with the relevant regulations.

Are services responsive to people's needs?
We found that this service was providing responsive care in accordance with the relevant regulations.

Are services well-led?
We found the provider was providing well-led care in accordance with the relevant regulations.

Are services safe?

Our findings

At our last inspection we found that there was no risk assessment specifically for the CSAAS premises relating to suicide and self-harm. There were inadequate systems in place to enable the trust to ensure that the facilities were forensically clean to comply with the guidance provided by Faculty of Forensic and Legal Medicine (FFLM). The management of medicines was not effective. There was no standard operating procedure in place for medicine stock rotation and storage room temperature monitoring.

At this desk-based inspection we received assurance that the provider had addressed the failings set out in the S29a Warning Notice. We also found that the provider had addressed the areas where we identified they should make some improvements.

These are the areas we reviewed during this desk-based inspection:

Risks to patients

Following our last inspection, the trust immediately implemented a risk assessment tool identifying areas where children and young people were exposed to ligature risks. There were clear steps to manage each risk and mitigations included having anti-ligature pull cords and completing an individual mental health assessment, as well as not leaving children unsupervised.

Premises and equipment

The trust had taken action to reduce the infection control risks within the forensic examination room that we identified at our last inspection, such as storing necessary paperwork appropriately in plastic folders. We reviewed photographic evidence of a new examination trolley and a clutter free examination room, that ensured the room could be cleaned to meet the standards set out by the Faculty of Forensic and Legal Medicine (FFLM).

The waiting room was now de cluttered to allow for better cleaning. Managers had removed books, DVD's and soft furnishings that could not be cleaned, from the waiting area, which was tidy, with toys kept to a minimum. Managers carried out weekly checks to ensure this was done.

A Toy Cleaning Policy, which outlined how all toys should be cleaned and stored away before and after a child's medical examination was available to staff. This reduced the risk of contamination to children and young people wishing to play with a toy before an examination. We reviewed a copy of the toy cleaning log. This demonstrated staff had up to date records of each toy and how it should be cleaned to meet the standards set out by the Faculty of Forensic and Legal Medicine.

Managers said that during the COVID-19 pandemic restrictions, all toys were removed, to reduce the risk of passing infection. However, staff would give each child and young person a choice of a new toy, which they could play with and take away after their visit to the service.

Safe and appropriate use of medicines

The trust had developed a standard operating procedure for medicines stock rotation for the Anlaby Suite to ensure that adequate stock of medicines was available to patients. This had been fully implemented and used alongside the trust's drug policy. The lead nurse for the CSAAS was now responsible for carrying out monthly stock checks.

Records showed that staff checked and recorded the temperature of the room where medicines were stored daily, and the date and time of each check. The record sheet contained guidelines for staff to follow should the temperatures fall out of range. This meant that the integrity of medicines was maintained.

Are services effective?

(for example, treatment is effective)

Our findings

At our last inspection we found that the trust did not have a specific induction or competency programme for any new staff joining the CSAAS team to ensure they were fit to undertake their role.

At this desk-based inspection we received assurance that the provider had addressed the failings set out in the S29a Warning Notice. We also found that the provider had addressed the areas where we identified they should make some improvements.

These are the areas we reviewed during this desk-based inspection:

Effective staffing

The trust had made improvements to the arrangements for ensuring that staff were suitably trained and competent in their roles.

We reviewed a new staff competency programme that was in line with the Forensic Science Regulator guidance and had been implemented alongside the trust's induction training plan. This included relevant guidance for staff, such as, safeguarding children and young people, training for supporting a child/family through a child protection medical and training to use the equipment. Managers confirmed that 100% of staff had completed their competency checks.

The lead physician updated all staff training to ensure it was service specific and compliant with guidance from the Faculty of Forensic and Legal Medicine and the Royal Collage of Paediatrics and Child Health. Other learning was disseminated to staff via emails, which meant staff were engaged in continuous learning and development.

Are services caring?

Our findings

At our last inspection the patient information available did not meet the needs of children and young people who may have communication difficulties to understand the service. There were limited leaflets and information in easy read format.

At this desk-based inspection we received assurance that the provider had addressed the areas where we identified they should make some improvements.

These are the areas we reviewed during this desk-based inspection:

Involving people in decisions about care and treatment

The trust had made improvements to the range of information and communication aids for patients

We reviewed some leaflets and photographs of the leaflets that were displayed and available to children and their families in the Anlaby Suite, which showed a wide range of information, including mental and sexual health advice. Managers confirmed they would source any additional relevant information from services such as substance misuse and mental health. Managers told us that they had arranged for the local substance misuse service to attend the unit and share learning to help promote both services; however, this had been postponed due to COVID-19 restrictions. Managers said that staff had built up good relationships with other community services and charities in the area.

We reviewed copies of the photographs taken of each room, staff dressed in protective clothing and the equipment that was used in the service. Staff showed these photos to children and young people to support those that may be anxious about using the service and to better understand the examination process.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our last inspection we found staff did not demonstrate they had offered, where possible, a choice of gender of forensic examiner to all children and young people.

At this desk-based inspection we received assurance that the provider had addressed the areas where we identified they should make some improvements.

These are the areas we reviewed during this desk-based inspection:

Taking account of particular needs and choices

Since the last inspection, managers had amended the patient record so staff could capture that they had offered the choice of gender of a forensic examiner to children and young people. There was also a space for staff to record where circumstances meant choice of gender was not available. Managers audited this and said that, they had been able to provide children and young people with a physician of their choice of gender.

Are services well-led?

Our findings

At our last inspection we found that managers did not take steps to assess and monitor the effectiveness of decontamination of the examination suite and waiting room in line with the Forensic Science Regulator guidance The trust did not provide staff responsible for decontaminating the examination suite and waiting room with any guidance on how to meet the Forensic Science Regulator guidance. Managers did not have sufficient assurance that staff were decontaminating the examination suite and waiting room.

At this desk-based inspection we received assurance that the provider had addressed the failings set out in the S29a Warning Notice. We also found that the provider had addressed these areas where we identified they should make some improvements.

These are the areas we reviewed during this desk-based inspection:

Governance and management

At this inspection we found that managers had established effective monitoring arrangements to help manage the risks of cross-contamination.

We reviewed a copy of the new standard operating procedure for forensic cleaning. Guidance had been developed alongside this to fully inform staff of their duties with regards to forensic cleaning. This had been fully implemented and helped ensure consistency of the forensic cleaning for the Anlaby Suite. We were also sent a copy of the examination room and forensic cleaning log, that demonstrated how staff carried out forensic cleaning in line with the guidance when required.

Managers monitored the effectiveness of decontamination of the forensic suite and waiting room in line with the Forensic Science Regulator guidance. Managers had carried out an environmental contamination audit, which helped staff and managers to identify any areas where cross-contamination could occur. The examination room was now locked and only required persons entered the examination suite. Staff logged their entry and the reasons for entering the examination suite. These actions help to reduce the risk of contamination.

Managers had facilitated a programme of testing rooms and equipment to check the effectiveness of decontamination procedures. A forensic assessment audit was carried out on 18 March 2020. DNA samples of the environment enabled assessment of whether the forensic cleaning was effective. Results had been delayed due to the COVID restrictions. However, managers had escalated this to commissioners.

During this inspection we reviewed staff training logs for forensic cleaning, which showed that all staff had completed this. This provided assurance to managers that staff were practising correctly, in accordance with the guidance set out by the Forensic Science Regulator.