Mountain Healthcare Limited

Beech House

Inspection Report

North Court
Armstrong Road
Maidstone
Kent
Tel: 01622 726461
Website: www.beechhousesarc.org

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Overall summary

We carried out this announced inspection on 12 and 13 February 2019 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a CQC inspector who was supported by a second CQC inspector, and a specialist professional advisor.

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

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

These questions form the framework for the areas we look at during the inspection.

Background

Beech House SARC is in Maidstone and provides services to adults and children who have experienced sexual abuse or sexual violence either recently, or in the past.

NHS England commission community paediatricians to deliver the medical examinations for under 13 year olds, who are overseen by a Mountain Healthcare Forensic Medical Examiner.

The service is delivered from secure rented premises and offers access for patients with disabilities. The accommodation includes three forensic suites, each contains an adjoining forensic waiting area, medical examination room, shower room and aftercare room.

The team includes a service manager, one doctor, eight forensic nurse examiners, and eight crisis workers.

The service is provided by Mountain Healthcare Limited and as a condition of registration must have a person registered with the Care Quality Commission as the registered manager. Registered managers have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

During the inspection we spoke with four staff members, and looked at policies, procedures and other records about how the service was managed. We reviewed care records for 8 patients who had accessed the SARC within the last 6 months.

The service is accessible 24 hours a day, seven days a week.

Our key findings were:

Summary of findings

- The provider did not have adequate local systems and processes in place to identify where quality and safety were compromised.
- The SARC did not have effective leadership and there was no culture of continuous improvement.
- The premises were clean and well maintained.
- The staff used infection control procedures which reflected published guidance.
- Staff knew how to deal with emergencies. Appropriate medicines and life-saving equipment were available.
- The staff followed suitable safeguarding processes and knew their responsibilities for safeguarding adults and children. However not all staff had not received up to date safeguarding training.
- The provider had thorough staff recruitment procedures.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- The appointment/referral system met patients' needs.
- The provider asked patients for feedback about the services they provided but this was limited and therefore learning from patient feedback was under developed.
- The staff had suitable information governance arrangements.

We identified one regulation the provider was not meeting. The provider must:

- Ensure that there are local systems and processes to identify where quality and safety are compromised.
- Provide regular supervision for all staff in accordance with the provider's policy.
- Monitor and ensure all staff are up to date with their mandatory training.

Full details of the regulation the provider was not meeting are at the end of this report.

There were areas where the provider could make improvements. It should:

- Risk assess first floor windows where no window restrictors were in place.
- Ensure that care records thoroughly detail the rationale for determining whether a patient does or does not have capacity to consent to treatment.
- Provide child-friendly literature for children to take away following their treatment at the SARC.
- Embed new patient feedback mechanisms to obtain detailed feedback from patients to help improve the service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

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 safe care in accordance with the relevant regulations.

Are services caring?

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

Are services responsive to people's needs?

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

Are services well-led?

We found that the provider was not delivering well-led care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notice at the end of this report). We will be following up on our concerns to ensure they have been addressed by the provider.

Are services safe?

Our findings

Safety systems and processes (including staff recruitment, Equipment & premises)

The provider had clear systems to keep patients safe and safeguarded from abuse.

Staff we spoke with knew their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. The provider had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. We found that not all staff had completed level 3 safeguarding children or adults training in the last 12 months in line with the provider's policy and intercollegiate guidance.

There was a system to highlight vulnerable patients on their records. For example, children with child protection plans, adults where there were safeguarding concerns, people with a learning disability or a mental health condition, or who required other support such as with mobility or communication.

All health equipment was safe and appropriate. Equipment was regularly checked and serviced accordingly. The service had a business continuity plan describing how the service would deal with events that could disrupt the normal running of the service. Records showed that fire alarms were tested regularly.

Staff followed appropriate infection control procedures, and forensic samples were managed in line with guidance from the Faculty for Forensic and Legal Medicine (FFLM). Nursing staff carried out forensic cleaning and an external contractor maintained cleanliness of communal areas.

Staff were trained to use a colposcope (specialist equipment used for making records of intimate images during examinations, including high-quality photographs and video).

The provider had a staff recruitment policy and procedure to help them employ suitable staff. Staff received supervision periodically, and nursing staff were able to access clinical supervision each quarter, however the manager's capacity to manage sixteen staff (eight crisis workers and eight forensic nurse examiners) was limited; this was acknowledged by local and senior managers, and discussions regarding additional management resources were in progress. Staff completed relevant continuing professional development (CPD).

Risks to clients

There were systems to assess, monitor and manage risks to patient safety.

Risks to patients were immediately assessed, monitored and managed. These included signs of deteriorating health, including mental health, medical emergencies, child sexual exploitation, female genital mutilation, domestic abuse or behaviour that challenges. Staff knew who to contact in an emergency, including for incidents of self harm, violent behaviour and minor injury.

Where a patient was identified as at risk of harm or urgent health concerns were noted, immediate and continuing action was taken to safeguard the patient. This included a comprehensive assessment for post-exposure prophylaxis after sexual exposure (PEPSE), antibiotic and/or hepatitis B prophylaxis, the need for emergency contraception and physical injuries that needed urgent treatment.

The provider's health and safety policies, procedures and risk assessments were up to date and reviewed regularly to help manage potential risk. The provider's health & safety lead visited the service annually to carry out a health and safety audit of the premises, however we identified that the first floor windows did not have restrictors to prevent them being opened too widely and this had not been identified on the latest risk assessment. We raised this with the provider during the inspection, and a visit was scheduled with the health and safety lead to assess this risk in the week following our inspection. The provider had suitable risk assessments to minimise the risk that can be caused from substances that are hazardous to health.

Staff we spoke with knew how to respond to a medical emergency and had completed training in emergency resuscitation and basic life support (BLS). Emergency equipment and medicines were available. Staff kept records of their checks to make sure these were available, within their expiry date, and in working order.

The service carried out infection prevention and control (IPC) audits; the most recent audit took place in January 2019 which showed that the provider was meeting the Health and Social Care Act 2008: Code of Practice for health

Are services safe?

and adult social care on the prevention and control of infections. The provider had identified during the recent IPC audit that not all staff had received a hepatitis B vaccination. This was being addressed at the time of our inspection. Clinical waste was managed appropriately.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

We discussed with staff how information to deliver safe care and treatment was handled and recorded. We looked at a sample of care records to confirm our findings and noted that individual records were written and managed in a way that kept patients safe. Care records we saw were accurate, complete, and legible. Care records were held securely and complied with data protection requirements.

There were clear procedures adopted for the management of photo documentation and intimate images resulting from the assessment in line with guidance from the Faculty for Forensic and Legal Medicine (FFLM).

Patient referrals to other service providers contained specific information which allowed appropriate and timely referrals in line with service protocols.

Staff worked well with the local authority, social workers and police when working with both children and/or vulnerable adults. They obtained details during the initial assessment to identify safeguarding risks and ensured that information was shared appropriately. Care records we reviewed reflected this.

Safe and appropriate use of medicines

The service had reliable systems for appropriate and safe handling of medicines.

There was a suitable stock control system of medicines which were held on site. This ensured that medicines did not pass their expiry date and enough medicines were available if required. Room and fridge temperatures were monitored and medicines were stored in locked cupboards.

Patient Group Directions (written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment) we reviewed were fit for purpose, and a Patient Group Direction (PGD) policy was in place and in date at the time of our inspection. We saw evidence that PGD audits were carried out monthly, and learning identified and shared.

The service stored and kept records of NHS prescriptions as described in guidelines from the British Medical Association(BMA).

Track record on safety & lessons learned and improvements

The provider monitored and reviewed incidents separately for the paediatric and adult pathways. In the previous 12 months there had been no serious incidents reported for the adult pathway, however 12 incidents were reported that related to the paediatric pathway in 2018. These incidents had been recorded on a spreadsheet which did not allow for the date of the incident, the reporter, or the action taken and lessons learned to be documented. This meant that there was no evidence of incident reviews or investigations taking place, and the provider did not have systems in place to enable them to learn and make improvements when things went wrong.

Managers discussed a recent incident at a different location, however the learning from this had not yet been shared with staff at Beech House SARC and there was limited evidence of lessons learned shared organisationally. In contrast, learning from local incidents was shared during team meetings.

There was a system for receiving and acting on safety alerts. Staff learned from external safety events as well as patient and medicine safety alerts which were shared with staff during team meetings. Safety alerts were accessible to staff in the main office.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

Clinicians assessed patients' needs and delivered care and treatment in line with guidelines from the Faculty for Forensic and Legal Medicine (FFLM) supported by clear clinical pathways and protocols to include plans for immediate healthcare including emergency contraception, antibiotic or HIV/Hepatitis B prophylaxis.

The staff were involved in quality improvement initiatives including peer review as part of their approach in providing high quality care.

Where people were subject to the Mental Health Act (MHA), their rights were protected and staff we spoke with were aware of their responsibilities under the MHA Code of Practice.

Staff ensured that patients received food and drink as needed. Tea, coffee and soft drinks were available as well as toast and soft drinks.The service could take steps to meet cultural needs where required and had recently brought in products to accommodate patients with lactose intolerance.

Staff advised patients where to seek further help and support, such as local sexual health and counselling services, placing an emphasis on the importance of seeking further medical advice if needed following their treatment at the SARC.

Consent to care and treatment

Staff understood the importance of obtaining and recording patients' consent to treatment. Staff we spoke with told us they gave patients information about treatment options, and the risks and benefits of these so they could make informed decisions. This was corroborated within patient records we reviewed during the inspection.

The provider's consent policy included information about the Mental Capacity Act 2005. The team understood their responsibilities under the act when treating adults who may not be able to make informed decisions. However, we found that records did not suitably detail the discussions leading to the decision, therefore it was difficult to assess the quality of decision making. The policy also referred to Gillick competence, by which a child under the age of 16 years of age can consent for themselves. Mountain Healthcare Limited staff were aware of the need to consider this when treating young people under 16 years of age.

Staff described how they involved clients' relatives or carers when appropriate and made sure they had enough time to explain treatment options clearly.

Monitoring care and treatment

Medical staff completed detailed forensic medical examination records, containing information about the patient's current needs, any mental health issues and physical needs. Assessment, examination and aftercare recording templates ensured that the clinical staff assessed patients' treatment needs in line with guidelines from the Faculty for Forensic and Legal Medicine (FFLM).

We saw that the service audited patients' medical care records to ensure that clinical staff recorded the necessary information. A monthly audit plan was in place for staff to peer review care records which were then forwarded to the local manager as well as senior organisational staff to monitor compliance.

Effective staffing

Staff new to the service had a period of induction based on a structured induction programme. We confirmed that clinical staff completed their annual continuing professional development and revalidation, and annual appraisals were completed.

We found that training was not effectively monitored, and as a result we were not assured that staff had the appropriate skills and competencies to carry out the roles they were employed for. Records held by the provider showed that not all staff had completed their mandatory training, including safeguarding level 3 for adults and children, mental capacity and infection prevention. Staff had access to specialised training courses such as trauma, mental health and colposcope training. Joint training with custody staff or other SARC services was also held on site to build working relationships. Monthly professional development days were scheduled for 2019 to provide additional support and training for staff.

Staff we spoke with were competent in both forensic medical examinations and in assessing and providing for the holistic needs of patients, including safeguarding from all forms of maltreatment and in the assessment and

Are services effective?

(for example, treatment is effective)

management of physical and emotional conditions that may or may not be related to the alleged sexual abuse. Crisis workers were trained to provide immediate support to patients and refer to specialist services as required.

Staff were able to access clinical and managerial supervision, however the manager's capacity to oversee 18 staff members meant that staff did not always receive the regular support they required for their roles in line with the provider's policy. This was acknowledged by the provider who advised that they were considering options to increase management capacity within the SARC.

Co-ordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment, including local social care, mental health and primary care providers.

Patients were referred promptly to an independent sexual violence advisor (ISVA) or child ISVA as appropriate. Patients received coordinated care from a range of different staff, teams and services, including local mental health teams, sexual health services and the police.

There were clear arrangements in place for patients to be referred to other health care professionals, and effective pathways into and from the SARC for clinical care. There were clear and effective pathways to psychosocial, advocacy, counselling and ongoing support services. There was a well established relationship with the local mental health service which gave the opportunity for regular dialogue between clinicians and mental health specialists.

Are services caring?

Our findings

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Staff were aware of their responsibility to respect people's diversity and human rights, however the majority of patients attending the SARC were of a white british background, representative of the local population. Staff were aware of the importance of considering varying cultural needs should these arise.

The provider had received positive patient feedback regarding the SARC, however a choice of a male or female professional was not routinely offered to patients. We were advised that patients would be able to see a male forensic nurse examiner if requested, and the provider was in the process of recruiting a male crisis worker.

Patients could access washroom facilities after their treatment and a change of clothes was made available for patients if required. Care bags containing toiletries were provided to use at the SARC and to take away, suitable for both males and females.

Information leaflets about the SARC and other local services were available for patients to read in waiting areas and aftercare rooms within the service. Literature was not readily available in alternative languages or an easy read format, however could be provided from national organisational resources on request.

Privacy and dignity

The service respected and promoted patients' privacy and dignity.

Staff were aware of the importance of privacy and confidentiality. The layout of the waiting areas provided privacy when staff were dealing with patients. Computer screens were not visible to patients and staff did not leave personal information where other patients might see it.

Staff password protected patients' electronic care records and backed these up to secure storage. They stored paper records securely.

Staff we spoke with understood the importance of not disclosing information about the patients they supported with unauthorised individuals and organisations.

Involving people in decisions about care and treatment

Staff we spoke with said that they encouraged patients to be involved in decisions about their care and treatment with family members if relevant. They also told us that they supported patients and their carers/family to access further information or other services where required, such as advocacy and counselling.

Staff communicated with patients in a way that they could understand. Interpretation services were available for patients who did not have English as a first language, and information could be translated into other languages if needed.

The service's website and information leaflets provided patients with information about the range of treatments available at the service. They covered what to expect, what happened next, and explained the importance of choice and confidentiality. The leaflets were not available in a child friendly format for children to take away following a treatment at the SARC.

Clinical staff described the methods they used to help patients understand the treatment pathway within the SARC and options available to them. Staff told us that they regularly checked whether patients felt comfortable and continued to consent to treatment throughout their time at the SARC, including during the examination.

Emotional support was provided to people close to patients using the SARC through a referral to the local ISVA (Independent Sexual Violence Advisor) or Talking Therapies teams. All care records we reviewed showed that patients had been referred to these services to access further support in a timely manner.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The provider organised and delivered services to meet patients' needs, and mostly took account of patient needs and preferences.

Staff were clear on the importance of emotional support patients needed when receiving care. We saw examples within records of how the staff worked with local Children and Adolescent Mental Health Services (CAMHS) and local authority social workers to support vulnerable patients in accessing the best support available to them.

The SARC had facilities for patients with disabilities including step free access, and an accessible toilet. However, patients requiring an examination who could not transfer to a clinical bed would be seen in their own home or hospital on occasion if this was in the best interests of the patient. There were lone working and risk assessment procedures in place for this. A portable colposcope was not currently available to use outside the service however plans were in development to introduce this.

Patients were not routinely offered a choice in the gender of their examiner, however managers assured us that a choice of gender could be met where requested.

The provider sought feedback from patients attending the SARC, however this was very limited and only gave information as to whether the patient was happy with the service or not. While feedback collected to date had been positive, managers recognised the need for more qualitative feedback and work was underway to implement a new, more comprehensive, patient feedback form.

Timely access to services

Patients could access care and treatment from the service 24 hours a day, seven days a week and were seen within an acceptable forensic timescale for their needs. The provider displayed access and referral details on the premises, in their service information leaflet and on their website.

Referrals were received from a wide range of external agencies, as well as the patient themselves.

There was an efficient appointment system to respond to patients' needs. Staff confirmed that patients could make routine and emergency appointments and they worked flexibly to cope with the high local demand for the SARC. During our inspection a high number of referrals were received which were handled efficiently to ensure patients were not waiting for long periods of time.

Listening and learning from concerns and complaints

A policy was in place providing guidance for staff on how to handle a complaint. The service information leaflet and website explained how to make a complaint, and information was available in waiting areas telling patients how they could complain if they were not happy with the service they received.

Systems were in place for recording and managing complaints, however there had been no complaints received in the last 12 months so we were unable to fully assess how complaints were managed.

Are services well-led?

Our findings

Leadership capacity and capability

The service manager was a trained forensic nurse examiner with the relevant training to demonstrate experience and skills to deliver high-quality, sustainable care. However, capacity to oversee key areas such as training and risk management was reduced by their line management responsibilities and involvement in the day to day running of the SARC. This was acknowledged by local and senior managers within Mountain Healthcare Limited.

Staff were knowledgeable about issues and priorities relating to the quality and future development of services. They understood the challenges specifically relevant to working in a SARC and were addressing them. There was no service development plan in place, and smaller action plans developed from audits were not overseen strategically.

Vision and strategy

The SARC did not have a clear vision or set of values relating to that specific service. Organisational values were not shared locally, and there was no local strategy or supporting business plans to achieve priorities.

Culture

The service had a culture of high-quality sustainable care. Staff we spoke with were passionate about their work, and the team as a whole focused on the needs of clients. Staff we spoke with felt respected, however management support was not always available due to the service manager's capacity.

Staff demonstrated openness, honesty and transparency in their work. The provider was aware of and had systems to ensure compliance with the requirements of the Duty of Candour.

Staff told us they were able to raise concerns and were encouraged to do so. Team meeting minutes reflected staff suggestions being taken on board and concerns addressed. For example, in a team meeting held in December 2018 staff raised concerns regarding a high number of friends/ family members attending with some patients. This was difficult to accommodate due to a lack of space, and the SARC manager was able to raise this with the police following the meeting. Staff also brought a query to this meeting regarding the management of patients who self-referred and had a high risk based on a DASH assessment. This was due to be discussed during a planned paperwork training session in the next month.

Governance and management

The provider had a system of clinical governance in place which included policies, protocols and procedures that were accessible to all members of staff and were reviewed on a regular basis. Integrated governance meetings took place regularly to support clinical governance.

The service manager was also the registered manager and held overall responsibility for the management and clinical leadership of the service, and its day to day running. Staff knew the management arrangements and their roles and responsibilities. There were clear systems of accountability. However the provider did not have effective local systems and processes in place to identify where quality and safety had been compromised.

We found that processes for managing risks were not clear or effective, and while a risk register was in place for the service, there was no evidence of the oversight and monitoring of this register. During the inspection we identified that the recording and oversight of training was not effective, and mandatory training was not up to date for all staff. This issue was known to the provider; however, it had not been recorded on the local risk register.

There were regular monthly team meetings. Not all staff were able to attend these due to other work commitments however minutes from the meetings were circulated to all staff.

Appropriate and accurate information

Quality and operational information was not always used to ensure and improve performance. For example, audit findings and organisational learning from similar services was not shared with the wider team.

The service had effective? information governance arrangements and staff were aware of the importance of these in protecting clients' personal information.

Engagement with patients, the public, staff and external partners

The provider's involvement of patients, the public, and external partners to support high-quality sustainable services was limited. Managers acknowledged that current

Are services well-led?

feedback mechanisms were very limited, and work was ongoing to implement a new, more detailed approach to patient feedback. The provider used patient satisfaction forms to obtain views about the service, however these did not allow for quality feedback on how to improve the service.

Feedback was sought from staff and external partners through meetings, organisational surveys, and informal discussions.

Continuous improvement and innovation

Systems and processes for learning, continuous improvement and innovation were limited. The service had a basic audit schedule but was lacking quality assurance processes to encourage learning and continuous improvement. Some individual audits were being completed such as health & safety, infection prevention and control and record keeping. However action plans were not developed and there was no evidence that the findings of these audits had been shared with the wider team.

Staff received annual appraisals in which they discussed learning needs, general wellbeing and aims for future professional development, as confirmed by staff records.

Staff told us they completed training in line with the provider's training policy, undertaking medical emergencies and basic life support training annually. However, oversight of training was poor and it was unclear which staff had completed which training courses, and on what dates. A new system for mandatory training had recently been implemented across the organisation, however the local manager was unable to view local staff training records and was monitoring training on an individual basis during supervision. Supervision was not regular for staff, and therefore the provider could not assure themselves that all staff were up to date with their mandatory training.

All clinical staff completed continuing professional development days, with protected time allocated each month to do this.

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
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have effective systems and processes to monitor and identify all risks, or to evaluate and improve the service; • There was no oversight or routine review of the local risk register, which did not include a risk regarding staff access to training, of which the provider was aware. • The provider did not have an effective system to identify and monitor staff training, and as a result staff mandatory training was not up to date. • The monitoring of staff supervision was newly implemented and did not evidence regular supervision in line with the provider's policy.