G4S Health Services (UK) Limited

Grange Park SARC

Inspection report

Building B Cobridge Community Health Centre
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Overall summary

Grange Park SARC provides forensic medical examinations and some sexual health and aftercare services for adults in Stoke-on-Trent and surrounding areas who have been sexually assaulted. Further details about the nature of the service provided at this location can be found in the 'background' section of the report from our initial inspection of this service we published in July 2019

We previously inspected Grange Park SARC in January 2019. At that time, we found the centre was providing, effective, responsive and caring services. There were some breaches of regulations in relation to safe care and governance. We issued a warning notice in February 2019 and the provider sent us an action plan.

We inspected the service again in June 2019 and found that, although the requirements of the warning notice had been met, the change was ongoing and new systems were not fully embedded into day-to-day processes. We required the provider to continue make some improvements. The reports of both our inspections in January and June were published in July 2019.

In July 2020 we carried out a desk-based review of the Grange Park SARC to follow-up on their progress against their action plan. This included a review of documentation previously sent by the service in August 2019, a virtual meeting with the registered manager on 06 July 2020 and a review of further documentation sent to us following this meeting. We did not visit the centre at this time owing to the restrictions on our inspection activity arising from the COVID-19 pandemic.

We found that the provider had completed all their actions intended to address our findings from the initial and second inspections. We were assured that the provider had taken positive steps to ensure patients remained safe whilst using the service and there was no longer a breach of the relevant regulation.

Summary of findings

The five questions we ask about services and what we found

We asked the following question(s).

Are services safe? No action 

Are services safe?

Our findings

We initially inspected the Grange Park SARC on 29 and 30 January 2019. Overall, we found the service was, effective, caring and responsive to people's needs. However, there were a number of shortfalls that led us to conclude that the service was not providing safe care, as the service did not always effectively operate systems and processes in relation to safeguarding service users from abuse or improper treatment. Specifically, these processes related to staff training and record keeping for safeguarding purposes. Additionally, we found that the service was not well-led as it did not establish and operate effective systems and processes to monitor the service and governance arrangements were not fully embedded. Specifically, assessments had not identified all risks and record keeping audits had not identified areas where improvement was required. On 18 February 2019 we issued a warning notice and the provider sent us an action plan setting out how they would rectify those shortfalls.

On 11 June 2019 we carried out a follow-up inspection, which included a site visit, a review of patient records and an interview with the registered manager. We found sufficient evidence to show that the requirements of the warning notice had been met and risks to patients were reduced. However, whilst we found that immediate improvements had been made, we saw that change was ongoing and new systems were not fully embedded into day-to-day processes. Further work was required ensure these improvements were sustained. We required the provider to continue to address the areas we found in our initial inspection through their action plan.

We carried out a desk-based follow-up review of the Grange Park SARC on 06 July 2020, following the findings of our two previous inspections. We contacted the provider to advise that we would be carrying out a desk-based review to follow-up on their action plan. We used a desk-based approach because of the restrictions on our inspection activity arising from the COVID-19 pandemic. The desk-based review comprised a review of documents sent by the provider following the inspection on 11 June 2019, a virtual meeting with the registered manager on 06 July 2020 and a subsequent review of supporting documents sent by the manager following our conversation.

In advance of our meeting we reviewed the following documents supplied by the provider in August 2019:

- The provider's nine-point action plan from February 2019
- The provider's updated safeguarding policy dated February 2019
- The domestic violence referral pathway
- Safeguarding referral pathways for adults and children
- Mental Health referral pathway
- Training matrix showing safeguarding training
- Individual patient safeguarding actions template
- Individual patient risk assessment checklist for patients aged 16-17 and those 18 and over
- Multi-agency safeguarding template audit from January to February 2019
- Suicide and self-harm risk assessment dated January 2019

Following our virtual meeting we were sent and then reviewed the following documents;

- The updated suicide and self-harm risk assessment dated May 2020
- Revised patient aftercare safeguarding document dated March 2020
- Training matrix showing safeguarding training compliance as of July 2020
- Safeguarding audit data from January 2020, February 2020 and June 2020

The manager explained how improvements had been made and sustained as a result of auditing activity since the inspection of June 2019. Two examples illustrated this.

The detail and quality of the analysis in safeguarding referrals had improved through the introduction of a new aftercare safeguarding document. This was demonstrated through data showing 98% - 100% compliance with expected record keeping standards in patient records.

The revised suicide and self-harm risk assessment had been updated following an incident in December 2019. This had resulted new arrangements being made to ensure staff had unrestricted access to ligature cutters.

Following our review of the action plan, the submitted documents and our conversations with the registered manager we are satisfied that the provider had taken positive steps to ensure patients remained safe whilst using the service. There was no longer a breach of the relevant regulation.