# Mountain Healthcare Limited

# Topaz Centre

## Inspection Report

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## Overall summary

We carried out this announced inspection on 26 and 27 March 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**

The Topaz Centre SARC is in Nottingham and provides services to adults aged 18 and over. Children aged 16 or 17 may be seen at the centre upon request.

The service is delivered from secure rented premises and offers access for patients with disabilities. The accommodation includes two forensic suites, one with a separate waiting area and shower room, and one with an adjoining waiting area and shower room.

The team includes a service manager, seven forensic nurse examiners (three of whom have zero hour contracts), and eleven crisis/admin workers.

The service is provided by Mountain Healthcare Limited and as a condition of registration they 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 regarding how the service is run.

During the inspection we spoke with six staff members, and looked at policies, procedures and other records about how the service was managed. We reviewed care records for 12 patients who had accessed the SARC within the last 12 months.

The service is accessible 24 hours a day, 7 days a week.

**Our key findings were:**

- The provider did not have effective systems in place to help them monitor staff training, and supervision was not documented.

# Summary of findings

- The staff used infection control procedures which reflected published guidance, however the premises were not fit for purpose and new premises were being discussed with commissioners.
- 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.
- The provider had thorough staff recruitment procedures.
- The clinical staff provided patients' assessment, care and treatment in line with the Faculty for Forensic and Legal Medicine (FFLM) 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 offerred and made changes as a result of feedback.
- The staff had suitable information governance arrangements.

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

- Document 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:

- Ensure all risks known to managers are documented on the local risk register.
- Embed daily monitoring and recording of room and fridge temperatures where medicines are stored.
- Review patient group directions ensuring these are individually signed by all clinical staff.

# 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 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 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 associated with patients, young people and adults who were vulnerable due to their circumstances. Staff were able to describe how they would identify and act upon a safeguarding concern; safeguarding referrals we reviewed were appropriate and timely. The provider had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse, and local pathways were displayed in staff areas. We found that not all staff had completed level three safeguarding children or adults training in the last 12 months in line with the provider's policy and intercollegiate guidance.

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.

There was a system to highlight vulnerable patients on their records. For example, patients' 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 the 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. Managers told us that staff received supervision periodically, and nursing staff were able to access clinical supervision each quarter, however these individual and group meetings were not documented. Staff completed relevant continuing professional development.

**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, 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 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 however mandatory training records showed that two crisis workers had not completed training in emergency resuscitation and basic life support. 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 audits; the audits demonstrated that the facilities did not always comply with the Health and Social Care Act 2008: Code of Practice for health and adult social care on the

prevention and control of infections. Issues regarding the fabric of the clinical rooms were out of the provider's control and had been escalated appropriately to commissioners. A visit was scheduled for commissioners to review the suitability of the premises in June 2019. 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 were documented within aftercare paperwork and were prompt, however it was not possible to review the content of referrals made as a copy of each referral was not held by the provider.

**Safe and appropriate use of medicines**

The provider 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. Medicines were stored securely in a lockable safe within staff offices. Storage room temperature monitoring had commenced on 21 March 2019 and had not exceeded the recommended maximum temperature of 25 degrees to date. However, room temperatures were not monitored during weekends, and the recording sheet did not allow the actual room temperature to be recorded alongside the minimum and maximum temperatures reached.

The provider had an appropriate range of Patient Group Directions (PGD) (written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment), however these were not individually signed by all staff. A PGD policy was in place and in date at the time of our inspection.

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

**Track record on safety & lessons learned and improvements**

The provider had a comprehensive system to record and review incidents within the service. Incident forms were submitted and logged centrally with local actions assigned to the service manager. Learning from incidents was documented on the central tracker which was overseen by the director of nursing, and local learning was shared with staff during team meetings. Following an incident of a patient disengaging from treatment prior to attending a sexual health appointment, the provider held local genito-urinary medicine (GUM) training to highlight the importance of this service to staff.

Incidents were reported appropriately by the provider. The incident tracker showed that 33 incidents were reported between April and December 2018, and 10 incidents were reported between January 2019 and the time of our inspection. One serious incident had been reported in 2019 and escalated to commissioners. This related to the storage of personal samples which were inherited from the previous provider in April 2018.

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 for reference.

# 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 interventions, including emergency contraception and antibiotics. Prompt referrals were made to local GUM services for patients to receive 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, soft drinks and snacks were available for patients if required, and should the need arise the service could take steps to meet cultural needs.

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.

Staff described how they involved patients' relatives or carers when appropriate and made sure they had enough time to explain treatment options clearly. The facilities did not allow for many relatives or carers to attend with a patient, however the staff did their best to accommodate patients' needs and utilised the space available as effectively as they could.

**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). A review of proformas used to gather information from patients was in progress and staff had the opportunity to share their feedback and contribute to the review process.

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, however annual appraisals had not yet been completed. The provider took over the service in April 2018 and all except two staff members had joined the organisation within the last 11 months. All staff were scheduled to have an appraisal in April 2019.

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. A local training log was used by managers to monitor safeguarding, life support and data security training, however this log showed that not all staff had completed their mandatory training, including safeguarding level three for adults and children, and basic/intermediate life support. Other mandatory training data was held on an online system, however this was not accessible for managers to oversee staff individual staff's training, and the system could not provide an up to date overview of staff training completion at the time of our inspection.

# Are services effective?

## (for example, treatment is effective)

Staff were able to access additional training opportunities locally; a number of external agencies had delivered training in the last ten months including one equipment supplier for the use of their products, the local GUM clinic, and police custody staff who had also facilitated a tour of the neighbouring custody suite. The local Independent Sexual Violence Advisers (ISVA) team had attended the team meeting in December 2018 to share information and updates regarding their services.

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 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. A crisis worker and sexual offence training framework was in place.

Staff were able to access clinical peer review sessions and one to one support sessions with local and regional managers, however supervision sessions were not routinely documented. This was acknowledged by the provider as an area in which they could improve. Staff told us they felt well-supported by each other as well as managers and could always speak with someone when required.

**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.

We saw clear evidence from record reviews of regular onward referrals to sexual health services and general practitioners' (GPs) via a Topaz Centre template/referral form for patients who give consent for these referrals. Patient records also indicated regular referrals to the local ISVA service provided by Nottingham Sexual Violence Support Services. Whilst referral forms were completed using an online template, which meant that we could not comment on the quality of referrals, aftercare records we reviewed demonstrated that referrals were made and followed up in a timely manner.

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. Within the office there were details of local mental health services and counselling for young people/adults aged 11 to 25 however patient records indicated an underutilisation of referrals into alternative counselling services and also substance misuse services for patients presenting with drug or alcohol concerns.

# Are services caring?

## Our findings

**Kindness, respect and compassion**

Staff we observed treated patients with kindness, respect and compassion. Staff we spoke with 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. Staff we spoke with were aware of the importance of considering varying cultural needs should these arise.

The provider had received positive patient feedback regarding the SARC service?, 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 examiner if requested.

Patients could access washroom facilities after their treatment. Care bags containing toiletries were provided for patients to use at the SARC and to take away, which were 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**

Staff we spoke with were aware of the importance of privacy and confidentiality. Computer screens in offices 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.

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.

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 Independent Sexual Violence Advisor (ISVA) 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 took account of individual patient needs and preferences. Nurse link roles had been established with one nurse leading on Lesbian, Gay, Bisexual and Transexual (LGBT) and hard to reach groups.

Staff were clear on the importance of the emotional support patients needed when receiving care. We saw examples within records of how the staff worked with 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, a lift and an accessible toilet. 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 the provider had plans in development to introduce this equipment.

The provider sought feedback from patients and other professionals attending the SARC; The 'Summary of Your Care' booklet given to patients highlights different ways of giving feedback such as during contact at the centre, via a feedback form posted out to the patient, online via the website or through the six week follow up phone call.

Feedback had been received from 57 patients between December 2018 and February 2019. This was generally positive, however some negative comments were made in relation to the premises, and its proximity to the next door police station. Actions taken based on patient feedback were displayed on 'You said, we did' boards within aftercare rooms. One example was a patient who fed back about a lack of food options for people with diabetes. This resulted in the provision of fresh fruit, and breakfast bars suitable for diabetics.

We reviewed feedback from CQC comment cards gathered in the two weeks prior to the inspection; One patient said they were 'made to feel really comfortable' from their first point of contact with the SARC, whilst another patient said that staff listened to them explaining everything clearly, and 'were helpful in giving advice about referrals, work, medication and everything else.'

The provider invited feedback from other professionals visiting the SARC and this was also positive. Professionals had commented that the SARC is a 'comfortable working environment and the staff are excellent.' Another professional commented on his first visit supporting a patient to attend the SARC and felt that 'the staff and facilities are professional & exceptional.'

**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, however one of the two forensic suites was out of use due to infection control issues. This was not currently impacting on service delivery, however should the number of referrals into the SARC increase, this could lead to a delay for some patients.

**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. Patient's received a 'Summary of your care' booklet following their treatment at the SARC which gave clear details on how to make a complaint, and crisis workers told us that they explain the complaints procedure to all patients when they attend the SARC.

Systems were in place for recording and managing complaints, however there had been no complaints received in the 11 months since the provider started delivering the service 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 forensic nurse examiner whose training record demonstrated experience and skills to deliver high-quality, sustainable care.

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. For example, a future meeting with commissioners was planned to review the premises suitability, and an action plan had been developed to monitor infection control issues; these issues had been discussed during team meetings.

**Vision and strategy**

Organisational values were shared locally, and staff talked of a shared vision to develop the SARC as they looked to move premises. This was evident from team meeting minutes, however was not documented within a local strategy as managers awaited the outcome of a premises review with commissioners.

**Culture**

Staff we spoke with were passionate about their work, and the team as a whole focused on the needs of patients. Staff we spoke with felt respected and well supported by local and regional managers.

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. A 'You said, we did' feedback board was displayed to demonstrate action taken from staff feedback. One recent example was a concern raised by staff that there were no blinds in the staff office within the SARC. This was rectified and new blinds fitted in a timely manner.

**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, and regular monthly team meetings were held.

The service manager 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.

We found that the provider did not have effective local systems and processes in place to assure themselves that staff had received appropriate training. A new system for mandatory training had been implemented across the organisation, however the local manager was unable to view staff's training completion and was monitoring only three training subjects on a local spreadsheet. This spreadsheet did not include the service manager who also worked as a forensic nurse examiner (FNE), or one of the other forensic nurse examiners. The local spreadsheet the manager maintained showed that of one of the six FNE's had not received safeguardig level three training for children or vulnerable adults but was booked on to a course in April 2019.

A risk register was in place for the service, this was monitored and reviewed by the SARC manager and regional managers. 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.

Staff and managers told us that they received the support they needed, however one to one supervision was not documented and the manager accepted this was an area they needed to develop.

**Appropriate and accurate information**

Quality and operational information was used to ensure and improve performance. For example, audit findings were shared with the wider team during regular team meetings.

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

**Engagement with patients, the public, staff and external partners**

# Are services well-led?

The provider's involvement with patients, the public, and external partners to support high-quality sustainable services was good. Feedback mechanisms were well-established and the provider was able to evidence actions taken to improve the quality and safety of services, based on feedback they received. For example, managers received feedback that the office area did not always feel private or safe for staff working at night time due to long windows with no blinds. The provider subsequently installed blinds.

Feedback was sought from staff and external partners through meetings, organisational surveys, and informal discussions. The SARC manager attended countywide Sexual Violence Action meetings which involved engagement with the council, street pastors, police, and local universities.

**Continuous improvement and innovation**

Systems and processes for learning, continuous improvement and innovation were in place. The service had an audit schedule which was adhered to, findings were quality assured by a regional lead, and shared with staff to encourage learning and continuous improvement. Some additional audits were completed, including a ligature points audit.

The provider started delivering services at the SARC in April 2018. Staff had not yet received annual appraisals to discuss learning needs, and aims for future professional development, however these meetings were scheduled to take place in April 2019.

Following the inspection, a training action plan was developed to address concerns regarding the oversight of staff training raised with managers during the initial feedback.

The provider had not acted upon some concerns raised during a recent inspection of a different registered location in February 2019. An improvement programme to update systems and roll out intercollegiate guidance were in place, however we found that the local oversight and monitoring of training had not been addressed in response to feedback highlighted during the recent inspection, and found a repeated breach of Regulation 17 Good governance during this inspection.

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<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>Regulation 17 (1) Good Governance.<br>The provider did not have effective systems and processes to monitor, identify and act upon all risks, including concerns identified at the provider's other registered locations.<br>• 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. This issue was known to the provider but had not been recorded on the local risk register.<br>• Supervision of staff was not documented in line with the provider's policy to aid monitoring.<br>• The provider had not shared the learning from, or made improvements in response to, our February 2019 inspection findings in another registered location in relation to the oversight and monitoring of training. |