Beacon House

Quality Report

Beacon House
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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Overall summary

Beacon House Ministries is a Christian charity established to help homeless people, those in insecure accommodation and those at high risk of homelessness. Beacon House is operated by Beacon House Ministries.

Beacon House offers practical help and a wide range of wellbeing services in Colchester and Essex. As part of this offer, it provides primary healthcare services to adults only. The healthcare clinic provides care and treatment which includes access to health services, physical health, mental health, drugs and alcohol support, vaccination and screening. Health and well-being assessments are offered to all new clients. The clinic is open Monday to Friday between 10am and 2pm.

Our inspection focused on the regulated activity delivered within the health clinic only.

We regulate this service but we do not currently have a legal duty to rate it. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

We found the following areas that the service provider needs to improve:

- Governance, risk management and quality measurement were not robust and we were not assured the provider was taking a proactive approach to continuous learning and improvement.
- The CQC had received no notification of change to service delivery in the required 28 days of the change.
- The registered manager did not demonstrate understanding of the legal responsibilities of the role. The statement of purpose required to be submitted to the CQC informing of change in service delivery was not up-to-date. The CQC had received no notification of this change.
- There was no formal process for reporting incidents at the time of our inspection. The service developed a draft incident reporting policy in March 2017. This had not been implemented and staff were not aware of this policy.
- Staff were not completely aware of their role and responsibilities for raising concerns, recording and reporting safety incidents, concerns and near misses, internally and externally.
- All staff were unaware of the principle of the duty of candour, however, all staff were able to tell us there was a genuine open and honest culture within the service, and this underpinned the ethos of the service.
- There was no duty of candour policy for the service.

Summary of findings

- There was minimal resuscitation equipment available at the service.
- The service had a blood glucose monitoring machine which was used to test a patient's blood sugar. We found this had been serviced, however, this had not been calibrated to the manufacturers instruction. This meant there was a risk of inaccurate readings.
- We reviewed a selection of medical consumables and medications which demonstrated a proportion of these were out of date.
- The service recently produced a specimen handling policy, dated March 2017. This policy was not embedded at the time of our inspection and did not include information about the safe and correct process for transporting specimens which staff had to adhere to.
- At the time of our inspection, staff could not produce a risk assessment or policy for the prevention of risk associated with legionella. Information received after the inspection demonstrated a risk assessment was conducted in 2014; however, there was no evidence of on-going monitoring of the risk.
- Staff had not completed all mandatory training requirements.
- Staff had adopted an open door policy for safety purposes, however there was no evidence of a risk assessment which supported this action.
- The service had developed a deteriorating patient procedure which was dated March 2017. The procedure provided details around the use of an Early Warning Score (EWS) however there appeared to be no details of actions for staff to follow if a patient was identified with an altered EWS. At the time of our inspection, this procedure was not embedded. We were not assured patients would be identified and receive the required intervention.
- There was no major incident reporting policy in place at the time of our inspection.
- Personnel files of both registered nurses demonstrated out of date, additional training.
- The service regularly supervised student nurses and allied health professionals, however no staff in the clinic had completed the mentorship programme. Mentorship involves a more senior or experienced person helping a student to develop clinical competence. It is a requirement of the NMC for students to be assessed and supported by qualified mentors.
- There was limited evidence of additional training or up-dates related to nurse prescribing in the personnel file and within the appraisal documentation of the registered nurse prescriber.
- During our inspection we observed other members of staff from the wider organisation entering the clinic environment whilst patient consultations were occurring. This action failed to take into account the privacy and confidentiality of the patients being treated.
- There was no process in place for staff to escalate disrespectful or abusive behaviour or attitudes at the service.
- Staff had not received training for caring and meeting the needs of patients living with dementia or learning disabilities.

However, we also found the following areas of good practice:

- The service had recently moved to an electronic notes system which is commonly used in primary healthcare. This enabled more information sharing with other providers and more information was available to the staff reviewing patients in the clinic.
- The clinical environment was well maintained and met the needs of the patients and staff.
- Staff had access to sanitising gel for hand decontamination. We saw staff using this after contact with patients.
- Staff at the clinic worked with local GPs to provide a coordinated delivery of care for patients who required further care.
- Staff made referrals to mental health organisations for the patients who attended the service. There was immediate access to a community mental health team for patients who required immediate intervention.
- The service had clear referral protocols in place so patients could access more specialist services.
- Staff completed Mental Capacity Act training every three years. Information provided by the service showed staff last completed this training in 2017.
- We observed staff treating patients with sensitivity and a supportive attitude. Staff demonstrated positive engagement with patients which was free of any discrimination against them.
- Staff demonstrated sincere compassion and empathy to the patients they provided care for.

Summary of findings

- The clinic did not run specified timings for the appointments given to patients. The staff gave the patient as much time as required for their needs. If the problem was complex, the patient would be given the opportunity to attend for a follow up appointment the next day.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached. We also issued the provider with seven requirement notices that affected community health services for adults. Details are at the end of the report.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community health services for adults		We do not currently have a legal duty to rate independent community health services but we highlight good practice and issues that service providers need to improve.

Summary of findings

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Community health services for adults

Summary of this inspection

Background to Beacon House

Beacon House Ministries is a Christian charity. Beacon House is operated by Beacon House Ministries.

Beacon House provides primary healthcare services in Colchester and Essex to homeless people, those in insecure accommodation and those at high risk of homelessness. The clinic provides care and treatment to adults only which includes access to health services, physical health, mental health, drugs and alcohol support, vaccination and screening. Health and well-being assessments are offered to all new clients. Approximately 550 people per year access this service. The clinic is open Monday to Friday between 10am and 2pm.Two registered nurses work part-time sharing the responsibility to run the clinic.

Beacon House also offers people practical help and a wide range of wellbeing services to meet their needs which includes showering facilities, laundry, a food bank, clothing and toiletries, a cafe offering hot food and drinks. In addition life skills classes are offered including computing, support around cooking and budgeting, counselling, a computer suite and an arts and crafts room. The provider works in partnership with other services and organisations to provide support such as specialist services, the local authority, alcohol and drug services. These services fall outside the scope of regulation and we did not inspect these services.

We regulate this service but we do not currently have a legal duty to rate it. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

Beacon House offers a health clinic which provides care and treatment to adults only. The clinic is registered with the CQC for:

- Diagnostic and screening procedures
- Treatment of disease, disorder or injury

Our inspection focused on the regulated activity delivered within the health clinic only.

We inspected Beacon House using our comprehensive inspection methodology, on the 28 March 2017. This identified the provider was in breach of eight regulations of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014. These were:

- Regulation 10: Dignity and Respect
- Regulation 12: Safe care and treatment
- Regulation 13: Safeguarding service users from abuse and improper treatment
- Regulation 16: Receiving and acting on complaints
- Regulation 17: Good governance
- Regulation 18: Staffing
- Regulation 20: Duty of Candour

Registration Regulations 2009 (part 4)

- Regulation 12: Statement of Purpose

We also carried out an unannounced inspection again on the 10 April 2017 as part of the routine inspection process.

The service has been previously inspected 29 January 2014 using previous inspection methodology.

The Registered Manager of Beacon House is a registered nurse from the clinic and has been in post since June 2011.

Our inspection team

The team that inspected the service comprised of two CQC hospital inspectors, a CQC Inspection Manager for mental health and a specialist advisor with expertise in community nursing and human immunodeficiency virus (HIV) specialist nursing.

A Head of Hospital Inspection oversaw the inspection team.

Summary of this inspection

Why we carried out this inspection

We inspected this core service as part of our comprehensive community health services inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

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

We inspected this service using our comprehensive inspection methodology.

Before our inspection, we reviewed performance information from and about Beacon House. We observed how people were being cared for, reviewed two care records and spoke with two patients, three staff including clinic nurses and one clinic administrator. We also received 13 'tell us about your care' comment cards which patients had completed prior to our inspection.

We interviewed all members of the Board of Trustees and the Chief Executive Officer.

What people who use the service say

People who used the service said:

- Patients told us they thought the service was so important to them and used words such as 'amazing', 'perfect' and 'professional' to describe it, and highlighted the medical care they received as being very good.
- Patients were complimentary about the staff that worked in the service. They told us they felt staff listened to them and they were approachable. At no point were patients ever made to feel as though staff were judging them. Patients were always treated with compassion and maintained their dignity.
- Patients felt the service was vitally important to them and without the service they would be lost in the system and would remain vulnerable. Patients felt involved in their care and staff would always ensure they had all the correct information during consultations. The language used was appropriate for the patients they were providing care and treatment for.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We do not currently have a legal duty to rate one core service for independent health providers.

We found the following issues the service provider needs to improve:

- There was no formal process for reporting incidents at the time of our inspection. The service developed a draft incident reporting policy in March 2017. This had not been implemented and staff were not aware of this policy.
- Staff were not completely aware of their role and responsibilities for raising concerns, recording and reporting safety incidents, concerns and near misses, internally and externally. At the time of our inspection, staff did not report clinical incidents through a formal incident reporting system.
- There was no duty of candour policy for the service.
- There was minimal resuscitation equipment available at the service.
- At the time of our inspection, staff could not produce a risk assessment or policy for the prevention of risk associated with legionella. Information received after the inspection demonstrated a risk assessment was conducted in 2014; however, there was no evidence of on-going monitoring of the risk.
- Staff had not completed all mandatory training requirements.
- The service had developed a deteriorating patient procedure which was dated March 2017. The procedure provided details around the use of an Early Warning Score (EWS) however there appeared to be no details of actions for staff to follow if a patient was identified with an altered EWS. At the time of our inspection, this procedure was not embedded.
- There was no major incident reporting policy in place at the time of our inspection.

However, we found the following areas of good practice:

- The service had recently moved to an electronic notes system which is commonly used in primary healthcare. This enabled more information sharing with other providers and more information was available to the staff reviewing patients in the clinic.
- Information provided by the service showed staff had completed their vulnerable adults safeguarding training in 2017. This was an annual requirement for all staff.

Summary of this inspection

- The clinical environment was well maintained and met the needs of the patients and staff.
- Staff had access to sanitising gel for hand decontamination. We saw staff using this after contact with patients.

Are services effective?

We do not currently have a legal duty to rate one core service for independent health providers.

We found the following issues the service provider needs to improve:

- Personnel files of both registered nurses demonstrated out of date, additional training.
- Staff completed formal clinical supervision sessions, there was no consistent format, neither the supervisor or the nurse had signed the document and there was no planned date for the next session.
- One of the staff files we checked did not have a record of the nurse's personal identification and Nursing and Midwifery Council (NMC) registration.
- We saw evidence of inconsistent practice with appraisals.
- The service regularly supervised student nurses and allied health professionals, however no staff in the clinic had completed the mentorship programme. Mentorship involves a more senior or experienced person helping a student to develop clinical competence. It is a requirement of the NMC for students to be assessed and supported by qualified mentors.
- There was limited evidence of additional training or up-dates related to nurse prescribing in the personnel file and within the appraisal documentation of the registered nurse prescriber.

However, we found the following areas of good practice:

- Staff at the clinic worked with local GPs to provide a coordinated delivery of care for patients who required further care.
- Staff made referrals to mental health organisations for the patients who attended the service. There was immediate access to a community mental health team for patients who required immediate intervention.
- The service had clear referral protocols in place so patients could access more specialist services.
- Staff completed Mental Capacity Act training every three years. Information provided by the service showed staff last completed this training in 2017.

Summary of this inspection

Are services caring?

We do not currently have a legal duty to rate one core service for independent health providers.

We found the following areas of good practice:

- We observed staff treating patients with sensitivity and a supportive attitude. Staff demonstrated positive engagement with patients which was free of any discrimination against them.
- Staff demonstrated sincere compassion and empathy to the patients they provided care for.
- Staff communicated with patients in a manner they understood. Time was taken to ensure patients understood what was happening and planned and confirmed this when the patient left the clinic. The patient survey conducted by the clinic in March 2017 also supported these comments.
- Staff made sure patients had the opportunity to ask questions about their care and treatment during and after their consultation.

However, we found the following issues the service provider needs to improve:

- The clinic followed an open door policy which was in place in the wider organisation.During our inspection we observed other members of staff from the wider organisation entering the clinic environment whilst patient consultations were occurring. This action failed to take into account the privacy and confidentiality of the patients being treated.

Are services responsive?

We do not currently have a legal duty to rate one core service for independent health providers.

We found the following areas of good practice:

- The clinic did not run specified timings for the appointments given to patients. The staff gave the patient as much time as required for their needs. If the problem was complex, the patient would be given the opportunity to attend for a follow up appointment the next day.
- The patients who used the service were all regarded as vulnerable and the staff at the service worked hard to meet the individual needs of each patient. We saw staff sign posting patients to other services offered by the provider such as the laundry and food bank.

Summary of this inspection

- Staff told us if the clinic was running slowly or had complex patients that required additional time; staff kept all patients up-to-date with this information.
- Staff used an online translation service to meet the needs of patients where English was not their first language.

However, we found the following issues the service provider needs to improve:

- Staff had not received training for caring and meeting the needs of patients living with dementia or learning disabilities.
- Staff were required to complete equality and diversity training every three years. However, information provided by the service showed no recorded date for staff completing this training.
- At the time of our inspection the CEO gave us a comments and complaints policy and leaflet produced in March 2017. Staff were unaware of this at the time of our inspection.

Are services well-led?

We do not currently have a legal duty to rate one core service for independent health providers.

We found the following issues the service provider needs to improve:

- We had mixed responses from the trustees regarding the reporting of risks and incidents. We were not assured the board of trustees had oversight of risk or incidents to the service or had the information to have a proactive approach to continuous learning and improvement.
- There was no formal system to report clinical incidents.
- There was a lack of process to record the number and type of incidents therefore any actions, themes or shared learning to prevent a re-curing incident was not taking place.
- There was no formal risk register for the service, however all staff were able to identify risks within the service and inform us of measures taken to mitigate these risks.
- There was no formalised process for risk assessments.
- There were outstanding actions following a report undertaken by an external agency in 2014 which provided an assessment of Beacon House continuity plans.
- The registered manager did not demonstrate understanding of the legal responsibilities of the role. The statement of purpose required to be submitted to the CQC informing of change in service delivery was not up-to-date. The CQC had received no notification of change to service delivery in the required 28 days of the change.

Summary of this inspection

- The CEO prepared reports for the board meeting. From these reports there was one reference made about the clinic which related to the installation of the electronic patient record system. We were not assured there was a detailed oversight of the governance related to the clinic activity.
- The CEO had completed a clinical management course to strengthen their leadership ability for the clinical side of the service. However, there was a lack of understanding for the responsibilities, clinical skill and importance of training required for the registered nurses role who ran the clinic.
- The CEO told us the panic alarm in the clinic was not re-connected following routine electrical work. We were told this was due to the open door policy and did not conform to the open culture of the service as staff did not need it. We did not see any risk assessment or staff communication to support this decision.
- During our inspection we saw a number of recently written policies which were waiting approval from the board of trustees. Whilst the provider had taken steps to create these policies staff were not aware of them and had not been consulted, they were not embedded into practice and two did not demonstrate clear, clinical guidance for staff to follow. We were not assured patients would be identified and receive the required intervention.
- Records demonstrated and staff gave us examples of people under the age of 18 who had accessed the service. This could potentially happen again, however, there was a lack of acknowledgment of the importance of having a policy to aid staff in safeguarding this vulnerable group.
- The trustees we spoke with told us they relied on one trustee to oversee the running of the clinic due to their professional background being medical. This meant there was not a collective oversight of the governance, risk and quality measurement of the clinic.
- The CEO had poor oversight of the completion of mandatory and additional training required for the registered nurses.
- The CEO was not aware of this and had no oversight as to when the re-registration of the clinic nurses were due. The staff files were disorganised and incomplete.
- There were no arrangements in place to respond to emergencies and major incidents for example in the event of a fire or power outage. There was no major incident policy for staff to refer to at the time of our inspection. Staff had not received appropriate training and education on the actions to take in the event of a fire, which included evacuation drills.

However, we found the following areas of good practice:

Summary of this inspection

- Staff participated in team development days three times per year. Staff we spoke with valued these days.
- Staff from the clinic had received the Queen's Nursing Institute award in 2016 for the services provided to this patient group. The Queen's Nursing Institute award is to honour nurses who have demonstrated a high level of commitment to patient-centred values.
- The larger organisation had a page on social media which publicised the work they conducted and engaged with the local community, including patients they had previously helped.

Community health services for adults

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are community health services for adults safe?

Safety performance

- The service did not record information on their safety performance and did not monitor harm free care as this was not deemed appropriate for the patients accessing the clinic.

Incident reporting, learning and improvement

- There were no never events reported by this service from February 2016 to January 2017. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- There were no serious incidents reported by the service from February 2016 to January 2017. Serious incidents are events in health care where there is potential for learning or the consequences are so significant that they warrant using additional resources to mount a comprehensive response.
- There were no incidents reported from February 2016 to February 2017 as there was no formal process for reporting incidents.
- The service developed a draft incident reporting policy in March 2017. This had not been implemented at the time of our inspection and staff were not aware of this policy.
- Staff were not aware of their role and responsibilities for raising concerns, recording and reporting safety incidents, concerns and near misses, internally and externally. At the time of our inspection, staff did not report clinical incidents through a formal incident reporting system.
- At the time of our inspection the electronic patient record system was unable to be accessed due to technical issues. Staff did not recognise this as an incident, even though patient information could not be accessed. However, there was a plan in place to manage this situation. A document was also being written to instruct others of who to report this to if it happened again.
- Staff did report accidents which may have occurred at the workplace under the reporting of injuries, diseases and dangerous occurrences (RIDDOR) regulations 2013. Staff gave us examples of accidents they had reported however we did not see the records these were documented in.
- Staff in the clinic held regular informal meetings where they discussed any scenarios which they were involved in. We saw minutes of these meetings where learning from these shared scenarios had taken place despite no incidents being reported.
- Staff received alerts and updates from the central alerting system. All alerts and updates were reviewed to identify if there was any relevance to the service and if there was, what actions were required. There was no documented evidence to support which alerts and updates had been actioned.

Duty of Candour

- All staff carrying our regulated activity were unaware of the duty of candour, however all staff were able to tell us there was a genuine open and honest culture within the service, and this underpinned the ethos of the service.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients or other relevant persons of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff were aware of their duty for being open and honest when incidents had occurred.

- The incident reporting policy and complaints policy did not refer to the duty of candour regulation within them. There was no separate duty of candour policy for the service. This means appropriate processes may not be followed as staff may not be clear about what they needed to do.

Safeguarding

- Information provided by the service showed staff had completed their vulnerable adults safeguarding training in 2017 which was an annual requirement for all staff. However, we were not assured the training reflected all relevant legislation and did not contain all relevant requirements.
- We were told only adults accessed the service, however records demonstrated patients under the age of 18 had attended. Staff provided examples of when they had to initiate safeguarding children alerts to the local authority due to situations experienced in the service.
- There was no formal safeguarding children policy or training for the service. Safeguarding Children: roles and competences for healthcare staff Intercollegiate Document (March 2014) states that a minimum Level Two safeguarding training is required for non-clinical and clinical staff who have some degree of contact with children and young people, their parents and/or their carers. This would train staff to identify and refer a child or young person suspected of being a victim of trafficking, sexual exploitation, at risk of female genital mutilation (FGM) or at risk of radicalisation. FGM is a procedure where the female genitals are deliberately cut, injured or changed, but where there is no medical reason for this to be done. Radicalisation is the process by which a person comes to support terrorism and extremist ideologies associated with terrorist groups.
- There was a system in place for patients under the age of 18 years accessing the clinic. The service had a system in place for staff to transfer them to a provision which helped homeless and vulnerable children. Staff were aware of this and gave examples of when this had happened.
- One staff member had recently attended an 'abusive and toxic relationship' course. They told us this was a really useful training session which was relevant to the patient group they see in the clinic. They had shared the key learning points of the training to other staff members in an in-house training session.
- Staff told us they had not formally raised any safeguarding alerts with the local authority from March 2016 to February 2017.
- Staff told us they reported all safeguarding concerns or referrals to the Chief Executive Officer (CEO). If the CEO was absent the next senior person took on this responsibility.

Medicines

- There was a medicines management policy (February 2017 for review February 2018). Staff told us they were aware of this and knew where to access it.
- One member of staff was a qualified nurse prescriber. They prescribed from a limited formulary mainly containing antimicrobials, vaccines and nicotine replacement therapies. A local GP agreed this formulary with the nurse prescriber.
- We found emergency medicines left unsecure and unsupervised in the clinic room. We raised this with the CEO who took immediate action to rectify this. On our unannounced inspection, we found staff had moved these and secured them in a locked cabinet. The door to the clinic was locked at the end of the clinic session.
- The clinic had a supply of general sales list medicines which could be purchased by patients for a small donation. These included common pain relieving medications and cold and flu remedies.
- We found medicines in the locked cabinet which were out of date. We immediately highlighted this to the CEO who removed and disposed of them in line with the medicines management policy.
- Staff had access to a medication used in emergency situations for the treatment of potential overdose. Staff told us they had completed basic training on the safe administration of this medicine which included watching a video.
- Staff checked and recorded the temperature of the medicines refrigerator each working day. We found staff had regularly recorded a temperature below the accepted range of temperatures. No vaccinations or medications were in the refrigerator at the time; however staff had not reported the issue. Following our inspection we requested further information of guidance for staff to follow if the fridge temperature was out of range. Information received demonstrated there was no policy or procedure in place.

Community health services for adults

- The service provided patients with a repeat prescription service for those who were on regular medications. Patients completed a request form 48 hours in advance.
- The nurse who prescribed medications had their own clinic prescription pad which was for use by the nurse prescriber. Staff stored the prescription pads in line with best practice. The local pharmacy that provided the prescription pads sent the clinic a list of prescriptions dispensed. The staff member could cross check medicines prescribed at the clinic. This safety check assured the nurse prescriber the prescription originated by the staff at the service.

Environment and equipment

- The clinical environment was well maintained and met the needs of the patients and staff.
- There was minimal resuscitation equipment available at the service. The clinic had a box which contained a bag valve mask and a small selection of emergency drugs, however there was no defibrillator or oxygen available in the event of a medical emergency. A bag valve mask is a self-inflating, hand-held device used to provide ventilation to patients who are not breathing or not breathing adequately. A minimum list of resuscitation equipment in a primary care setting was provided by the UK Resuscitation Council, included within this was oxygen and a defibrillator. This was escalated at the time of the inspection.
- We observed staff correctly segregated clinical and domestic waste. Waste bins provided for the clinic were enclosed and foot operated. The management and disposal of sharps was completed in accordance with policy.
- Staff completed a decontamination certificate before sending equipment off to contractors for servicing or repair.
- Staff maintained a document which contained the next service and electrical safety testing dates for all medical equipment used for treatment and care. We checked equipment within the clinic and found all items were in date for their service with the exception of the medicines refrigerator.
- The service had a blood glucose monitoring machine which was used to test a patient's blood sugar. We found this had been serviced, however, this had not been calibrated to the manufacturers instruction. Calibration is a process of comparing the readings of an instrument with those of a standard order to check the instrument's accuracy. This meant there was a risk of inaccurate readings.
- We reviewed a selection of medical consumables including wound dressings, blood bottles, urine analysis testing sticks, blood glucose testing sticks and pregnancy tests. We found two pregnancy tests and blood glucose testing sticks were out of date. We alerted a member of staff of the out of date items which they disposed of.
- Staff told us they reordered stock when items were getting low due to the lack of space to store additional stock and to keep items from going out of date to a minimum.
- Equipment was stored appropriately within the clinic environment with no items stored on the floor preventing cleaning of the room or presenting a trip hazard.
- In the clinic room there was a panic alarm located near the door with a sticker on it stating 'this panic alarm is not active'. Staff told us the alarm had been disconnected and staff maintained an open door policy for safety purposes.
- The service recently produced a specimen handling policy, dated March 2017. This policy was not embedded at the time of our inspection and did not include information about the safe and correct process for transporting specimens which staff had to adhere to.

Quality of records

- Staff used an electronic system mainly used in primary healthcare for documenting the care and treatment provided to patients. Staff told us this new system enabled them to provide safer care as they were able to access any previous medical history recorded for the patient.
- Staff used a specific template designed to meet the requirements for their patients. Staff told us they were in the process of uploading a national template used for care of the homeless patient on to the electronic system which would be an improvement on the current form they used. This was not in place at the time of our inspection.
- We reviewed two electronic patient records and found them to be detailed with a clear treatment plan documented. Staff completed records in a timely manner.

- The paper records previously used by staff were stored on site in locked filing cabinets. Staff told us they would archive and keep them for five years, however the policy document stated documents would be stored for seven years.

Cleanliness, infection control and hygiene

- The service had a policy manual which contained details about infection control principles including sharps management, decontamination of equipment and single use items. However, this did not contain information about hand hygiene and personal protective equipment for staff to follow.
- The clinic environment was visibly clean and tidy. Staff recently completed a cleaning audit which demonstrated compliance in most areas. The only area found to be non-compliant was the lack of deep cleans being completed. We raised the results of the audit with the manager of the service to action.
- The clinic had one sink which was used for hand washing purposes. This did not conform to the Health Building Note (HBN) 00-09 infection control in the built environment standards as this was not a stand-alone unit and did not have taps which could be elbow operated. The room which contained a day bed did not have a sink present for staff to wash their hands.
- Staff had access to hand cleansing gel for hand decontamination. We saw staff using this after contact with patients.
- Staff had access to all methods of personal protective equipment (PPE) to enable them to protect themselves and patients during care and treatment. However, the masks provided for use when patients had or were suspected of having a respiratory infection were not filtered face masks and would not protect them from infections such as influenza or tuberculosis. Filtered face pieces are face masks used to protect staff when treating patients with a transmissible respiratory infection. It is a Health and Safety Executive requirement for staff to be fitted for and trained in the use of these masks.
- Staff used single use arm protectors when undertaking blood pressure readings. This prevented any potential transmission of infection between patients.
- Wipes were available for staff to decontaminate equipment after use. Staff also had access to spillage kits in the event of a spillage of blood or bodily fluids.
- Staff accessed specialist infection prevention and control advice from the local acute hospital if they had any queries.
- Systems to manage the risk of legionella were not robust. At the time of our inspection, staff could not produce a risk assessment or policy for the prevention of risk associated with legionella. Information received after the inspection demonstrated a risk assessment was conducted in 2014, however, there was no evidence of on-going monitoring of the risk.

Mandatory training

- Data provided by the service before the inspection showed staff had not completed all mandatory training requirements. Staff were not in date with mandatory training for fire training, equality and diversity and information governance.
- Staff were in date for basic life support training, infection prevention and control and safeguarding training. Staff completed a mixture of electronic learning and face-to-face sessions for their mandatory training.
- Staff told us they were able to attend mandatory training sessions and additional training sessions. They felt supported to seek additional training opportunities relevant to their roles.

Assessing and responding to patient risk

- Staff used an early warning scoring (EWS) system to identify a deteriorating patient to record routine physiological observations including blood pressure, temperature, respiratory rate, and heart rate. The recording generates a score, which acts as a trigger for further interventions from increased frequency of observations to urgent medical intervention. The EWS system was designed to enable staff to recognise and respond to acute illness, clinical deterioration and to seek appropriate medical assistance.
- The service had developed a deteriorating patient procedure dated March 2017. The procedure provided details around the use of EWS however there were no details of actions for staff to follow if a patient had a raised EWS. We were not assured patients would be identified and receive the required intervention.
- The procedure required staff to record oxygen saturations; however, the clinic did not have an oxygen

saturation monitor. Oxygen saturation is the amount of oxygen the blood is carrying expressed as a percentage. At the time of our inspection, this procedure was not embedded.

- At the time of our inspection, the service had not provided staff with formal sepsis training, however information provided after the inspection showed staff had completed sepsis screening and action training in April 2017. Sepsis is a life threatening condition that arises when the body's response to an infection injures its own tissues and organs.
- Staff told us about an example where a patient had attended the clinic and they had escalated concerns due to displaying potential signs of sepsis. The staff transferred this patient to the local acute hospital for further care and treatment. Staff told us they would access 999 services in an emergency.
- The service had a day bed where patients who were unwell could go and sleep whilst the clinic was open. Staff told us they would assess the patients first and would regularly check on the patients and complete observations if necessary. The administration support worker would also stay in this room and monitor the patient. However, there was no formal procedure available for staff to follow when monitoring patients using the day bed.

Staffing levels and caseload

- Two registered nurses were employed by the service to run the clinic with the support of a member of staff who undertook administration duties.
- The clinic was open between 10am and 2pm. One nurse ran the clinic for the four hour duration it was open with exception of the Wednesday clinic which had an overlap of both nurses for a handover. The case load for that period could be between five and 19 patients.
- Staff told us in the event of both nurses being unable to provide a service, agency staff would be used to run the clinic. Staff told us this had previously happened, but found it difficult to find an agency nurse with the required skills due to the specialised nature of the clinic and the patients they treat. Information provided by the service showed no agency nurses had worked in the clinic between January 2016 and January 2017.

Managing anticipated risks

- Information collected on homelessness demonstrated an increase in the numbers of those requiring the care and treatment provided by the service in the winter. Additional provisions were made by the service during the winter months to meet the additional demands. This included opening up the service during the weekend and staff attending other locations to identify patients who may require their care and treatment and sign posting them on for this.
- Staff told us there was no official plan which took into account planned staff absence. Staff would try to cover the absences between themselves to ensure the service was not disrupted. However, on the unannounced visit the clinic was closed as there was no cover arranged for the planned absence.
- Staff told us they completed violence and aggression training and de-escalation training to enable them to manage a patient whose behaviour was challenging and/or aggressive. If staff were unable to de-escalate the situation, they would vacate the area and call for emergency services to intervene in the situation. However, we found no evidence of staff completing this training on the training matrix.
- The service developed a draft protocol for maintaining a peaceful environment for staff, service users and visitors in March 2017. This was to support staff to manage with situations of violence and aggression. This had not been implemented at the time of our inspection and staff were not aware of this policy.

Major incident awareness and training

- All staff told us they were aware of the risk fire posed to the service. The larger organisation covered four floors, with the clinic located on the ground floor. The service regularly invited external agencies to inspect the safety of the building and the equipment used to fight fires. The service also had a member of staff who acted as a fire warden. However, staff had not received appropriate training and education on the actions to take in the event of a fire, which included evacuation drills.
- There was no major incident policy in place at the time of our inspection.

Are community health services for adults effective?

(for example, treatment is effective)

Evidence based care and treatment

- There were minimal numbers of policies and procedures available based on National Institute for Health and Care Excellence (NICE) guidelines. New policies produced did include relevant NICE guidance. An example of this was the protocol for maintaining a peaceful environment for staff, service users and visitors which referenced NICE guidance 10 (violence and aggression: short term management in mental health and community settings). However, this was in draft and had not been implemented at the time of our inspection and staff were not aware of this policy.
- Staff practiced clinical procedures such as dressing a wound based on guidance from national evidence based clinical skills and procedures manual.
- At the time of our inspection there was no policy in place for the management of sepsis based on NICE guidance 51 (sepsis: recognition, diagnosis and early management).
- Staff used tools which were evidence based to assess patients for specific requirements. This included assessment tools for cognitive and respiratory complaints.

Nutrition and hydration

- There were facilities available on site for patients to access food and drink. Patients who attended the clinic would regularly stay and have a meal following their appointments.
- There was a food bank on site for patients to visit and take a parcel of food away with them after their appointments.

Technology

- The service had recently moved to an electronic notes system which is commonly used in primary healthcare. This enabled improved information sharing with other providers and meant information was available to the staff reviewing patients in the clinic.

Patient outcomes

- The clinical commissioning group (CCG) which funded the clinic services set patient outcomes. The Chief Executive Officer (CEO) sent a report each quarter to the CCG to demonstrate how the clinic met each outcome during the quarter.
- There were no official key performance indicators set for this service; however the service was required to demonstrate they had achieved each patient outcome once for each quarter. Data provided by the service showed the patient outcomes set by the CCG were met each quarter.
- Staff told us they were unable to make comparisons of outcomes against other services due to the bespoke service provided.
- Staff told us there were other patient outcomes which they considered important however the nurses had not audited these. Staff told us due to better facilities in place, this would be a possibility for the future. Outcomes they identified but not audited were patients becoming well, becoming registered with a GP, appropriate diagnosis and correct treatment for that diagnosis.
- Staff submitted information about patients who entered the smoking cessation programme to the national database statistics for smoking cessation. The clinic staff did not receive any feedback about the information submitted.
- Staff submitted information about influenza vaccination uptake amongst their patient group to the national database of statistics. The clinic staff did not receive any feedback about the information submitted.
- Staff submitted data on other initiatives which they participated in, this included needle exchange and a sexual health programme called 'frisky/risky'. The staff did not receive feedback about the information they submitted and did not have processes in place to review their own performance.

Competent staff

- The service had a comprehensive induction policy for all new staff members to complete. We saw evidence in four staff files of checklists, however all files we saw the checklist had only partially been completed. We were not assured staff had fully completed their service induction.
- Staff completed formal clinical supervision sessions which staff documented and kept in their personal files, one of the trustees' conducted this. The service had recently introduced this, clinical staff told us they were pleased this was in place. The previous system was more informal and had no records produced from the meetings. The nurses had received one session each

(February 2017 and March 2017) on reviewing the notes there was no consistent format, neither the supervisor or the nurse had signed the document and there was no planned date for the next session.

- Staff told us poor performance was managed efficiently and effectively. The CEO would identify those who were underperforming and discuss this with them. If the individual's actions did not improve, the CEO would take appropriate action. The Beacon House policy manual supported staff going through this process.
- During our inspection we checked the personnel files of both registered nurses. We found both files demonstrated out of date, additional training. This included needle exchange, smoking cessation, venepuncture (the puncture of a vein to withdraw blood) and ear care.
- One of the files we checked did not have a record of the nurse's personal identification and Nursing and Midwifery Council (NMC) registration. We discussed this with the nurse and the CEO, they told us the information had been taken out and not returned to the file. The NMC states an employer must ensure all nurses are registered before they begin employment which must be regularly checked throughout the time they are employed. We checked and verified at the time of inspection that the nurse was registered with the NMC. The CEO did not appear to be aware this information was missing. On the unannounced inspection there was evidence the CEO had checked and documented these details in the personnel file.
- Staff in the clinic had supported each other in preparation for revalidation with the NMC. Revalidation is the process all nurses had to complete to renew their nursing registrations and continue practising. The staff files demonstrated revalidation was in progress and evidenced.
- The service regularly supervised student nurses and allied health professionals; however no staff in the clinic had completed the mentorship programme. Mentorship involves a more senior or experienced person helping a student to develop clinical competence. It is a requirement of the NMC for students to be assessed and supported by qualified mentors.
- Staff had appraisals each year. They told us they were meaningful and helpful to reflect on what had occurred during the year to enable them to focus on setting goals for the next year. However, we saw evidence of inconsistent practice with appraisals. One staff member received an appraisal annually as required, however one staff member only had an appraisal every two years. One appraisal did not have any goals set for the following year.
- One member of staff was a qualified nurse prescriber (September 2009). The NMC states it is the nurse's responsibility to remain up to date with knowledge and skills to enable to prescribe competently and safely. During our inspection we did not find any evidence of additional training or up-dates related to prescribing in the personnel files. Following our inspection we requested additional information. We received a certificate for a prescribing study day (December 2016). We were told on-going support to discuss prescribing decisions was discussed during clinical supervision. We reviewed clinical supervision notes February 2017 and found one discussion had taken place; however, this had not been signed as agreed by either parties.

Multi-disciplinary working and coordinated care pathways

- Staff at the clinic worked closely with local GPs to provide a coordinated delivery of care for patients who required further care.
- The service had strong links with local housing organisations, external care agencies and the local authority to provide joined up and holistic care for the patients who required it.
- Staff at the service had a strong working relationship with the local pharmacy who dispensed prescriptions from the service.
- The service had strong links with several substance misuse services which they referred patients to. One of the external services attended the location to conduct parts of the treatment.
- Staff made referrals to mental health organisations where appropriate for patients who attended the service, these included independent and local NHS providers. There was immediate access to a community mental health team for patients who required immediate intervention.
- Clinic staff were working with multidisciplinary professionals from a local hospice to develop a care pathway for homeless patients who may require end of life care.

Referral, transfer, discharge and transition

Community health services for adults

- The staff in the clinic referred on patients who needed access to a GP. Each local GP service took it in turns to review a patient referred on from the service. During our inspection we observed the service referring a patient to an alternative GP practice as the original one had refused to see a patient referred to them.
- The service worked to empower people to make their own decisions and take back control of their lives. This included moving on from the clinic services. All patients who discharged from the clinic had established mainstream care with a GP.
- The service had clear referral protocols in place so patients could access more specialist services. This included referrals for counselling and specialist testing for blood borne viruses.
- The service received referrals from other external agencies for patients to receive care and treatment at the clinic. The service had no official referral paperwork for external agencies to complete.
- The service had good links with the local acute hospital. Staff would liaise with the local acute hospital if any patients were discharging back into the community.
- Staff transferred 15 patients to the local acute hospital between March 2016 and February 2017. A further five patients had an ambulance requested to take them to the local acute hospital; however they were treated and discharged at the clinic.

Access to information

- Staff received information from outside GP practices related to any patients referred to them. This enabled staff at the service to provide appropriate ongoing care and treatment. Staff told us one example of where information was shared to allow them to conduct follow up blood tests.
- Staff shared information with outside GPs through the use of secure facsimile despite having a computer system which was able to share information. Staff told us they hoped to utilise the computer system effectively once it had been in place for a longer period.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- The service had an informed consent policy which staff adhered to. This was displayed within the clinic room so patients were also aware of this policy.
- Patient's consent was sought to share their health records with other parties, for example GPs where patients were referred to. This consent was documented on the patient's records.
- Staff were aware of the process and procedures for guardianship. Guardianship is being legally responsible for the care of someone who is unable to manage their own affairs.
- Staff completed Mental Capacity Act training every three years. Information provided by the service showed staff last completed this training in 2017.
- Staff did not use restraint against any patients and were not trained to do so. The policy supported de-escalation of a volatile situation and to exit the area if de-escalation failed.

Are community health services for adults caring?

Compassionate care

- The clinic followed an open door policy which was in place in the wider organisation. During our inspection we observed other members of staff from the wider organisation entering the clinic environment whilst patient consultations were occurring. This action failed to take into account the privacy and confidentiality of the patients being treated at the time.
- We observed one member of staff asking a patient if they consented to having the door left open during their consultation. We did not observe this in all consultations which meant it was not common practice on all consultations that took place.
- We observed staff treating patients with sensitivity and a supportive approach. Staff demonstrated positive engagement with patients which was free of any discrimination against them.
- Staff demonstrated sincere compassion and empathy to the patients they provided care for.
- We received 13 comment cards from patients which stated all staff were compassionate, caring and respectful towards them. The patient survey comments conducted by the clinic in March 2017 also supported these views.

Understanding and involvement of patients and those close to them

Community health services for adults

- Staff communicated with patients in a manner they understood. Time was taken to ensure patients understood what was happening and planned and confirmed this when the patient left the clinic. The patient survey conducted by the clinic in March 2017 also supported these comments.
- One patient highlighted that staff gave adequate, clear information and were not vague.
- Staff made sure patients had the opportunity to ask questions about their care and treatment during and after their consultation.

Emotional support

- The patient group that attended the clinic were vulnerable, staff understood the impact of care and treatment on the patients overall wellbeing.
- The clinic was part of a larger organisation where the holistic needs of a patient were considered and met. We saw staff in the clinic allocate an appropriate amount of time for each patient so all aspects of their wellbeing could be discussed. If further support was required, we saw staff signpost to other members within the larger organisation.

Are community health services for adults responsive to people's needs?
(for example, to feedback?)

Planning and delivering services which meet people's needs

- A local clinical commissioning group (CCG) funded the clinic services. The Chief Executive Officer (CEO) occasionally invited commissioners into the service to review how staff provided services to meet the patient's needs.
- The service monitored the local homeless population and used this intelligence in the planning of the services. This intelligence was instrumental in the forward planning of acquiring alternative premises to meet the rise in demand for services provided at Beacon House, including the clinic services.

Equality and diversity

- The vision and ethos of the service was to provide a primary healthcare service to individuals who were considered as marginalised. Individuals who used the service were homeless people, those in insecure accommodation and those at high risk of homelessness.
- Staff used an online translation service to meet the needs of patients where English was not their first language.
- The clinic services were located on the ground floor. This provided easy access for individuals who may have a disability or a physical impairment.
- Staff were required to complete equality and diversity training every three years. However, information provided by the service showed no recorded date for staff completing this training.

Meeting the needs of people in vulnerable circumstances

- Staff told us the open door policy was in place not only for their safety, but also to break down barriers for patients who may have trust issues. The open door signified an open and transparent environment which was there to make patients feel safe but did not protect patient's confidentiality or privacy.
- The patients who used the service were all regarded as vulnerable and the staff at the service worked hard to meet the individual needs of each patient. We saw staff sign posting patients to other services offered by the provider such as the laundry and food bank.
- Staff had not received training for caring and meeting the needs of patients living with dementia or learning disabilities. One staff member told us they occasionally have patients attend the clinic with alcohol induced dementia, so there was a requirement for improved knowledge of meeting the individual needs of a patient living with dementia.

Access to the right care at the right time

- The clinic opened between 10am and 2pm, Monday to Friday. Outside of these hours patients were given a 'non clinical triage form' which directed them to the local walk in centre or the local acute hospital if deemed an emergency.
- The clinic was closed on the unannounced visit due to the nurse taking leave. The CEO told us this was well publicised the week before, however patients had still turned up wanting to see a clinical member of staff.

Community health services for adults

- The clinic did not run specified timings for the appointments given to patients. The staff gave the patient as much time as required for their needs. If the problem was complex, staff gave the patient the opportunity to attend for a follow up appointment the next day.
- Staff told us if the clinic was running slowly or had complex patients that required additional time; staff kept all patients up-to-date with this information. A member of staff would also collect patient details and a reason for attendance to enable appropriate triage and prioritisation of those with more urgent requirements.
- The service provided a seasonal influenza vaccination service. The local pharmacist provided these vaccinations to the clinic and would be collected by staff and stored in their medicines refrigerator as required.
- There was no 'did not attend' policy for the clinic; however staff would attempt to contact patients using details provided at registration to check on them if they had arranged a follow up appointment at the clinic which they failed to attend.

Learning from complaints and concerns

- The service had received no formal complaints from March 2016 to February 2017.However, we reviewed the most recent patient complaint (July 2013) which demonstrated investigation and the outcome of this, response to the complainant and actions taken as a result.
- A complaints box was located at the reception desk for patients to use if they had any complaints or concerns which they wanted to raise.
- At the time of our inspection the CEO gave us a comments and complaints policy and leaflet produced in March 2017. Staff told us they were not aware of this so it was not embedded within the service.

Are community health services for adults well-led?

Leadership of this service

- The Beacon House board consisted of eight trustees who had delegated areas of responsibilities which included quality, safeguarding, patient experience and complaints, finance, property, clinical commissioning group (CCG) compliance, Mental Health Act, church and local authority relations. Some trustees were not aware of their allocated responsibilities and felt they were a trustee by name only.
- The experience the trustees had was variable, for example, the trustee responsible for safeguarding had the basic level of safeguarding training, however, the trustee responsible for finance had professional experience of managing accounts.
- The board of trustees told us they delegated authority to the Chief Executive Officer (CEO).
- At the time of our inspection the registered manager (RM) was one of the nurses who ran the clinic. We were told the current RM was waiting to handover the responsibility of registered manager to the CEO. There was some uncertainty from the current RM as to how long they had been in the role. We were told all issues would be referred to the CEO for consideration.
- We were told the RM was clinic focused and the CEO had overall responsibility for the clinic and the larger organisation. It was demonstrated during inspection the CEO was the link between the trustees and the clinic staff. All members of staff we spoke with were aware of the reporting structure.
- The registered manager did not demonstrate understanding of the legal responsibilities of the role. The RM was required to inform the CQC of changes to service delivery so that the statement of purpose could be up-dated. The CEO had stopped services being delivered from another location. The CQC had received no notification of this change therefore the statement of purpose was not up-to-date. This is a legal requirement of the RM role. A statement of purpose is a legally required document under the Health and Social Care Act 2008 that includes a standard set of information about a providers service. The statement must describe aims, objectives and a current description of the services provided. Every registered provider must have a current statement of purpose.
- The chair of trustees reported directly to the charity commission, it was unclear as to how often this happened. We were told contact had not been made since the chair had been in post (October 2016) and would only contact if there was any new information. The charity commission is an independent organisation that makes certain charities are working legally and effectively.

Community health services for adults

- We had mixed responses from the trustees regarding the reporting of risks and incidents. The trustees told us there was a risk register and incident reporting was a management responsibility. Some of the trustees were not aware or not sure of an overarching incident reporting system. They told us the CEO held incident report documentation. We were not assured the board of trustees had oversight of risk or incidents to the service or had the information to have a proactive approach to continuous learning and improvement.
- The CEO reported to the trustee board every two months. We reviewed trustee meeting minutes (November 2016 and January 2017) which had set agenda items that included financial reports, the CEO's report, re-location of Beacon House and fundraising.
- The CEO prepared board reports for the meeting. We reviewed two CEO reports (September 2016 to October 2016 and November 2016 to December 2016) which included educating and equipping others, empowering projects to work and improving the potential of the organisation. From these reports there was one reference made about the clinic which related to the installation of the electronic patient record system. We were not assured there was a detailed oversight of the governance related to the clinic activity.
- The CEO had completed a clinical management course to strengthen their leadership ability for the clinical side of the service. However, there was a lack of understanding for the responsibilities, clinical skill and importance of training required for the registered nurses role who ran the clinic.

Service vision and strategy

- The vision for the service was to provide excellent care for individuals who were marginalised. This was provided through 'acceptance, empowerment and change'. All staff were able to recall the vision for the service.
- We saw evidence of a Beacon House Ministries five year strategic plan (October 2014). This stated their mission and five year plan under the headings of acceptance, empowerment, change and steady growth. Consultation had been sort from the other members of staff.

Governance, risk management and quality measurement

- The arrangements for governance did not always operate efficiently or effectively. There was no effective system for identifying, capturing and managing issues and risks.
- There was no formal risk register for the service, however all staff were able to identify risks within the service and inform us of measures taken to mitigate these risks. The most common risk which staff informed us of was the volatile patient group who they provided care and treatment for.
- There was no formalised process for risk assessments. We requested details of any risk assessments carried out between January 2016 and January 2017. We received a completed legionella risk assessment dated 2014 but no others were forwarded despite staff identifying examples of risk such as the safety of staff and patients due to the potential of violent and aggressive behaviour.
- Staff had adopted an open door policy for 'safety purposes', this meant leaving every door open at all times, however, there was no evidence of a risk assessment which supported this action, no previous incidents had occurred which indicated there was a risk to staff in the clinic so the rationale for the decision was not fully assessed.
- There was no formal system to report clinical incidents. We were told incidents and concerns were raised at the daily team meeting, however, there was no record of these. The CEO told us this would be looked in to. Following our unannounced inspection we were told a recording template was to be developed.
- There was a lack of process to record the number and type of incidents therefore any actions, themes or shared learning to prevent a reoccuring incident was not taking place.
- There were outstanding actions following a report undertaken by an external agency in 2014 which provided an assessment of Beacon House continuity plans. The outstanding actions included the instigation of a near miss register, a business continuity plan, legionella checks and fire training for staff. The CEO told us they were aware of these actions and they would action them but did not provide a timeframe.
- The CEO told us the panic alarm in the clinic was not re-connected following routine electrical work. We were told this was due to the open door policy and did not conform to the open culture of the service as staff did not need it. We did not see any risk assessment or staff communication to support this decision.

- There was a policy manual revised February 2017 for review February 2018. It provided a central reference point of policies and guidance for all staff employed by Beacon House. For example, it covered recruitment and selection, induction, standards of business conduct, internet and email usage, performance and appraisal. During our inspection we saw a number of recently written policies which were waiting approval by the board of trustees.
- These included the incident reporting procedure, specimen handling protocol, deteriorating patient, maintaining a peaceful environment for staff, service users and visitors and the complaints and comments policy with a complaints leaflet attached.
- Whilst the provider had taken steps to create these policies staff were not aware of them and had not been consulted, they were not embedded into practice and not suitable for clinical use. These included the protocol for handling specimens and the procedure for patient deterioration.
- Records demonstrated and staff gave us examples of people under the age of 18 who had accessed the service. This could potentially happen again, however, there was a lack of acknowledgment of the importance of having a policy to aid staff in safeguarding this vulnerable group. The CEO told us a children's safeguarding policy was not in place as it would be perceived children were accepted into the service.
- The trustees we spoke with told us they relied on one trustee to oversee the running of the clinic due to their professional background being medical. The trustee would then feedback their findings to the rest of the trustees. This meant there was not a collective oversight of the governance, risk and quality measurement of the clinic.
- A trustee told us if there were any issues with the clinic service it would be highlighted by the CEO or the RM. We were told the RM had not personally spoken with the trustees for one to two years, however, it was hoped the new chair of governors would improve this. We were not assured there was a robust system in place to hightlight issues related to the clinic.
- There was a system in place for recording the overall completion of staff training however, this demonstrated the mandatory and additional training of both of the nurses to be incomplete and some were out of date. The CEO had poor oversight of the completion of mandatory and additional training required for the registered nurses.
- We checked three staff files which were incomplete. There was no employment history for two out of the three files, references were incomplete for one file, and there was no health questionnaire present in all three files which meant assurance could not be evidenced regarding immunisation status. There was proof of registration with the Nursing and Midwifery Council (NMC) for one nurse. For the remaining nurse there was no evidence of this. The CEO was not aware of this and had no oversight as to when the re-registration of the clinic nurses were due. The staff files were disorganised and incomplete. Following our unannounced visit some effort had been made to organise and up-date these.
- The board of trustees and the CEO were undertaking a series of governance development days being delivered by an external organisation. We saw formal notes from the day (January 2016) which included evidence of discussion relating to trends and changes, awareness of the skills for the board of trustees, understanding changing needs of service users and the trustees' contribution to the development of Beacon House. All the trustees spoke positively of this.
- Staff told us there were monthly team meetings where the entire service was discussed. We reviewed Beacon House team meeting minutes from January 2016 to January 2017; each area had a standing item on the agenda, including the clinic. We saw evidence of discussion related to clinic activity and progress. One or both of the clinic nurses attended all of these meetings.
- The clinic nurses met monthly, we reviewed minutes of these meetings (August 2016 and September 2016). Information discussed in both meetings included an increase in patient numbers attending the clinic and concerns being raised about not meeting the needs of the patients due to lack of time, the need for clinical supervision, outstanding training which needs to be arranged and clinic administration support.
- Staff had recently begun formal clinical supervision sessions supervised by the chair of the trustees. Both nurses had received one session each (February 2017 and March 2017). On reviewing the documentation the nurses had raised concerns about the incompleteness of their mandatory training having been due to

computer failures. The supervisor recorded this in the supervision notes (February 2017) that computer failure was a valid reason and would be an acceptable explanation to the CQC.

Culture within this service

- Staff told us they felt valued and respected and were comfortable in approaching the CEO if they experienced any problems. There was a whistle blowing policy at the service which supported them to raise concerns.
- The safety of the staff was paramount at the service. The service had an open door policy which was not only to promote openness with the patients, but also addressed concerns about staff safety.
- All staff told us they worked at the service because they wanted to be there and make a difference to the individuals. Staff from the clinic also volunteered outside of their paid employment to undertake work in the wider organisation.

Public engagement

- The service obtained service user feedback from customer surveys and monthly service user forums. Feedback comments included 'Beacon House is like a family to me', 'so helpful, I couldn't have survived without you', 'the nurse allowed you to time to fully describe your illnesses, 'the nurse was friendly and treated you with respect'. We saw minutes, actions and topics discussed (September 2016) which included extending the opening hours to the weekend, an art workshop and a cinema trip.
- The larger organisation had a page on social media which publicised the work they conducted and engaged with the local community, including patients they had previously helped.
- The local population nominated the service to receive a grant from the local authority in 2016.

Staff engagement

- The team met daily before the service opened to allow open communication with all of the staff and to have an opportunity to discuss any issues, concerns, work load, team thoughts and share a team prayer.
- Staff participated in team development days three times per year. These days were not about the delivery of training, but were about the staff developing who they were and how they react to scenarios. We saw notes from the day held on 22 March 2016 where topics such as the importance of measuring outcomes and strengthening staff team work in using outcomes undertaken by Beacon House. Staff we spoke with valued these days.
- The larger organisation which the clinic was part of received recognition by the high sheriff of Essex for their valuable contribution to community safety.

Innovation, improvement and sustainability

- Staff from the clinic had received the Queen's Nursing Institute award in 2016 for the services provided to this patient group. The Queen's Nursing Institute award is to honour nurses who have demonstrated a high level of commitment to patient-centred values.
- Staff told us the sustainability of the service depended on the negotiations with the CCG who funded the clinic's service. The negotiations were centred around the provision of evidence to support the requirement for the service and the continual provision of the CCG quarterly report.
- Staff told us of plans to improve the service by looking at new premises to provide care and treatment. These plans also included the possibility of the current premises being rented out which would provide more funds for the service, enriching the sustainability of the service.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure systems and processes are implemented to assess, monitor and improve the quality and safety of the services.
- The provider must ensure incidents that affect the health, safety and welfare of people using the services are investigated and actions taken to prevent recurrences.
- The provider must implement and monitor systems to ensure children are safeguarded from abuse.
- The provider must ensure there is a policy which identifies and manages the deteriorating patient.
- The provider must ensure all staff have full understanding of duty of candour which is supported by a policy and procedure.
- The provider must ensure there is a policy in place to respond to emergencies and major incidents.
- The provider must ensure a system is developed and implemented to manage complaints that include learning from complaints.
- The provider must design and implement a system which records and monitors risks.
- The provider must ensure all staff receive the appropriate support, supervision, on-going training and appraisals to enable them to carry out the duties they are employed to perform.
- The provider must ensure all staff complete their mandatory training.
- The provider must ensure all staff undergo complete checks and record of a full induction to enable them to work at the service and evidence maintained in their personal files.
- The provider must ensure there is adequate equipment available to use in the event of a medical emergency.
- The provider must ensure there are systems in place to maintain safe handling and management of medicines.
- The provider must ensure the privacy, dignity and confidentiality of patients being treated in the clinic is upheld at all times.
- The provider must ensure the registered manager is aware of their legal obligations required of them to undertake the role.
- The provider must esure the statement of purpose is current and up-to-date in accordance with the the regulations.
- The provider must ensure any changes to the statement of purpose are communicated to the CQC within 28 days of that change.

Action the provider SHOULD take to improve

- The provider should ensure actions advised as part of the legionella risk assessment are completed and processes are in place to protect patients from the risk of legionella.
- The provider should ensure staff adhere to correct processes when transporting specimens.
- The provider should ensure the infection control policy contains all relevant details for staff members to follow to ensure adherence to infection prevention and control standards.
- The provider should ensure all staff have access to all relevant personal protective equipment to enable them to protect themselves and their patients from potential infections.
- The provider should ensure hand washing sinks conform with Health Building Note (HBN) 00-09 infection control in the built environment standards for both the clinic rooms.
- The provider should ensure the refrigerator is serviced as required and staff know what to do if recorded temperatures are out of an accepted range.
- The provider should ensure all equipment is renewed, replaced, in date and ready to use.
- The provider should ensure recording actions taken in response to any alerts or updates received.
- The provider should ensure undergoing training around incident reporting and what constitutes and incident to strengthen the reporting culture.
- The provider should ensure providing staff with formal dementia training.

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 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Health and Social care Act 2008 (Regulated Activities) Regulation 2014 Regulation 10 (2) (a) Dignity and Respect:** Ensuring the privacy of the service user. **How the regulation was not met:** The clinic room door was left open in accordance with a wider open door policy at the service. Patients were not always asked if it was acceptable with them to have the door left open during consultations and treatment. Other members of staff walked into the clinic room during patient consultations.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Health and Social care Act 2008 (Regulated Activities) Regulation 2014 Regulation 12 (2) (a):** Assessing the risks to the health and safety of service users **How the regulation was not met:** There were no formal risk assessment tools or risk assessments undertaken for patients with disturbed behaviour or violent and aggressive patients. There was no policy embedded to identify or manage a deteriorating patient.

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Requirement notices

No formal training in sepsis recognition or recognising a deteriorating patient had been delivered for staff at the time of our inspection.

Health and Social care Act 2008 (Regulated Activities) Regulation 2014 Regulation 12 (2) (b): Doing all that is reasonably practical to mitigate risks

How the regulation was not met:

There was no formal risk assessment tools or risk assessments undertake for patients using the service.

There was no policy or procedure in place at the time of our inspection to guide staff how to manage disturbed, violent or aggressive patients.

No evidence for staff training in violence and aggression or de-escalation training was provided.

Staff were not completely aware of their role or responsibility in raising concerns, recording and reporting safety incidents or near misses. At the time of our inspection, staff did not report clinical incidents through a formal reporting system.

A panic alarm in the clinic room had been disconnected.

Health and Social care Act 2008 (Regulated Activities) Regulation 2014 Regulation 12 (2) (f): Where equipment or medicines are supplied by the service provider, ensuring that there is sufficient quantities of these to ensure the safety of the service user and to meet their needs.

How the regulation was not met:

There was minimal resuscitation equipment available at the service, which did not include the recommended items by the Resuscitation Council UK.

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Health and Social care Act 2008 (Regulated Activities) Regulation 2014 Regulation 12 (2) (g): The proper and safe management of medicines

How the regulation was not met:

At the time of our inspection emergency medicines were left unsecure and unsupervised in the clinic room.

There was no evidence for the administration of emergency medicines for anaphylaxis overdose.

We found out of date medicines during our unannounced visit.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Health and Social care Act 2008 (Regulated Activities) Regulation 2014 Regulation 13 (2):** Systems and processes must be established and operated effectively to prevent abuse of service users **How the regulation was not met:** Safeguarding policies and procedures for children were not in place. There were no formal safeguarding children training for the service although patients under the age of 18 had attended. Safeguarding Children: roles and competences for healthcare staff Intercollegiate Document (March 2014) states that a minimum Level Two safeguarding training is required for non-clinical and clinical staff who have some degree of contact with children and young people, their parents and/or their carers. This would train staff to identify and refer a child or young person suspected of being a victim of trafficking, sexual exploitation, at risk of female genital mutilation (FGM) or at risk of radicalisation.

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Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **Health and Social care Act 2008 (Regulated Activities) Regulation 2014 Regulation 16 (1):** Any complaint received must be investigated and necessary and proportionate action must be taken in response to any failure identified by the complaint or investigation. **How the regulation was not met:** A policy for complaints and concerns was not embedded at the time of our inspection. Staff were unaware of the steps to take in response to receiving complaints and concerns.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Health and Social care Act 2008 (Regulated Activities) Regulation 2014 Regulation 17 (2) (a):** Assess, monitor and improve the quality of the services provided in the carrying on of the regulated activity. **How the regulation was not met:** Policies and procedures did not always contain the necessary information and guidance for staff. Examples of this was the deteriorating patient policy and Safeguarding policy. The trustee board relied on one trustee for oversight and validation of the clinic.

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The registered manager (RM) did not demonstrate understanding of the legal responsibilities of the role. The RM was required to inform the CQC of changes to service delivery so that the statement of purpose could be up-dated. The CEO had stopped services being delivered from another location. The CQC had received no notification of this change therefore the statement of purpose was not up-to-date. This is a legal requirement of the RM role.

No formal auditing of systems and practice to assess, monitor and identify improvements in the service.

No rigorous system in place to manage staff personnel files and ensure their completeness.

There was no major incident policy in place at the time of our inspection.

Health and Social care Act 2008 (Regulated Activities) Regulation 2014 Regulation 17 (2) (b): Assess, monitor and mitigate risks relating to health and safety and welfare of service users and others who may be at risk which arise from the carrying on of regulated activities.

How this regulation was not met:

There was no risk register for the service and no formalised risk assessment process.

There was no incident reporting policy in place at the time of our inspection.

Staff were unsure what constituted an incident.

Learning from incidents could not be evidenced at the time of our inspection.

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Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Health and Social care Act 2008 (Regulated Activities) Regulation 2014 Regulation 18 (2) (a):** Receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. **How the regulation was not met:** Clinical supervision had not been completed for all staff. Not all staff had an annual appraisal. There was limited evidence of a staff member completing ongoing training for their prescribing qualification. Staff had not completed mandatory training as directed. We were unable to find evidence staff had ever completed some topics (information governance, fire training and equality and diversity). Both nurses were out of date with additional training. This included needle exchange, smoking cessation, venepuncture (the puncture of a vein to withdraw blood) and ear care. There was limited evidence of additional training or up-dates related to nurse prescribing in the personnel file or within the appraisal documentation of the registered nurse prescriber.

Regulated activity	Regulation

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Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour **Health and Social care Act 2008 (Regulated Activities) Regulation 2014 Regulation 20 (1) (2) (3) (4) (5) (6) (7) (8) (9):** Registered persons must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity. **How the regulation was not met:** Staff employed in the area where regulated activity was conducted were unaware of the duty of candour. There was no duty of candour policy at the time of our inspection. The new incident reporting policy and complaints and concerns policy produced since our inspection did not contain details about the duty of candour.
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose **Regulation (2) of the Health and Social Care Act 2008 (registrations) regulations 2014:** (2) The registered person must keep under review and, where appropriate, revise the statement of purpose. **How the regulation was not met:** The statement of purpose required to be submitted to the CQC informing of change in service delivery was not up-to-date.

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(3) The registered person must provide written details of any revision to the statement of purpose to the Commission within 28 days of any such revision.

How the regulation was not met:

The CQC had received no notification of change to service delivery in the required 28 days of the change.