Sheffield Alcohol Advisory Service

Quality Report

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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

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Overall summary

We do not rate substance misuse services.

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

• Staff did not identify or manage risk effectively. Staff did not record the risks in sufficient detail or review clients' risk assessments regularly. Clients did not have a risk management plan. This meant staff relied on verbal information from discussions with client and information recorded in the handover diary.

• Four out of the five care plans we looked at identified areas where changes could aid a person's recovery. However, it was unclear what the actual goals were and how they could be achieved. This meant there was no clear indication that the client was involved in constructing their care plan or agreed with it. Clients could have a copy of their care plan if they requested it.

Summary of findings

• The clients' induction pack provided clear information on confidentiality and sharing of information. However, staff did not ask clients for consent to share information with the National Drug Treatment Monitoring System (NDTMS).

• While there was clear learning from serious incidents, staff did not to follow the governance structure for reporting all incidents. Staff dealt with some incidents informally and did not record them according to policy. This meant they could not identify trends.

• Staff did not document informal complaints raised during the daily 'feelings' meeting or how these complaints were resolved.

However we also found the following areas of good practice:

• The environment was homely and welcoming, with supportive and empathic staff.

• Clients were involved in decisions about their care and the service. They regulated their own code of conduct and agreed house rules with other clients.

• Staff had regular supervision and ongoing appraisals of their work performance from their manager, giving them the support and professional development needed to carry out their duties.

• Clients received care and treatment underpinned by best practice, and had access to psychosocial therapies, group work sessions and individual one to one sessions with a counsellor.

• Discharge planning included an aftercare package to support clients for up to five years following rehabilitation.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Substance misuse services		This report describes our judgement of the quality of care provided within this core service by Sheffield Alcohol Support Service. Where relevant we provide detail of each location or area of service visited. Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations. Where applicable, we have reported on each core service provided by Sheffield Alcohol Support Service and these are brought together to inform our overall judgement of Sheffield Alcohol Support Service.

Summary of findings

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Summary of this inspection

Our inspection team

Our inspection team was led by: Jacqui Holmes

The team that inspected Sheffield Alcohol Advisory Service included two CQC inspectors, a mental health nurse and an expert by experience (someone with experience of similar services – for example, as a client or carer).

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive substance misuse 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?

Before the inspection visit, we reviewed information that we held about the location During the inspection visit, the inspection team:

• visited the premises and observed how staff were caring for clients

• spoke with four clients who were using the service

• spoke with the registered manager

• spoke with three other staff members; including counsellors and sessional workers

• attended and observed a feelings meetings and a therapy meeting

• looked at five care and treatment records of current and previous clients

• carried out a specific check of the medication management

• looked at policies, procedures and other documents relating to the running of the service.

Information about Sheffield Alcohol Advisory Service

The Sheffield Alcohol Advisory Service (SAAS) at Priory Road is one of two residential alcohol rehabilitation services provided by Sheffield Alcohol Support Service Limited. The regulated activity for this service is accommodation for persons who require treatment for substance misuse. The service has a registered manager.

Psychosocial interventions based on cognitive behavioural therapy (CBT) underpin the service's residential rehabilitation treatment for people who have a problem with alcohol. In addition, the service offers clients training, peer recovery support, counselling and aftercare.

The rehabilitation service at Priory Road comprises a large house consisting of five bedrooms, lounge/dining room, kitchen, utility room and private garden. It is located in a residential area of the city, situated close to

Summary of this inspection

local amenities and public transport. The service gives people an opportunity to rebuild their lives without alcohol in a supportive and stable environment. At the time of our inspection, four clients were in residence.

Clients follow a 26-week rolling programme. Following a 13-week review and funding report, clients transferred to the house from the nearby residential rehabilitation service (Steade Road) run by the same provider. At this stage, clients could apply for leave. This gave them greater independence and prepared them for returning to their communities.

SAAS and the Steade Road service share facilities to deliver the same therapeutic programme. Clients from both services attend joint group therapy sessions and meetings, which can take place at either location. Clients have to attend mandatory sessions and one to one interventions. Thereafter, they have the option of attending further therapeutic and social activities. The service did not provide 24-hour cover, clinical interventions or prescribe medication.

What people who use the service say

We spoke with four people using the service.

Clients spoke positively about the service and described staff as kind, supportive and understanding. They felt staff treat them with respect and that they were in the best place for their treatment.

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 found:

• Staff did not ensure the safety of clients by identifying past and current risks. For example, clients may have a history of drug abuse and possible relapse. They relied on conversations, handover information from colleagues and from clients themselves to identify and manage risk rather than following an individualised risk management plan.

• Staff discussed incidents and documented them in clients' care plans. However, they did not adhere to policies and procedures for reporting incidents.

However:

• Staff demonstrated a good understanding of procedures for safeguarding clients from abuse and the team had a nominated safeguarding lead who dealt with all referrals and alerts.

• Permanent and sessional staff had completed core skills training to their required level.

Are services effective?

We found:

• Staff completed clients' care plans using the assessment paperwork. In four out of the five records we looked at, they had identified areas that could improve a person's recovery. However, it was unclear what the clients' goals were and how they would achieve them. This meant that clients did not clearly know how to progress with their recovery.

However:

• All staff received support and professional development through regular managerial supervision, which included an appraisal process. This meant staff had the skills necessary to carry out their duties and that the manager could assess the quality of care given.

• Sessional staff had undertaken further training for their own personal development, including mentoring and coaching, person-centred care, effective interpersonal skills and motivational interviewing.

• The partnership arrangements ensured a multidisciplinary approach. Interagency work with the SASS 'alcohol recovery

Summary of this inspection

community' and the 'families together' project provided clients with further support, activities and training. Staff had formed effective working relationships with external agencies to support clients during and after their rehabilitation.

Are services caring?

We found:

• Staff established a therapeutic relationship with clients and enabled them to be involved in their care.

• Clients told us that staff treated them with respect and kindness and supported them throughout their stay within the service.

• We saw positive interactions between staff and clients and evidence of good client involvement across the service.

Are services responsive?

We found:

• The house was warm and welcoming. It offered clients the comfort of a home, companionship when needed and privacy when needed.

• Clients had access to a range of therapeutic and community based activities provided by the organisation.

• Staff tried to meet the needs of all people using the service. For example:

▪ separate cooking arrangements could be used to accommodate different faiths.

▪ staff would read and explain induction information to clients who couldn't read.

• Discharge planning included an aftercare package to support clients for up to five years following rehabilitation.

However:

• Staff did not document informal complaints raised during the 'feelings' meeting or how these complaints were resolved.

Are services well-led?

We found:

• The clients' induction pack provided clear information on confidentiality and sharing of information. However, staff did not ask clients for permission to share information with the National Drug Treatment Monitoring System (NDTMS) in line with their guidelines.

However:

Summary of this inspection

- Staff felt supported by the organisation, their manager and colleagues. Morale was good and staff found their work fulfilling.
- The service was responsive to feedback from clients, staff and external agencies.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

This residential service had a warm and welcoming environment. It was clean and well maintained and appropriate for use as a rehabilitation house. During their residency, clients adhered to a behavioural code of conduct and set house rules. This happened during the first two weeks of a new client's rehabilitation stay. They attended a meeting with existing clients to agree the behaviours they considered important. This formed the basis of the house rules, which applied to both locations.

Staff allocated client bedrooms according to gender, with female clients on one floor and male clients on another. All bedrooms had lockable doors. Clients shared the bathroom facilities for their floor. This respected clients' right to privacy and dignity.

Sheffield Council completed the infection control audit and we observed posters promoting hand-washing techniques on an information board and in the bathrooms.

Safe staffing

Permanent staff comprised of a part time manager, a deputy manager, a therapeutic worker, and part time administration support. In addition, there were three regular sessional workers. Sheffield Alcohol Advisory Service (SAAS) shared its staffing complement with Steade Road, the second residential rehabilitation service managed by the Sheffield Alcohol Support Service (SASS). The two locations also shared facilities to deliver the same therapeutic programme.

Permanent staff had low sickness rates. Sessional workers or permanent staff covered any sickness. In an emergency, the service had access to staff working at the Alcohol Recovery Community, which was also part of SASS. This meant the service could always cover client group work.

Permanent and sessional staff had completed identified core skills training to their required level. For example, all staff had undertaken counselling training but only the permanent members of staff who were qualified counsellors had undertaken cognitive behavioural therapy training.

Assessing and managing risk to patients and staff

Staff carried out initial risk assessments on clients when they entered treatment at the Steade Road service. This risk assessment remained in place when the client transferred across to SAAS. The service did not periodically review and update clients' risk assessments.

In all of the records we reviewed of clients staying at SAAS, staff had not fully explored potential risks on admission. The assessment paperwork had unanswered questions, or contained minimal detail. It did not seek all necessary detail to assess risk effectively, which could result in harm to clients, staff or others. For example, staff did not explore risks associated with domestic violence, previous use of other substances, blood borne viruses or details relating to children.

Where staff had identified risks, none of the clients' records detailed any interventions to manage these risks. Staff told us that they would verbally discuss between themselves how to manage risks to clients. However, staff did not record this or use risk management plans. This meant that there were no assurances that all staff knew about individual client risks or how to minimise them. For example, we looked at the records of a client who had a history of harm to others.

Substance misuse services

Some specific activities did have comprehensive risk assessments. These occurred when a client requested leave or a visit. Staff completed a risk assessment detailing the concerns, the likelihood of the risk occurring and the impact. This included actions that either staff or the client would take to minimise the risk. Clients provided staff with details of where they were going and used a register to sign in and out of the premises.

The service did not run a prescribing clinic. The clients' general practitioner prescribed all medication and was responsible for individual physical healthcare needs. In an emergency, clients attended the nearest accident and emergency site or called the emergency response services. Clients had responsibility for managing their own medication, which they kept in a secure locker in their rooms. Following an incident earlier in the year, the service introduced a new medicines management processes based on individual risk.

The service had an identified safeguarding lead. All staff had undertaken basic level safeguarding adults training, which was mandatory. In addition, permanent staff had also undertaken training in safeguarding children. All staff we spoke to had a good understanding of safeguarding procedures and knew when to make referrals to the safeguarding lead. There had been one safeguarding referral made in the last 12 months.

The service had a lone worker policy to safeguard staff.

Track record on safety

There had been one serious incident in the last year. The manager reviewed the incident and implemented changes to minimise the risk of clients from self-harming.

Reporting incidents and learning from when things go wrong

The service had a formal incident reporting policy. However, staff discussed incidents informally with their manager and recorded the incident in the client's file instead of following the incident reporting policy. This made it difficult for the service to audit the incident records and identify trends. All staff received feedback from incidents across the organisation either informally or in team meetings. They were aware of changes made to support clients based on individual risk as part of lessons learned. The service manager would debrief staff immediately after an incident, for example after an eviction. Staff held group sessions to support clients after an incident if appropriate.

Are substance misuse services effective?
(for example, treatment is effective)

Assessment of needs and planning of care

Assessment of needs and the planning of care took place at the start of a client's rehabilitation treatment at the Steade Road location. Although Staff prepared a report for the client's funder detailing their progress, they did not document any changes to risk assessments or care plans throughout their stay.

The initial assessment included the Alcohol Use Disorders Identification Test (AUDIT). This is a recognised tool, which assessed a client's alcohol use and level of dependence. The assessment paperwork included questions relating to a person's physical health. These were limited to current medications and previous complications. As the service provided therapeutic care and treatment only, staff encouraged clients to register with a nearby GP practice. Staff supported clients to appointments as needed.

During the induction process, the client's designated worker completed a care plan. The service used a recovery star tool to gather information from the client about key areas to create a recovery focused care plan. Four of the five records we looked at included this tool. Areas identified were personalised to the individual and covered a range of areas including parenting, physical, recreation, spiritual, family and mental health. Staff had identified areas where changes were required. However, it was unclear from the records what the client's actual goals were and how they would achieve them. This meant it would be difficult for a client to understand how they could progress with their recovery. The service also did not review the care plans throughout a client's stay.

The transfer between locations was seamless, clients continued to attend one-to-one sessions with the same designated worker on a weekly basis. All the records we looked at showed contemporaneous notes. These notes were personalised and explored barriers to a person's recovery. However, care plans and risk assessments did not reflect discussions that had taken place.

The service used paper records for clients. These were stored securely at the Steade Road service. Staff worked across both locations and clients also attended Steade Road for groups, this meant that records were accessible to staff as needed.

Best practice in treatment and care

Clients attended group and individual cognitive behavioural therapy (CBT) focused sessions that followed British Association for Counselling and Psychotherapy guidelines. CBT is a talking therapy that aims to manage problems by changing thoughts and behaviours associated with the problem. It is a recognised therapy for alcohol misuse. Treatment focused on using the valued directions tool, which is a key component of acceptance and commitment therapy within CBT. This intervention tool explored the values that were important to the client. The key worker helped the client identify valued life directions that promoted a meaningful life and supported soberness.

The service worked with clients to help them to develop and sustain recovery capital that was appropriate to their individual needs. Recovery capital predicts the likelihood of achieving sustained recovery and is dependent on internal and external resources. The factors that contribute to recovery following treatment included:

• the personal and psychological resources a person had

• the social supports that were available to them

• the basic foundations of quality of life (i.e. a safe place to live, meaningful activities and a role in their community).

The service did not measure recovery capital as it was individual to each client.

Staff did not carry out any clinical audits for the service; the service manager did this. However, they attended whole organisation meetings, as well as staff away days, during which they received feedback and best practice guidance on the outcomes of audits.

Skilled staff to deliver care

Permanent members of staff had appropriate counselling qualifications that enabled them to deliver CBT to clients. The manager was undertaking further management training funded by the organisation. The team had access to specialist training and could request courses relevant to their role. For example, sessional staff had undertaken further training for their own personal development. This included mentoring and coaching, person centred care, effective interpersonal skills and motivational interviewing.

Staff had the skills and experience necessary to carry out their duties and deliver care. All staff received support and professional development through regular supervision every eight weeks. Supervision included an ongoing appraisal process. This meant staff had clear goals and objectives, which their manager reviewed regularly. This allowed the manager to identify improvements and assess the quality of care staff provided.

Multi-disciplinary and inter-agency team work

The partnership arrangements ensured a multi-disciplinary approach. Staff had formed effective working relationships with external agencies to support clients during and after their rehabilitation. Staff encouraged clients to register with the local GP during their stay making it easier for them to attend appointments. If a client's mental health deteriorated, staff would support them and make referrals to mental health services. The service had good links with mental health services, local GP, safeguarding teams and mutual aid groups. For example, Alcoholics Anonymous, Al-Anon family support, Al-Ateen and SMART recovery. The majority of clients maintained their own tenancies while in rehabilitation. Staff referred clients who did not have housing to a local authority housing association for priority housing.

Sheffield Alcohol Support Service also comprised of 'the families together' project, waypoint training and the alcohol recovery community (ARC). This meant that both staff and clients could access aftercare, support and training when necessary.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

The service did not admit clients detained under the Mental Health Act 1983.

Good practice in applying the Mental Capacity Act

The MCA was not part of core training or personal development. Staff knew that the service had a MCA policy. Although staff had an awareness of mental capacity, they

had limited knowledge of their responsibilities under the MCA. This was because staff assumed that their clients had capacity when entering the residential service and seldom had to assess anyone's capacity.

Are substance misuse services caring?

Kindness, dignity, respect and support

We saw positive verbal interactions between staff and clients. Staff were kind and approachable, treating clients with respect and empathy. This helped establish a therapeutic relationship. We observed clients to be relaxed and well supported in their treatment with staff understanding their individual needs and providing guidance when needed. Clients told us they felt supported both emotionally and in a practical way.

The service had a clear confidentiality policy in place that both staff and clients respected. This was in order to protect individual clients during and after their stay in the house. For example, no one revealed clients' identities when answering incoming phone calls.

The involvement of people in the care that they receive

Clients took responsibility for their treatment during their stay with the service.

A member of staff facilitated the morning 'feelings' group, which all the clients from both services attended. Clients had time to discuss how they felt and what support they thought they may need that day. If a client was feeling particularly low, staff offered counselling in addition to the planned daily activities. Clients attended all the mandatory group work as part of their recovery and could choose to opt in or out of other activities as they wished.

Family members had limited involvement with the service or in their relatives care and treatment. However, clients had contact with their families during their rehabilitation if they wanted.

Staff did not offer clients copies of their care plans. They told us that a client could have a copy if they requested one.

Are substance misuse services responsive to people's needs?

(for example, to feedback?)

Access and discharge

Access to the service followed on from the client having completed the first 13 weeks of their rehabilitation at Steade Road, a nearby residence run by the same organisation. At the 13 week stage, staff reviewed the client's progress and prepared a report to secure funding for the rehabilitation programme to continue. The client transferred locations and continued with treatment. Staff did not reassess the client or revisit the induction process, confidentiality and consent to treatment because the rehabilitation programme was the same. The client was already familiar with the residence, having attended group sessions and meetings there during the first 13 weeks.

At this stage, clients started planning for their discharge. Staff and clients develop an after care package with links to support services. The aftercare package was available for five years following completion of rehabilitation.

Staff breathalysed clients daily as part of their treatment plan. Clients could also be subject to random tests if staff suspected they had been drinking. Any client who tested positive automatically lost their right to treatment and left the service. Staff ensured that anyone leaving unexpectedly had somewhere to go to and remained safe. The client handed in their keys to the house before leaving ensuring the safety of remaining residents.

The facilities promote recovery, comfort, dignity and confidentiality

The facilities promoted the steps needed for independent living. Clients had responsibility for their own cooking, cleaning and washing. Their rooms were large, well maintained and could be personalised with pictures and ornaments. Clients had free access to their rooms during the day. The house offered a warm and comfortable home to the client. There was companionship from other clients if needed or privacy if needed. Staff did not provide cover overnight but clients could contact staff if an emergency arose.

Clients and staff planned and discussed activities during the clients' meeting, including the monthly community activity. During the day, clients had to attend all mandatory sessions. They could then access further optional therapeutic activities or make their own plans.

Substance misuse services

Meeting the needs of all people who use the service

The service provided welcome packs in other formats if needed. The service was able to accommodate clients with specific religious needs. For example, a Muslim client could have a room appropriate for daily ablutions, access to halal cookery utensils and food storage, and access to a nearby mosque.

Listening to and learning from concerns and complaints

The service had a complaints policy. Clients had not made any formal complaints in the past 12 months. Staff dealt with and resolved any informal complains during the clients meeting. Although the nature of the complaint and the outcome was not documented anywhere. Information about how to make a complaint was included in the welcome pack given to clients. The notice boards also contained information about how to make a complaint.

Are substance misuse services well-led?

Vision and values

The service did not have a mission statement. Their aim was to promote recovery and work with clients to develop the skills necessary to make recovery a reality. Staff felt included as part of the wider organisation attending meetings and being kept up to date with developments on a regular basis.

Good governance

As the service was small, staff tended to discuss their practice and any matters informally on a daily basis. This meant that staff did not always follow policies and procedures. For example, whilst there was clear learning from serious incidents, staff did not appear to follow the governance structure for reporting all incidents. Staff dealt with some incidents informally and did not record them according to policy. This meant they could not identify trends. Overall, there was a lack of effective local audit systems in relation to risk assessments and care plans. However, safeguarding, supervision and mandatory training processes were all in place.

The residents' induction pack provided clear information on confidentiality, the sharing of information and obtained the clients consent. However, consent to share information with the NDTMS was not sought. Substance misuse services submit specific data to NDTMS, who produce reports on the service outcomes to the service commissioners. The commissioners and Public Health England can then monitor the effectiveness of these services and ensure they meet the needs of the local population. Consent to NDTMS has a specific format, which informs the client about the role of NDTMS. The induction pack did not include this. This meant that staff shared client information without the appropriate consent form being in place.

Leadership, morale and staff engagement

The service manager had been in post less than a year and said they felt well supported by the chief executive officer. Staff told us they felt well supported by their colleagues, manager and the organisation. The service had no vacancies and low sickness rates among permanent staff. Morale was good and staff found their work fulfilling.

Staff were aware of the whistleblowing policy and said they would use it if they felt it was necessary.

Commitment to quality improvement and innovation

The service was responsive to feedback from clients, staff and external agencies. The chief executive of the organisation held a meeting with the clients twice a year in order to get feedback on the service. They used these consultations to improve the service.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

• The provider must ensure that all clients have a comprehensive risk assessment on admission. The risk assessment must inform a risk management plan. Staff need to regularly review the risk assessment and risk management plan, and update it if necessary.

• The provider must ensure that clients have an individual care plan in place that is comprehensive, holistic and recovery focused with clear goals. Staff must regularly review this with the client.

• The provider must ensure that they obtain consent from clients before sharing information with NDTMS.

Action the provider SHOULD take to improve

• Staff follow the policies and procedures for reporting and documenting incidents.

• Staff should document informal complaints raised during the 'feelings' meeting and their outcomes.

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
Accommodation for persons who require treatment for substance misuse	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment** **The records we reviewed contained very basic risk assessments. These were not detailed and there was no risk management plan. The risk assessments were not reviewed.** **This was a breach of regulation 12(2) (a)**

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9 HSCA (RA) Regulations 2014 Person-centred care** **The five care plans we looked at were incomplete, not recovery focused and not regularly reviewed.** **This was a breach of Regulation (3) (b)**

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 HSCA (RA) Regulations 2014 Good governance** **Appropriate consent to share information with NDTMS was not sought from the client.**

This section is primarily information for the provider

Requirement notices

This was a breach of Regulation 17 (2)