Haringey Advisory Group on Alcohol (HAGA)

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 currently rate independent standalone substance misuse services.

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

- Staff did not always follow the provider's alcohol detoxification guidelines around safe detox. Staff did not always complete comprehensive risk assessments for clients who were starting a community detox or have plans in place to manage the risk of withdrawal seizures if a client stopped their detox early. The provider's guidelines did not clearly outline who would not be suitable for a community alcohol detoxification. Staff did not always record the handover of important information.
- Staff stored prescribed detox medication in unsafe places. The provider did not prescribe medication as stated in their alcohol detoxification guidelines.
- The provider had not clearly identified the level of mandatory training required for staff and staff did not receive regular supervision and appraisals.

Summary of findings

- The provider did not have a formal procedure to demonstrate how staff should respond to a client in an emergency.
- Staff did not always complete physical health examinations during assessment or monitor physical health throughout treatment.
- The provider did not have a clear policy in place to guide staff in how to assess a client's capacity in the event that this was required. The provider had guidance in place for assessing clients' cognitive functioning and referred to this as their guidelines in assessing capacity. The lack of understanding across the provider meant that clients might be at risk.
- Staff we spoke with had a limited understanding of how to test a client's capacity. We did not see records of capacity assessments, when needed for specific decisions. However, staff acknowledged that if they were concerned they would raise this with their line manager and in the team meeting.
- Staff did not routinely use the severity of alcohol dependence questionnaire (SADQ) validated tool in order to formally assess for the severity of alcohol dependence.
- Staff did not adhere to the providers discharge and re-engagement policy as staff did not follow up all clients who did not attend appointments.
- There was a lack of regular discussion about risk and how best to manage clients at risk. Whilst the service had access to local GPs for advice, the service lacked medical support and guidance. There was no system in place for the doctor and nurses to review high risk and complex clients on a regular basis.
- The service did not handle complaints consistently.
- The provider had not ensured that employment records were up to date and included references and application forms.
- The service had not ensured that all statutory notifications had been submitted to the CQC.
- As a result of the concerns identified in the report, we issued a warning notice under Section 29 of the Health and Social Care Act 2008. We took this action, as we believed people using the service might have been exposed to a serious risk of harm.

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

- Staff discussed incidents and changed practice as a result.
- A member of the team attended the multi-agency risk assessment conferences (MARAC) every three weeks at Haringey local authority.
- The service offered blood borne virus (BBV) and hepatitis C testing.
- The service monitored their performance for successful completions and discharges. Between November 2015 and October 2016, the service had a 10.9% increase in completions, as opposed to the data that was reviewed from April 2015 to March 2016.
- Clients had access to a range of therapy groups, pre and post-detox planning as well as individual therapy sessions with a counsellor.
- Overall feedback from clients was very positive about the service and staff.
- The service provided clients opportunities to provide feedback about their care and made changes as a result of this feedback.
- The service developed a counsellor role to provide more appointments to clients who required psychological therapies.
- The service had a range of specialist support workers such as a domestic abuse support worker, a Polish speaking member of staff and a hospital link worker who provided support to clients who had been seen at the local accident and emergency department.
- Staff were committed to supporting clients in their recovery. Staff felt supported and confident to raise concerns to their line manager.
- The provider had quarterly governance meetings where staff discussed incidents and good practice. The service had a risk register and a comprehensive business continuity plan in place.

Summary of findings

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Summary of this inspection

Background to HAGA

HAGA is a community based alcohol treatment service, which provides treatment and support to people who misuse alcohol. The service is a charity and provides one to one support, community detoxification from alcohol, counselling, online appointments, a Polish speaking service and support for domestic violence. The service provides support to GP practices, called the 'Hub clinic', set up to reach out to people in the community.

The service has a hospital link worker who works with the local A&E department with clients who have attended A&E several times for alcohol related problems. The service produced an online service called 'Don't bottle it up' in 2012. This was designed for people to assess whether their drinking was risky, make a plan to reduce drinking and seek local help and advice. 'Don't bottle it up' is anonymous and reaches people who may not attend services. 'Drink coach' is another intervention created which is accessible by an application on a mobile phone, which allows people to set goals, reminders and offers mindfulness videos.

During 2016, the service had supported on average 123 clients per week with 12 clients to each key worker. The service provides three client pathways; counselling, detox service and a day programme. The day programme includes an abstinence based group and a stabilisation group. These programmes last for 12 weeks. The service offered a blood borne virus testing service.

The service is funded by the Haringey local authority and Haringey clinical commissioning group.

The service has a registered manager in place and is registered by the CQC to provide treatment of disease, disorder or injury. The service registered with the CQC in 2014 and has not been inspected before. The inspection team visited the service on 5, 6, 7 December and 19 December 2016.

Our inspection team

The team that inspected the service on the first day was a CQC inspector, an assistant inspector, a pharmacy inspector, one specialist advisor who was a nurse with a background in substance misuse and an expert by experience. An expert by experience is a person who has personal experience of using, or supporting someone using, substance misuse services. On the second day, the team included a CQC inspector, one inspection manager, one specialist advisor who was a psychiatrist with a background in substance misuse and an expert by experience. On the third day, a CQC inspector and an assistant inspector attended the service.

Two CQC inspectors returned to the service on 19 December 2016.

Why we carried out this inspection

We inspected this service as part of our comprehensive substance misuse inspection programme.

Summary of this inspection

How we carried out this inspection

To understand the experience of people who use services, we ask the following five questions about every service:

- 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, asked other organisations for information, and gathered feedback from staff members in response to an email we asked the provider to send to them.

During the inspection visit, the inspection team:

- visited both buildings where the service was located, looked at the quality of the physical environment, and observed how staff were caring for clients
- spoke with five clients
- spoke with the registered manager
- spoke with six other staff members employed by the service provider, including nurses and support workers
- attended and observed one multidisciplinary meeting, a service-user meeting and one therapy group
- collected feedback using comment cards from five clients
- looked at 13 care and treatment records,
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

We collected feedback from clients and from comment cards. Overall, the feedback was positive and clients commended staff for their help and support. Clients said that staff were understanding and clients felt happy to have found a good service. Some clients found ex-clients who worked at the service useful as they felt they understood their problems; others found the service to be accommodating for evening appointments.

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 rate standalone substance misuse services.

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

- Staff did not always follow the provider's alcohol detoxification policy for safe detox. Staff had not ensured that clients were comprehensively risk assessed prior to starting a community detox. There was a lack of risk management plans in place and no record of how clients would be supported in the event that they stopped their detox early.
- Staff did not always record the handover of important information.
- Staff had stored prescribed medication in unsafe places. The provider did not offer clients medication that was stated in their alcohol detoxification guidelines.
- The provider did not have a formal procedure in place to respond to a medical emergency. The lack of guidance increased the risk of staff not being aware of what to do in an emergency.
- The provider had not ensured that staff received appropriate training to meet the needs of clients. The provider had not clearly identified in the training and development policy the level of mandatory training required for staff.
- There was a lack of regular discussion about risk and how best to manage clients at risk. Staff in the service did not discuss risk on a daily basis formally, despite the service having complex, high-risk clients on the caseload.
- Lone working arrangements were not operating safely for staff.
- There was a lack of medical support at the service. A senior doctor attended the service on an ad-hoc basis and for the quarterly clinical governance meetings. However, there was no system in place for the doctor and nurses to review high risk and complex clients together.
- The provider was not adhering to infection control principles. The clinic room was not equipped with paper towels in order for staff to dry their hands.

The above concerns were a breach of a regulation. You can read more about it at the end of this report.

We found the following areas of good practice:

Summary of this inspection

- We saw evidence of the service discussing and learning from incidents. Most staff we spoke with was able to identify practice that had changed because of an incident.
- A member of the team attended the multi-agency risk assessment conferences (MARAC) every three weeks at Haringey local authority. Information that related to clients at HAGA was shared with relevant staff.

Are services effective?

We do not currently rate standalone substance misuse services.

We found the following areas for improvement:

- Staff did not always assess clients' needs prior to starting a community detox. Staff did not routinely assess clients' cognitive function before starting a community alcohol detoxification. The lack of cognitive assessments meant that clients could have had neurological impairments, which were not recognised.
- The provider's alcohol detoxification guidelines did not clearly demonstrate that there was a clear exclusion criterion for detox.
- Staff did not always complete physical health examinations during assessment or monitor physical health throughout treatment for clients that were undergoing community detox. Staff had not clearly recorded the rationale for treatment in some records.
- Staff did not routinely use the severity of alcohol dependence questionnaire (SADQ) validated tool in order to formally assess for the severity of alcohol dependence, despite national guidance recommending this tool to be used.
- The provider did not offer medication in line with their alcohol detoxification guidelines.
- Staff were not receiving regular supervision and appraisals. The lack of supervision meant that staff performance and training was not being monitored.
- The provider had not ensured that employment records were up to date and included references and application forms.
- Staff did not understand how to carry out a capacity assessment and the provider did not have a clear policy in place to guide staff in how to assess a client's capacity in the event that this was required.

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

- The service employed a variety of staff such as counsellors, nurses, peer apprentices and ex-clients who had previously used the service. The variety of staff ensured that clients were able to access staff with different experiences and knowledge.

Summary of this inspection

- Staff routinely asked clients whether they would agree for blood borne virus (BBV) and hepatitis C testing. Staff could refer the client back to their GP if a vaccination was required.
- Clients had access to a range of therapy groups, pre and post-detox planning as well as individual therapy sessions with a counsellor.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Feedback from clients was very positive about the service and staff.
- Staff involved clients in their recovery plans.
- The service provided ways for clients to give feedback about the service. Staff made changes as a result of the feedback.
- A member of staff led the service-user forum, which clients said they found useful. The forum was an opportunity for clients to discuss the service.

Are services responsive?

We do not currently rate standalone substance misuse services.

We found the following areas for improvement:

- The service did not handle complaints consistently. There were no records to show that two complainants had received an acknowledgement or a formal response to their complaint.
- Staff did not always document reasons for clients not attending appointments or the action they had taken to follow this up.

We found the following areas of good practice:

- The service monitored their performance for successful completions and discharges.
- The provider worked hard to develop pathways for clients to access treatment. The service developed a counsellor role to offer clients therapy sessions as the local improving access to psychological therapies (IAPT) service had a waiting list of six months.
- The service had a range of specialist support workers to meeting clients' needs.

Are services well-led?

We do not currently rate standalone substance misuse services.

We found the following areas for improvement:

Summary of this inspection

- The provider's governance system in place for monitoring quality and safety of care delivered was ineffective. The service had not identified the concerns raised during our inspection.
- The service had not ensured that a notification had been submitted to the CQC for the safeguarding alert that had been raised to the local authority.

The above concerns were a breach of a regulation. You can read more about it at the end of this report.

We found the following areas of good practice:

- Staff were happy at work and felt supported by their colleagues. Staff felt confident to raise concerns to their line manager.
- The provider had quarterly governance meetings where staff discussed incidents and good practice. The service had a risk register and a comprehensive business continuity plan in place.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

The provider did not have a clear policy in place to guide staff in how to assess a client's capacity in the event that this was required. The provider had guidance in place for assessing clients' cognitive functioning and referred to this as their guidelines in assessing capacity. The lack of understanding across the provider did not ensure that staff fully understood the main principles of assessing capacity, which put clients at risk.

Staff we spoke with had a limited understanding of how to test a client's capacity. We did not see records of capacity assessments, when needed for specific decisions. However, staff acknowledged that if they were concerned they would raise this with their line manager and in the team meeting.

Substance misuse/detoxification

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse/detoxification services safe?

Safe and clean environment

- The service completed health and safety assessments of the environment. The service used an external company to assess the environment in November 2016. The service also had health and safety representatives who carried out internal health and safety assessments on a monthly basis.
- The service had appropriate fire safety arrangements in place including a risk assessment, regular fire drills and fire wardens.
- The service had a clinic room, which had a full range of equipment to support people. However, sinks in the room did not have paper towels available room for staff to dry their hands.An external company serviced Alcometers, which test for how much alcohol is in person's blood, every six months.
- The environment was clean and tidy during the inspection. Domestic staff cleaned communal areas and toilets. Staff told us they cleaned the clinical room and clinical equipment, such as the blood pressure machine, but did not complete records to demonstrate they had done this. This meant that staff could not be assured that measures to reduce the spread of infection were in place.
- The service did not ensure all rooms were well decorated. For example, the paint in the ground floor assisted toilet had peeled off.
- The service did not have an effective alarm system to ensure staff worked in a safe environment.The door that led to the reception was not locked, despite the door being fitted with a keypad entry system, and the building did not have a panic alarm system. Staff did not wear personal panic alarms whilst in the building.

Safe staffing

- The service had a full time manager in place.The service had 17 staff in total, which included one team manager, 10 alcohol project workers, three nurses, two peer apprentices and one counsellor. The service had no vacancies at the time of our inspection. In the past 12 months, there had been a 26% turnover rate and a 21% sickness rate.
- The staffing establishment was based on the caseload. On average, a keyworker had approximately 12 clients on their caseload.
- The service employed four volunteers. The provider had a volunteer policy in place that clearly outlined the role of the volunteer. No volunteer was given access to the database or paper based filing system. Criminal records checks had been completed for volunteers and all staff.
- The service had not ensured that they had completed full recruitment checks for two staff. We reviewed eight employment records and found that two out of eight records lacked specific recruitment documentation. One record did not have any references and the other was missing an application form.
- The service lacked the presence of a senior doctor in order to support the nurses who carried out community detox. Whilst the service worked with a registrar and a senior doctor attended the service on an ad-hoc basis, there was no system in place for the doctor and nurses to review high risk and complex clients together. We

reviewed one treatment record for a client who had complicated physical health problems and there was no evidence to demonstrate that a senior doctor from the service had been involved in the treatment plan.

- The provider did not keep adequate records of staff training. Although staff told us they had received training, data provided by the provider suggested, only 47% had completed the four mandatory training courses all staff needed to complete. The provider also did not have a record of which members of nursing staff had completed training in the The service did not have a clear policy that outlined which staff needed to receive which training courses. Staff may not receive all the training they need to complete their role.

Assessing and managing risk to clients and staff

- Staff completed risk assessments and risk management plans, which met guidance, for most clients. We looked at the records for 13 clients and found staff had completed risk assessments for the 10 clients who had not undergone community detox; however, staff had not recorded assessments in line with National Institute for Health and Care Excellence (NICE) guidance for three clients who had undergone a community detox. For example, staff had not completed risk management plans for clients with a history of depression; staff had not completed plans for how to avoid the risk of withdrawal seizures for clients that stopped their alcohol detoxification early; and staff had not recorded that they had provided information to the three clients about physical health and signs of deterioration during the detoxification period. The service had previously identified gaps in risk assessment in a care record audit completed in September 2016, which found that three out of 14 records did not have a risk management plan in place.
- The provider did not have a formal procedure in place to respond to a medical emergency. The lack of guidance increased the risk of staff not being aware of what to do in an emergency.
- Staff did not consistently document interventions and contact with clients in treatment records. In two separate care records, staff had not documented the handover between the detox support worker during the night and the nurse arriving in the morning.
- The service had a daily morning meeting, which was an opportunity for the team to discuss the caseload and clients at risk. We reviewed meeting minutes from September 2016 to December 2016 and found that during 11 meetings there was no discussion of clients and any associated risks. On one occasion staff had documented that, a group of clients were an on-going risk. However, there was no elaboration in the meeting minutes to identify what the risks were and how staff was managing them. There were no other opportunities for staff to discuss high-risk clients on a daily basis.
- Staff had not recorded that they had sought consent from clients to share information with other agencies in two records we reviewed.
- Staff received safeguarding training for vulnerable adults and children. The team manager collated a report each month, which gathered safeguarding information about clients within the service. In the last 12 months, there had been one safeguarding referral to the local authority recorded. The manager told us that safeguarding concerns were flagged in the individual client record. Four members of staff we spoke with understood how to recognise safeguarding concerns. Staff gave clear examples of when they had been required to raise a safeguarding. One member of staff did not understand the term safeguarding, but felt confident to raise any concerns to their manager.
- A member of the team undertook the safeguarding lead role and attended multi-agency risk assessment conferences (MARAC) every three weeks at Haringey local authority. The meeting was chaired by the police with representatives from local mental health services, children's services and probation attending. The safeguarding lead was sent the meeting minutes with actions for the lead to complete in relation to clients based at HAGA.
- Staff stored prescribed detox medication in unsafe places. Although the service did not store or dispense any medicines on-site, staff stored some medication in their car or a desk drawer in the office. Staff told us that this was because the service did not have a lockable space to store medicines and it was not clinically safe to leave the medication with the client at their home. The

medication was for clients who were actively undergoing the detox programme. We raised this during the inspection and the service put plans in place to store medication at its sister service.

- The registered manager was a non-medical prescriber. A non-medical prescriber is a non-medical health professional who is able to prescribe within their specialist area. In this case, a doctor had made a diagnosis and had put a clinical management plan (CMP) in place for the client. The non-medical prescriber could then prescribe based on the plan in place.
- Staff did not always adhere to the providers' lone working policy. Although staff carried out joint home visits with clients who were starting a community detox, some staff did not always ensure other staff knew their whereabouts when they went on a home visit. In the administrators office there was a signing in and out board. However, staff told us that this was not always used. The providers' lone working policy stated that staff should preferably use a personal alarm or a mobile phone. Staff carried a mobile phone but not all staff had personal panic alarms. The inconsistent approach to lone working increased the vulnerability of staff coming to harm in the community.

Track record on safety

- There had been three serious incidents in the past 12 months. Two related to client deaths in the community and one related to an information governance issue. The two deaths were investigated and recommendations were made to the service. However, the incidents were not a result of the treatment that was delivered by the service**.** The provider had reported the client deaths to the CQC.
- Senior staff attended a clinical governance group meeting every two or three months. The meeting minutes demonstrated that the senior staff discussed incidents and feedback from incidents. Team meeting minutes demonstrated that learning from incidents was shared with the whole team.

Reporting incidents and learning from when things go wrong

- The provider ensured that staff reported incidents and investigated them to identify any lessons they could learn. Staff reported incidents using a dedicated incident record form. Completed incident forms were escalated to the clinical director. The service had an incident reporting policy in place, which included how to report serious incidents. Staff we spoke with told us that they understood how to report an incident. Most staff told us that learning from incidents was fedback in the monthly team meeting and reflective practice sessions. Staff provided examples of team debriefs that had taken place and where practice had changed. For example, staff and clients did not feel safe to continue the evening group meetings at HAGA. The venue and times were changed so everyone who attended the group felt comfortable.

Duty of candour

- 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. The provider's incident reporting policy outlined the duty of candour requirements and indicated their responsibility towards clients. The policy stated that clients and the next of kin would need to be informed and involved within the investigation. The policy included a list of agencies that should be informed if something went wrong. The provider had ensured that the duty of candour requirements had been explored for both serious incident investigations that had taken place in the past 12 months.

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

Assessment of needs and planning of care (including assessment of physical and mental health needs and existence of referral pathways)

- Staff completed initial assessments for all 10 clients whose records we reviewed that had not undergone community detox; however, they had not completed records to demonstrate they had assessed three clients who had undergone community detox in line with

Substance misuse/detoxification

National Institute for Health and Care Excellence (NICE) guidance. For example, in two records staff did not assess a client's cognitive function before undertaking community alcohol detoxification.

- Staff did not always consistently complete recovery plans that met clients' needs. Ten records included a recovery plan that was detailed and demonstrated client involvement. However, in three records we reviewed staff had not completed detailed recovery plans. Staff also did not always update plans following changes in circumstances. For example, staff had not updated a plan for a client who returned to the service after not using it for over six months. We reviewed one separate record that had not been reviewed since June 2016.
- Staff completed basic physical health assessments for all 13 clients whose records we reviewed but had not completed a comprehensive physical health examination for two out of three clients receiving community detox. For example, staff had not recorded that they had completed an abdominal examination prior to starting detox for one client who had complex physical health needs, which would be expected.
- Staff did not take bloods at the service but signposted clients to the local blood test service.
- The service carried out blood borne virus testing and hepatitis B screening on site. We saw evidence that clients were asked whether they would agree to these tests during the initial assessment stage. Staff could not vaccinate for hepatitis B but were able to refer to an external service if this was required.
- The service stored information securely in its electronic record system and in paper files, which staff scanned onto the electronic system.

Best practice in treatment and care

- The provider had protocols and procedures in place for managing detoxification and prescribing medicines. It had a standard 10-day detoxification regime in place, which could be varied for five and seven day detoxifications. The assessing nurse and non-medical prescriber advised the GP of the detoxification regime that would be required. A local GP and the service's non-medical prescriber prescribed medications.
- The provider's policy identified which clients would be eligible for residential and community detox but it did not contain clear exclusion criteria for clients who, because of their high risk of complications, would not be allowed a community detox.
- Staff did not always record they had completed cognitive assessments. Staff had not completed cognitive assessments for two out of three clients who were receiving community detox and should have received a formal assessment of their capacity. Staff told us that they assessed a client's cognition when necessary and used their clinical judgement.
- The provider did not have a system in place to offer clients a vitamin medication called pabrinex. The medication was used to treat clients who were at risk of developing neurological complications. The provider's alcohol detoxification guidelines stated that the service should offer this. This meant that clients were at risk of not receiving the correct treatment when required.
- Staff did not always use recommended tools when completing their clinical assessment. Staff had not used an additional validated alcohol assessment tool, such as the severity of alcohol dependence questionnaire (SADQ), in five out of 13 treatment records we reviewed.
- A local GP and the service's non-medical prescriber prescribed medications. The service had a clinical management plan in place with a local GP to manage the supplementary prescribing. The service had protocols in place for high-risk medications, such as Nalmefene. The service had the most up to date British national formulary (BNF) book available for the latest medicine guidance.
- The provider supported clients to access a range of therapy-based groups, support groups and mutual aid groups. Staff also supported clients through one-to-one brief intervention sessions. These explored a client's motivation to change and an opportunity to discuss possible treatment.
- Clients were required to be six months sober prior to being accepted into improving access to psychological therapies (IAPT) in Haringey, the service developed a role for a counsellor to support clients. The counsellor offered cognitive behavioural therapy and rational

emotive behaviour therapy. HAGA had identified gaps in provision of services and developed the hub clinics at four GP surgeries, which enabled the service to have direct links with the local community.

Skilled staff to deliver care

- HAGA employed nurses, keyworkers, detox support workers, a psychiatrist and a counsellor.
- The service provided staff with an induction programme.
- Staff did not always receive regular supervision. We reviewed 12 supervision records for the past 12 months. These showed that staff received on average four supervision sessions. One member of staff did not have any documented supervision notes and one key worker received supervision on only one occasion. The service had not followed its supervision policy that stated that staff should receive supervision every four to six weeks. The team manager told us that they received clinical supervision and attended a non-medical prescriber's support group at the local mental health trust. However, there was no formal record of the supervision meetings that had taken place. The lack of supervision meant staff were not being appropriately supported and their work was not routinely monitored.
- The provider did not ensure all staff received an annual appraisal. Nine out of 12 staff did not have an appraisal, two members of staff had an out of date appraisal and one member of staff had an in date appraisal.
- Staff had access to specialist training relating to supporting and treating clients with substance misuse problems. Courses included cognitive behavioural therapy, group facilitation, and mindfulness. However, only 54% of staff had completed the specialist training. The provider told us that specialist training was determined by staff role. However, this was not clearly set out in the provider's training and development policy.

Multidisciplinary and inter-agency team work

- Staff had access to a monthly team meeting. The meeting focused on individual clients as well as new referrals. We observed one allocation meeting and staff discussed external referrals and completed assessments. Staff discussed each client in detail, which included client risks, history of dis-engagement, physical and mental health, medication, AUDIT score, domestic abuse and related safeguarding's.

Adherence to the Mental Health Act

- The MHA was not reviewed as part of this inspection.

Good practice in applying the Mental Capacity Act (if people currently using the service have capacity, do staff know what to do if the situation changes?)

- The provider did not have a clear policy in place to guide staff in how to assess a client's capacity in the event that this was required. The provider had guidance in place for assessing clients' cognitive functioning and referred to this as their guidelines in assessing capacity. The provider encouraged staff to assess capacity by using the mini mental state examination (MMSE). This was not a recognised tool to assess a person's capacity. The lack of understanding across the provider did not ensure that staff fully understood the main principles of assessing capacity, which may have put clients at risk.
- Staff we spoke with could not explain how they would test a client's capacity. However, staff told us if they were concerned about a client's capacity they would raise this in the allocations meeting or ask a client to return on another occasion if they were intoxicated.

Equality and human rights

- The service had an equality and diversity policy in place. The environment enabled the service to provide support and treatment to clients who had protected characteristics. Staff could see clients at the service in a separate building if a client had a physical disability or limited mobility. The main building provided staff and clients with access to a toilet that supported people with mobility impairments. The building had a ramp so that clients could access the second floor of the main building.
- Staff had recognised and discussed in the team meeting the demographics of black and minority ethnic (BME) clients using the service and felt it was important to raise awareness of this across the staff team. A member of staff organised an event to celebrate black history month. Feedback from clients demonstrated that they appreciated the black history board that had been put up in the main building.

Substance misuse/detoxification

Management of transition arrangements, referral and discharge

- HAGA had created several pathways to enable clients to access the service easily. Fifty-three percent of clients self-referred into the service. Twenty-three percent of clients were referred from their GP and seven percent were referred from the local hospital. The service had a hospital link worker and the team manager had a contract with North Middlesex Hospital as a liaison worker.
- The provider used key performance indicators to monitor performance, which were monitored by the local authority and CCG. Data from November 2016 demonstrated that in the past 12 months, the service had performed well and successfully discharged 66% out of 562 clients. The unsuccessful discharges rate was 27% and seven percent of clients were transferred to another service. Over the past 12 months, the service had made 400 referrals to the Haringey recovery service. The Haringey recovery service worked in partnership with HAGA and provided recovery services such as recovery planning, key work, counselling and a drug rehabilitation requirement programme.

Are substance misuse/detoxification services caring?

Kindness, dignity, respect and support

- During the inspection, we observed positive interactions between clients and staff.We observed a group attended by eight clients and staff were seen to give clients an opportunity to have an input in to the meeting.
- The feedback from six clients and five comment cards was extremely positive. We heard positive comments such as 'the service saved my life', 'the staff are very understanding and helpful', 'staff support me' and 'without this service I wouldn't be alive'. Clients told us that they found ex-clients working at the service useful and felt they understood their problems. Other clients told us that they felt the service supported them to work and allowed them to attend appointments after work.

The involvement of clients in the care they receive

- Staff actively involved clients in their care. In the records we reviewed, staff had sought the views of clients and planned care with them.
- The service provided clients with information about the service when they first visited. Clients had the opportunity to attend groups that they felt would help their recovery.
- The service had a service-user involvement policy. The policy focused on how the service involved clients in decision-making and ensured client views, talents and experiences could help to improve the service.
- The service had a suggestion box for clients to provide feedback. There was also a feedback board where clients could write down their suggestions. We saw evidence of clients writing their thoughts and ideas to improve the service. Clients regularly attended the monthly service-user forums.
- Clients were able to access independent advocacy services and we saw evidence of this in the treatment records.

Are substance misuse/detoxification services responsive to people's needs? (for example, to feedback?)

Access and discharge

- Clients could access the service by self-referral or by visiting their GP. The service worked closely with a local recovery service, which provided a clear referral pathway in to the alcohol treatment service. Between November 2015 and October 2016, the service had 104 clients in treatment and there had been 40 successful completions. This demonstrated a 10.9% increase, which was compared to the data that was reviewed from April 2015 to March 2016.
- The service had identified a gap in service provision and developed new pathways for clients to access support and treatment. As clients were required to be six months sober prior to being accepted into improving access to psychological therapies (IAPT) in Haringey, the service developed a role for a counsellor to support clients. The counsellor offered cognitive behavioural therapy and rational emotive behaviour therapy. In addition to this, the service had identified gaps in provision of services

and developed the 'hub' clinics at four GP surgeries, which enabled the service to have direct links with the local community. The service designed a new treatment pathway called an enhanced community detox project. The project aimed to provide a safe detox for clients in the community rather than undergoing a residential detox.

- The provider had a discharge and re-engagement policy in place. However, staff did not always follow the policy. In two records, the clients did not attend a scheduled meeting and staff did not actively follow this up. In the team meeting minutes for October 2016, staff acknowledged that the team were not following the policy. During our inspection, we found that practice had not improved as a result.

The facilities promote recovery, comfort, dignity and confidentiality

- The service offered a variety of group and meeting rooms. Interview rooms were quiet and ensured clients had privacy. The main building had a clinic room with a portable examination bed for clients. Clients had access to making drinks.

Meeting the needs of all clients

- The service accepted clients from a wide range of backgrounds and worked hard to try and reach different community groups. A specialist domestic abuse worker from the service ran a project called Waterlilies. The group provided support for women who had suffered domestic abuse. A polish member of staff ran a support group for polish speaking clients. The service provided a hospital link worker at North Middlesex Hospital. The role involved engaging with frequent attendees at accident and emergency who presented three times in a year with alcohol related problems. This role was being decommissioned due to funding reductions. The team manager ran training programmes for other organisations and the local hospital to ensure that they were able to manage clients admitted with alcohol related problems. For example, the manager trained staff at the hospital to use CIWA-Ar).

Listening to and learning from concerns and complaints

- The provider did not keep clear records to demonstrate how complaints had been handled. Between December 2015 and December 2016, the provider received three formal complaints. Whilst the provider had investigated complaints, acknowledgement and response letters were not readily available in the complaint record.
- Staff understood how to raise their concerns and feedback about the service. Staff told us that they could complain through human resources or their line manager.
- Staff provided clients with evaluation forms at the end of the alcohol programme. There was a feedback board in the main building where clients could write down their thoughts and comments. Staff took photos of the board in order to ensure they had a record.

Are substance misuse/detoxification services well-led?

Vision and values

- Staff did not know the provider's vision but understood the overall aim of the service. Staff we spoke with were committed and wanted to ensure that clients recovered and maintained abstinence from alcohol.

Good governance

- Staff supervision did not take place on a regular basis and there was no system to ensure that staff received regular supervision.
- Whilst the provider had a system in place to monitor the quality and safety of the service being provided, the system in place was ineffective. The systems in place had not identified the concerns raised during the inspection. The service had carried out care record audits, which had highlighted the lack of risk assessments and poor record keeping. However, some records we reviewed still had a number of gaps. The service recognised that staff were not following the provider's discharge and re-engagement policy but practice had not changed as a result of this. The provider had not managed complaints appropriately and there was no clear record of responses that had been sent to complainants. The provider did not have a clear policy in place to guide staff in how to assess a client's capacity in the event that this was required. There was a lack of understanding across the provider as to how capacity assessments were carried out.

Substance misuse/detoxification

- The provider had a system in place to review all incidents and safeguarding alerts. Senior staff attended the clinical governance group meeting every two to three months. Meeting minutes demonstrated that learning from incidents was discussed. Learning from incidents was also discussed in team meetings. The manager ensured that the latest 12-month performance report for the service was available to the team to review.
- The service had submitted statutory notifications to the care quality commission (CQC) but had not notified CQC for one safeguarding alert it had raised with the local authority.
- The provider had a central risk register in place. The register included organisational risks, financial risks and risks to the service.
- The service had a comprehensive business continuity plan in place that was designed to ensure the service was prepared for a significant event, which could affect the running of the service. The plan covered the running of the community detox programme and how the service would manage if there was a staff shortage. Clear and detailed actions were recorded which included the recovery timeframe for each scenario.
- The service collected and monitored their performance. Performance data was sent routinely to the commissioners and the funding local authorities. The service measured their quality and performance by using a range of tools which included a patient health questionnaire, the and treatment outcome profiles (TOPs). The team manager had collated the results of the enhanced community detox project, which demonstrated the effectiveness of the project and included feedback from clients.
- Senior staff attended the clinical governance group meeting every two to three months. The last governance group meeting was held in November 2016. Staff in attendance included the trustees of the provider, chief executive, clinical directors, team leaders and a client representative. Staff from another service linked closely to HAGA attended the meeting
- There was also a monthly business meeting. We reviewed team meeting minutes from January 2016 to December 2016. Meeting minutes demonstrated a clear structured agenda and outlined the purpose of the meeting. These included guests, good news stories, organisational issues, client review and training.

Leadership, morale and staff engagement

- Morale was high and staff said they enjoyed working with their colleagues. Staff recognised that at times the job was stressful.
- Staff felt supported and able to discuss their concerns and comments with their line manager. Staff felt that they had a good relationship with their peers and felt the senior multidisciplinary team were good. Staff valued the annual team away day and the team worker of the month award. This was where staff nominated a colleague for their hard work and the winner received a voucher. The staff member who received the most vouchers was given a hamper as a reward for their contribution to the team.

Commitment to quality improvement and innovation

- The service carried out a pilot of enhanced community detox project in connection with public health England. The manager told us that the service had begun the process to publish the results of the pilot project in the European journal of addiction.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to meet the regulations:

- The provider must ensure that clients are always comprehensively risk and needs assessed. This includes risk management plans put in place prior to starting treatment.
- The provider must ensure that there is an assessment of cognitive function in order to rule out any neurological impairment.
- The provider must ensure that the alcohol detoxification guidelines clearly outline who would not be suitable for a community alcohol detoxification.
- The provider must ensure that staff always record the handover of important information.
- The provider must ensure that staff store prescribed medication in a safe place.
- The provider must ensure that there is a formal procedure to demonstrate how staff should respond to a client in an emergency.
- The provider must ensure that there is a system in place for staff to raise the alarm to others in an emergency.
- The provider must ensure that clients receive a full physical health examination prior to starting treatment and their physical health is monitored throughout treatment.
- The provider must ensure that there is a system in place to offer clients pabrinex medication as stated in the provider's alcohol detoxification guidelines.
- The provider must ensure that staff are appropriately trained to meet the needs of clients.
- The provider must ensure that the training and development policy clearly outlines which courses are required to be completed by staff.
- The provider must ensure that there is a clear policy in place in how to assess a person's capacity and staff to have an understanding of this.
- The provider must ensure that there is a system in place in order for the service to access medical advice and support when required.
- The provider must ensure that staff follow up all clients who do not attend appointments and record the action taken in the treatment records.
- The provider must ensure that staff receive regular supervision, appraisals and supervision sessions are formally recorded.
- The provider must ensure that complaints are handled consistently and there is a clear record of the documents that had been sent to complainants.
- The provider must ensure that there are paper towels available for staff to dry their hands in the clinic room and staff record when clinical areas and equipment is cleaned.

Action the provider SHOULD take to improve

- The provider should ensure that all employment records are up to date and include application forms and references.
- The provider should ensure that statutory notifications continue to be reported appropriately to the CQC as per guidance.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • The provider had not ensured that staff were appropriately trained to meet the needs of service-users. The provider had not clearly identified the level of mandatory training required for staff. • The provider did not have an adequate support system in place for the doctor and nurses to review high risk and complex service-users on a regular basis. This meant that staff were unable to access internal support and guidance for complex service-users. • The provider had not ensured that staff received regular supervision and appraisals. Supervision sessions were not always formally recorded. This was a breach of regulation 18(1)(2)(a).

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The provider had failed to ensure there were robust systems and processes in place to monitor, assess and improve the quality and safety of the services provided. The provider had recognised that there were issues within the service but practice had not changed as a result. • The provider had not put systems in place to ensure that staff were safe when working alone in the community and in the building. The service did not have any systems in place for staff to alert others in an emergency.

This section is primarily information for the provider

Requirement notices

- The provider had not ensured that there was an effective system in place to ensure infection control principles were adhered to. Staff did not record when clinical areas and equipment was cleaned and that there were no paper towels available for staff to dry their hands in the clinic room.
- The provider had not ensured that the complaints system was working effectively and that complaints were being handled and responded to. The provider had not maintained a record of all outcomes and actions taken in response to complaints.
- The provider had not ensured that staff followed up the service-users who did not attend their appointments and record the action taken in the treatment records.
- The provider did not have a clear policy in place to guide staff in how to carry out a capacity assessment. There was a lack of understanding about how capacity is assessed across the provider.

This was a breach of regulation 17(1)(2)(a)(b)(c).

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had failed to ensure that service-users were safe because: • The provider had not ensured that staff followed the provider's alcohol detoxification guidelines around safe detox. Staff did not always complete comprehensive risk assessments prior to service-users starting treatment. Service-users did not have unplanned exit plans in place in order to minimise risk in the event of a service-user stopping the detox early. Staff did not always record the handover of important information and did not clearly document the rationale for treatment. • There was a lack of regular discussion about risk and how best to manage service-users at risk. The service was not discussing risk on a daily basis despite the service having complex, high-risk service-users on the caseload. • Staff did not routinely assess service-users' cognitive function prior to undertaking a community alcohol detox. • Staff did not routinely use the SADQ validated tool in order to formally assess for the severity of alcohol dependence, despite national guidance recommending this tool to be used. • The provider's guidelines did not clearly outline who would not be suitable for a community alcohol detoxification.

This section is primarily information for the provider

Enforcement actions

- Medicines were not managed safely as staff had stored prescribed detox medication in unsafe places.
- The provider did not have a formal procedure to demonstrate how staff should respond to a service-user in an emergency.
- Staff did not always complete physical health examinations during assessment or monitor physical health throughout treatment.
- The provider did not have a system in place to offer service-users a vitamin medication called pabrinex. The provider's alcohol detoxification guidelines stated that the service should offer pabrinex medication. This put clients at risk of developing neurological complications.

This was a breach of regulation 12(1)(2)(a)(b)(g)