Linwood House

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

Overall summary

We do not currently rate independent standalone substance misuse services.

We found the following issues that need to improve:

- Infection control procedures were not adequate and had not been appropriately risk assessed.
- Facilities in the clinic room on the detoxification unit did not promote effective infection control.
- Risk assessments were not always reviewed following changes in clients circumstances
- The service relied on clients to provide relevant risk and medical history where they had not given consent for staff to contact their GP
- Staff practice in the recording of medication administration was not consistent.
- Care plans were generic in nature and did not reflect the clients' individual preference or support needs
- Information on how to complain was not displayed on notice boards or readily available to clients in the service welcome pack.

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

- Staffing levels in the service could be increased based on the level of occupancy and the needs of the clients.
- We observed genuine, caring interactions between staff and clients.
- The staff we spoke with demonstrated a thorough knowledge of the clients and their individual recovery plans.
- The service was able to respond promptly to requests for detoxification or rehabilitation, offering clients an admission date and time to suit their needs.

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Summary of this inspection

Background to Linwood House

Linwood House was part of the Care Plus Group and registered to provide residential alcohol and drug detoxification and residential rehabilitation to adults over 18. The service was provided in a large house over two floors, the detoxification unit on the first floor had 20 bedrooms. The rehabilitation unit on the ground floor had 14 bedrooms. At the time of the inspection, there were five clients on the rehabilitation unit and two on the detoxification unit. Over the period of the inspection, one person was admitted to the detoxification unit and some previous clients attended the day care sessions provided on the rehabilitation unit.

Clients are able choose whether to have a detoxification only or have rehabilitation as well as a detoxification.

The service was registered by the Care Quality Commission o provide the following regulated activities:

- The accommodation for persons who require treatment for substance misuse.
- Diagnostic and screening procedures.
- Treatment of disease, disorder or injury.

The service received referrals through several referral agencies or directly from people funding their own treatment. Framework agreements recently been agreed with both Manchester and Tameside. However, at the time of the inspection no referrals had been received through these contracts.

This was the first CQC inspection at this location under the current provider.

Our inspection team

The team that inspected the service comprised CQC inspector Martin Grinold (inspection lead); two additional CQC inspectors with a background in substance misuse services and one expert by experience. An expert by experience is a person who has personal experience of using, or supporting someone using, substance misuse services.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme to make sure health and care services in England meet the Health and Social Care Act 2008 (regulated activities) regulations 2014.

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 and clients through a series of focus groups.

Summary of this inspection

During the inspection visit, the inspection team:

- visited both units at this location, looked at the quality of the physical environment, and observed how staff were caring for clients
- spoke with six people who use the service
- interviewed the registered manager and the head of operations
- met with nine other staff members, including nurses, therapists and support workers
- spoke with one staff members who worked for the GP service that was contracted by the provider.
- collected feedback using comment cards from five clients
- reviewed in detail seven care and treatment records, including medicines records, for clients who were using the service and two care records of clients who had been recently discharged
- observed medicines administration
- examined policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with six clients and attended a focus group of people who used the service. All the people we spoke with spoke highly of the service and the support they received stating that staff went the extra mile and could identify individual needs and support.

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:

- Infection control procedures were not adequate and had not been appropriately risk assessed.
- The facilities and the provision of personal protective equipment in the clinic room were not in line with best practice.
- Medication administration records were not adequately completed and contained gaps in recording.
- The risk assessment process was not robust and did not demonstrate comprehensive person centred risk assessments.
- Risk assessments were not always reviewed following changes in clients circumstances.
- The service relied on clients to provide relevant risk and medical history where they had not given consent for staff to contact their GP.

These were a breach of a regulation; you can read more about it at the end of this report

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

- Staffing levels in the service could be increased based on the level of occupancy and the needs of the clients.
- When agency or bank staff were required to cover shifts the manager tried to use the same regular agency staff to maintain consistency.
- Ligature risks had been identified and the provider had plans to mitigate and manage these including introducing ligature cutters and replacing bathroom fittings with anti-ligature fittings.

Are services effective?

We do not currently rate standalone substance misuse services.

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

- Care plans were generic in nature and did not reflect the clients' individual preference or support needs.

Summary of this inspection

- The admission process was not robust and did not capture enough information from the client or others to enable a comprehensive risk assessment or treatment plan to be completed.

These were a breach of a regulation; you can read more about it at the end of this report.

However, we also found areas of good practice, including that:

- Eighty nine percent of staff had completed training in the Mental Capacity Act
- The service held monthly team meetings to share learning within the team.
- The service provided a range of individual and group therapy sessions.

Are services caring?

We do not currently rate standalone substance misuse services.

We found areas of good practice, including:

- We observed genuine, caring interactions between staff and clients.
- Clients spoke highly of all staff.
- The staff we spoke with demonstrated a thorough knowledge of the clients and their individual support needs.

Are services responsive?

We do not currently rate standalone substance misuse services.

We found areas of good practice, including that:

- The service was able to respond promptly to requests for support offering clients an admission date and time to suit their needs.
- The service offered flexible treatment options and clients could choose to stay for detoxification, rehabilitation or both.
- Formal complaints were investigated and lessons learned were identified.

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

- Some clients had to wait a long time to see the medical practitioner to complete their clinical assessment on admission.
- Information on how to complain was not displayed on notice boards or readily available to clients in the service welcome pack.

Summary of this inspection

Are services well-led?

We do not currently rate standalone substance misuse services.

We found areas of good practice, including that:

- The service was able to respond promptly to requests for support offering clients an admission date and time to suit their needs.
- The provider had reviewed all policies and procedures, which were accessible to all staff through an online portal.
- The provider collected feedback from all clients and incorporated these in to their monthly key performance indicators.

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

- The provider had not followed their own policy in the recruitment of a member of staff.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff had received training in the Act and could demonstrate an understanding of the Mental Capacity Act and its application to their role.

Staff assessed clients' capacity to consent to treatment on admission and would re-visit this if the client was assessed to not have capacity at the time due to being intoxicated. However, staff did not record the details of the decision in their assessment or refer to the principles of the act.

Substance misuse/detoxification

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse/detoxification services safe?

Safe and clean environment

The service employed both housekeeping and maintenance staff to maintain the environment, which was clean and tidy. There was a daily cleaning rota in place and we saw evidence of domestic staff completing daily cleaning sheets.

The housekeepers emptied the cleaning trollies daily and all materials were all stored securely in a locked store.

Maintenance staff conducted basic repairs and reported more serious repairs to the provider's estates department. The provider had a planned refurbishment programme in place including the ongoing refurbishment of client rooms and communal areas.

The provider had completed a waste management audit in October 2016, which included infection control. However, there had not been a specific infection control audit or risk assessment completed in the clinical areas. We found the clinic rooms did not have an effective clinical waste stream. The bins in the clinical areas were regular open top waste paper bins containing a yellow clinical waste bag without a lid. The service did not have an infectious waste stream in place despite admitting clients who may be positive for blood born viruses; this placed both staff and clients at risk.

We found no evidence of a urine testing procedure within the infection control policy, staff were conducting tests in clients' bedrooms utilising the ensuite facilities to maintain dignity and to dispose of the urine following the test. However, this meant staff had to walk through the building to the clinic room to dispose of the testing pot.

The facilities in the clinic room on the detoxification unit were not suitable. There was no access to a treatment couch despite staff completing physical examinations during admissions and throughout a clients' stay. The room did not have a phlebotomy chair for use when staff took blood samples. Instead, clients used a standard armchair. This presented a risk of infection if blood was spilt during the procedure.

There were no hand washing facilities in the room and no disposable aprons or surface wipes were available in the room for staff to use. Staff told us the previous clinical lead had been responsible for maintaining stock and this had not been identified since they had left. There was no evidence that the electronic blood pressure machine used was regularly cleaned or calibrated. The manager informed us the estates department completed the calibration of these across the provider. However, no evidence of calibration was available to substantiate this.

Before we left, the manager informed us they had identified an alternate room that could be converted to be used as a more suitable clinic room and they had been in contact with the provider's estates department to begin arrangements for this.

We observed potential ligature points throughout the service, which clients could use to attach a cord, rope or other material to for the purpose of hanging or strangulation. The service had completed an initial ligature inspection, highlighting the ligature risks to be included in the full ligature risk assessment, which the provider had scheduled for completion. There was a ligature policy in place and ligature training had been scheduled to take place before the use of ligature cutters was to be introduced. The manager informed us, that in the interim they mitigated risk through individual risk assessment and the use of enhanced observation. Ligature risks were also considered as part of the refurbishment plan and anti-ligature fittings were planned to be fitted to bathrooms throughout the building.

Substance misuse/detoxification

Each room had a call button and there were two panels on each unit to identify where the call had been made.

The layout of the building enabled separate male and female corridors on the detoxification unit however, this was not replicated in the rehabilitation unit, and staff managed this through an informal bed management process. Bedrooms were all ensuite, providing clients with a toilet and washbasin. Bathroom facilities were communal and all had locking doors. Although the service did not provide separate female only lounge facilities clients could access their bedrooms at any time outside of therapy sessions and were able to access the therapy room as an additional lounge if required. However, at the time of the inspection there was no formal protocol or risk assessment for the management of the mixed sex environment. This was raised with the provider who agreed to implement a risk assessment to support the operating model.

Safe staffing

Linwood house employed 36 staff made up of:

- the registered manager
- a deputy manager/clinical lead
- five nurses, including two vacancies the service was recruiting to
- eight support staff
- four night support staff
- five therapy staff
- three kitchen staff
- four housekeeping staff
- one maintenance person
- and one administrator

A local medical practice provided medical support through a service level agreement, providing:

- a medical practitioner to clinically assess new clients on admission.
- prescribing to support the detoxification regime.
- ongoing medical interventions to clients.
- provide emergency telephone support or a visit if a practitioner was available.

The service operated a rota comprising a nurse and support worker on the detoxification unit and a support worker on the rehabilitation unit. Therapy staff were available on both units between 9am and 5pm. The provider calculated staffing levels using a task based approach and recognised there were key times when staff may be busy if the unit was full. However, managers' believed that there was enough staff to meet the demands of the service. The manager could increase staffing levels if necessary depending on occupancy levels and individual needs of the clients.

The service used agency staff to cover vacant shifts. Where possible the service tried to use regular agency staff to ensure consistency. Where it was identified additional staff were required the extra shifts would be offered to substantive staff first before the use of agency staff.

Mandatory training comprised of thirteen courses including the provider's induction programme, safeguarding adults, safeguarding children and the Mental Capacity Act. The average mandatory training rate for staff was 81%.

There were lone working protocols in place to ensure the safety of staff whilst lone working. The service provided call buttons in rooms and staff used two-way radios as a means of raising and maintaining contact during lone working. The manager told us that as part of the refurbishment plan they were due to get an updated call system, which would provide staff with a personal alarm, linked to a monitoring system.

There was a registered nurse on duty at all times. Emergency telephone support was available through the service level agreement with the local medical practise. If a client required urgent medical attention this would be facilitated through the emergency services.

Assessing and managing risk to clients and staff

We looked at nine clients' records. These included pre admission information taken by the service. In all of the records we reviewed, staff had not fully explored potential risks on admission.

The initial assessment form allowed the client to consent to sharing information with their GP. Where clients did not consent, they would be asked to sign a disclaimer and staff would not seek any further information. Staff relied on clients to be open and honest about their history and potential risks during assessment. This process relied on

clients having the capacity to understand the impact of non-disclosure of some medical risk issues including double prescribing, allergies and interactions, history of complicated withdrawals, poly drug use or prescriptions of benzodiazepines. This meant staff were unable to develop a comprehensive risk assessments creating a potential risk to staff and clients. If a client did not disclose a medical condition, the GP could potentially prescribe a detoxification treatment that may place the client at risk. The general medical council advises that if a client refuses to provide consent to share information, the doctor may inform the person that they cannot refer or treat the client if the absence of sharing information would affect the safety of the treatment.

The contracted GP prescribed medication for the purpose of detoxification only. if a client required other medication this would need to be brought to the service in the original box clearly labelled with the patients name, administration instructions and date of dispensing. Medication that did not meet this criteria would not be dispensed without consent to contact the clients' GP.

The assessment paperwork covered set questions about risk but contained minimal detail necessary to assess them effectively. For example, staff did not explore risks associated with blood borne viruses other than recording the last time the client was tested. The service did not use a recognised risk-screening tool and had instead incorporated risk-screening questions within their assessment documentation.

Where staff had identified risks, there were set pro forma interventions to manage these risks. For example, there were management plans for epilepsy, allergies and diabetes, which contained a set of processes that staff, should follow if the risk occurred. The risk assessment template included clients' previous attempts at suicide. Although we noted that this did not address current suicidal thoughts. We found two instances where staff had recorded in daily notes that a client had informed them they were having suicidal thoughts and individual risk assessments had not been updated to reflect this.

We also found evidence of risk assessments not being updated following staff recording clients had suffered a seizure within their daily notes.

We saw evidence of poor record keeping in relation to medication including missed times on administration records and allergy information contained in client care plans not being highlighted on medication administration records. A review of the medication procedure had been completed by the provider on the 1 September 2017 which identified the procedure was overly complicated and recommended several amendments to simplify the process and reduce errors similar to the ones we highlighted in the inspection. The provider was due to implement these changes over the coming month.

Staff completed hourly observations of clients as standard regardless of their assessed level of risk. Where higher risks were identified staff would increase observations to half hourly.

The service stocked Naloxone and epinephrine injections for use in emergencies. Naloxone is a medication used to block the effects of opioids, especially in overdose. Epinephrine can reverse the symptoms of an allergic reaction. However, the service did not have any emergency resuscitation equipment and would call the emergency services in a medical emergency.

On the detox unit other items, identified as a potential risk including sharp items and aftershave or perfume were stored in the nurses' station. Clients could access these, as they required through the nurse on duty. Clients signed an agreement at the start of their stay agreeing to these restrictions.

Staff received training on safeguarding adults and all the staff we spoke to were able to outline the procedure they would follow to raise a concern.

On discharge, staff gave clients a discharge letter to give to their GP advising them of the treatment they had received. Staff also completed a personal recovery plan with clients highlighting potential triggers, coping strategies and community support available. Where clients chose to discharge themselves early against advice staff would also complete a risk assessment with the client and inform their next of kin.

Track record on safety

In the twelve-month period, ending 28 August 2017 there had been two serious incidents; one was an unexpected death following discharge against advice and the second a violent incident requiring police attendance. Staff recorded both incidents on the electronic incident recording system and notified the Care Quality Commission. The provider

completed an investigation in line with their policy including highlighting learning from the incidents. For example the introduction of a risk assessment which was given to clients who chose to discharge themselves against medical advice.

Reporting incidents and learning from when things go wrong

The provider used an electronic incident reporting system and 69% of staff had received training on using the system. Staff spoken with generally knew how to report incidents and we saw a copy of the incident log report produced by the incident reporting system. In the eight months between January 2017 and September 2017 there had been 67 incidents recorded of which 24 (36%) related to medication errors, the majority of which were missed signatures on medication administration records.

The registered manager had introducing a system for sharing learning following incidents through the team meetings. We saw evidence of incidents being discussed in team meeting minutes.

Duty of candour

Providers of healthcare services must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. The staff we spoke to were aware of the need to inform clients when things go wrong and there was evidence the Duty of Candour was highlighted as part of the electronic recording system.

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)

Clients were admitted to the detoxification unit in a staged approach; support staff completed the initial unit admission and orientation, nursing staff then completed an initial admission assessment. The duty medical practitioner would later complete a clinical assessment on the day of admission and prescribe the treatment regime to support the detoxification.

Staff relied on the information provided by the client on admission and through the initial enquiry to complete the admission. Where clients did not consent to staff contacting their GP or other third party staff would not seek any further information. The meant some clients did not have comprehensive risk assessments on admission creating a potential risk for staff and clients.

Some staff we spoke with felt the initial admission process was not robust and 1:1 sessions throughout the clients' stay would often identify further risks. All the clients' assessment records we reviewed confirmed the admission process relied on information provided only by the client during admission.

Staff utilised generic care plans and risk assessments, these included prepopulated actions, which were not specific to the need of individual clients or holistic in nature. Care plans generally focused on the medical regime the client was following and the physical interventions required to support this. Care plans did not reflect clients emotional, mental or physical health support needs beyond those of their detoxification.

When the client progressed from the detoxification unit to the rehabilitation unit an additional assessment took place with greater client participation. However, clients care plans remained generic, based on the first three stages of the twelve steps programme and again lacked the broader support needs of the client.

Clients' daily notes were very brief and lacked detail. For example, therapist notes stated that the client had attended/ not attended group and did not record any details of 1:1 therapy sessions. Nursing notes also lacked detail.

Best practice in treatment and care

The service followed National Institute for Health and Care Excellence (NICE) guidance and the Department of Health's, drug misuse and dependence guidance dated 2017.

Substance misuse/detoxification

The service provided a range of individual and group therapy sessions based on the twelve-step programme. Other therapy options available included life story sessions, cycle of change, cognitive behavioural therapy, art therapy auricular acupuncture and mutual aid groups.

Staff used the clinical institute withdrawal assessment of alcohol score to monitor outcomes for clients withdrawing from alcohol.

However there was no clear guidance with regards the administration of as and when required medication. There was no record in the clients' medical record why they were prescribed the as and when required medication or why this had been administered. When staff dispensed as required medication for symptomatic relief, there was no evidence staff linked the client's symptoms to their alcohol withdrawal assessment score before making a decision.

The contracted medical practitioner working for the local medical practice completed clinical assessments and subsequent treatment plans. Detoxification medication and reduction plans were a fixed regime based on the NICE guidelines. Chlorodiazapoxide was used during alcohol detoxification to manage the withdrawal symptoms.

Staff supported clients with routine health monitoring including blood pressure and checking blood sugar for diabetic clients.

The contracted GP was available to provide telephone advice if staff had concerns regarding a client's detoxification. Clients were able to register as a temporary resident with the local GP practise for the duration of their stay. Staff would seek support via the emergency services for clients suffering with a physical health or mental health crisis.

We saw evidence that the manager completed monthly medication audits on both the detoxification unit and the rehabilitation unit. The nurses on duty also completed medication checks at each handover.

Skilled staff to deliver care

The service employed a range of staff including both acute and mental health nurses, support workers and therapists. Therapists were all federation of drug & alcohol professionals or British association for counselling and psychotherapy accredited.

The service provided management and clinical supervision through a hierarchical structure. Nursing staff had not received supervision since July due to a vacancy in the structure for a clinical lead. However, the provider had identified this and had made arrangements for a lead nurse from another location to provide clinical support until he vacancy was filled. Support workers received supervision every two to three months in line with the providers' policy. Therapy staff received 90 minutes clinical supervision per month through an agreement with a GP who was employed on a sessional basis by the service. The GP had additional qualifications in addiction studies and counselling. The manager received regular supervision through the provider's head of operations.

Staff we spoke with were happy with the supervision arrangements and felt supported.

The staff we spoke with informed us the service supported them to access specialist training including health and social care level three and training to take blood samples for non-clinical staff.

Team meetings took part on a monthly basis with an additional quarterly meeting attended by the operations manager. The agenda for the meetings covered training, audits, recruitment, incidents, complaints and security. The manager disseminated relevant information through the team meetings, the supervision structure or through memos on the notice boards or in staff post trays.

Multidisciplinary and inter-agency team work

Neither medical practitioners nor external agencies had regular input in to the service therefore the service did not hold regular multidisciplinary meetings. However, nurses and therapists held daily meetings with the manager and shared information as necessary between teams or recorded details in progress notes.

Where a client was receiving support from another agency staff would involve the third party in the persons care planning and inform them of progress made. If the client gave permission for the service to share information

The service would seek support from the local mental health crisis team and probation services as necessary.

There was an agreement with the local GP to register clients admitted on the rehabilitation unit as a temporary resident.

Substance misuse/detoxification

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

The service had 89% compliance with Mental Capacity Act training; staff we spoke with told us they had had training and could demonstrate an awareness of the principles of the Act. Staff were aware that if a client was intoxicated on admission to the detoxification unit they should seek their consent and obtain a signature when they had 'sobered up' 24 to 48 hours later.

The service did not have access to advocacy support and staff were unaware of any local advocacy provision.

Staff demonstrated an understanding of the Deprivation of Liberty safeguards. Staff told us if a client wanted to leave they would not be able to stop them from doing so, though would try to persuade them to stay. They would allow them to leave after signing a disclaimer.

Equality and human rights

Seventy six per cent of staff had completed equality and diversity training and staff were able to demonstrate an awareness of equality issues. The service restricted the use of mobile phones and limited these to specific times of the day to enable clients to focus on their recovery. The provider had completed equality impact assessments in relevant policies to assess if these affected unduly on any clients identified under the protected characteristics under the Equality Act 2010.

Management of transition arrangements, referral and discharge

Staff worked across both units, this provided continuity as clients transitioned from detoxification to rehabilitation. Staff would have a handover and the clients file would transfer to the rehabilitation unit with them.

When a client transferred from detoxification to rehabilitation, they would receive an induction from another client who would show them around. Clients would spend increased periods in communal areas and attend group therapy before their move to the unit.

On discharge, staff developed a personal recovery plan with clients and gave them a discharge letter to give to their GP advising them of the treatment. Staff informed us that where another service had been involved in the clients care throughout the admission the service would invite them to a discharge meeting prior to discharge.

Staff advised us that should a client wish to leave before the end of their treatment they would encourage them to stay, clients would be asked to meet with a nurse or therapist prior to discharge and be asked to sign a disclaimer stating they were leaving against medical or therapeutic advice.

Where clients had provided consent for staff to contact their GP or other relevant parties, staff would also phone them to inform of the discharge.

The service did not routinely develop contingency plans for unplanned discharges to include for example guidance on harm minimisation or requesting a welfare check on clients thought to be at risk following discharge. However, staff reviewed the risks associated with unplanned discharge as part of the discharge process.

Are substance misuse/detoxification services caring?

Kindness, dignity, respect and support

We observed one group therapy session and general interactions between staff and clients on both units. We saw caring interactions between staff and clients throughout the service, staff engaged clients in a respectful manor. We spoke with six clients, and attended a focus group with people who use the service. All said staff were caring and treated them with respect. Clients said the staff went the extra mile.

Staff spoken with were caring and had knowledge of the individual clients and their support needs.

The involvement of clients in the care they receive

The clients we spoke with on the detoxification unit were all aware of their treatment felt they had been involved in discussions about their care, though were not aware of having a formal care plan.

Substance misuse/detoxification

We reviewed ten care records and saw evidence clients had been involved in their assessment and regular 1:1discussions and therapy sessions. We saw evidence of staff obtaining a second signature after clients completed detoxification.

We observed one group therapy session which staff facilitated; we observed staff encourage client' involvement in the session and support clients to take active roles within the session.

In the rehabilitation unit, clients were allocated weekly coordinator roles to encourage their involvement in the running of the service, for example, the activities coordinator planned the evening activities and the client coordinator helped induct new clients to the unit.

The service held monthly family days on a Sunday where clients' family could visit and take part in activities. Monthly aftercare days were held on one Saturday each month for both current and previous patients to attend. Day care sessions were also available through the week where previous clients could attend group therapy sessions.

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

Access and discharge

The bed occupancy rate for the service was low, between 20% and 23%. At the time of the inspection, there were two clients in the rehabilitation unit and five in the detoxification unit. One client was admitted over the course of the inspection.

The current occupancy rate enabled the service to be responsive in providing clients access to treatment; many clients told us they were admitted the day after making an initial enquiry.

Clients could be admitted at a time which suited them including in the evening. However, due to the contract agreement with the local medical centre to provide clinical assessments on admission clients could have to wait for long periods to see a medical practitioner. The provider was aware of the issues with the current agreement and were about to sign a new contract with another provider commencing in October. The manager told us the new provider would be more responsive completing a more holistic assessment on admission along with on-going medical support throughout a client's stay.

The service was flexible in the treatment options provided; clients could choose to stay for detoxification, rehabilitation or both. Alcohol detoxification was completed over seven days; the average stay for opiate detoxification was three weeks

The facilities promote recovery, comfort, dignity and confidentiality

Both units provided a lounge area, dining area and a quiet space. Clinic rooms were available on both units and a clinical admission room on the detoxification unit.

On the detoxification unit, the service provided a family room where clients could meet visitors or make phone calls in private. The service provided a smoking room on the detoxification unit for clients, as there was limited access to an outside space.

Clients were able to access an outside space following the first few days of their stay on the detoxification unit based on individual risk. Staff facilitated access to the garden a minimum of three times a day and clients could request access at any time throughout the day. If a client requested access to the garden staff would assess individual risk associated with facilitating this request and a support worker or member of therapy staff would support the patient to access the garden.

There was space for clients to engage in both group and 1:1 therapy sessions in each unit.

Bedrooms had a washbasin and a toilet; the service provided communal showers and bathing facilities. Bedrooms also had facilities for clients to have a locked cupboard to store personal items.

The layout of the building enabled separate male and female corridors on the detoxification unit however; this was not replicated in the rehabilitation unit, staff managed this through an informal bed management process.

The service provided meals for the clients who could choose from a range of options daily. The service was able

to cater for a range of dietary requirements on request. A range of snacks were readily available in both the lounge and dining areas and clients could help themselves to hot or cold drinks at any time.

Clients on the rehabilitation unit were able to access the local community in groups and could plan activities each week through the client activities co-ordinator.

There were three weekly alcoholics anonymous meetings held in the service including one female only meeting. The service supported clients who wanted to attend narcotics anonymous meetings to access these, although the nearest meeting was in Sheffield and required a member of staff to drive the clients. The service provided a car for this purpose.

Meeting the needs of all clients

The service was accessible and had a lift to enable access to the detoxification unit. Bathrooms on the detoxification unit were accessible although there was no handrail in the toilet. There was no accessible bathroom on the rehabilitation unit, this meant clients in wheelchairs would need to be supported to access the facilities on the detoxification unit. There was an on-going refurbishment plan in place that included a redesign of the bathroom facilities and would address this issue.

Staff informed us the service could cater for client's dietary requirements and that they would assess any cultural needs on admission.

The service had access to a telephone interpretation service. Although information provided within the welcome pack was only available in English.

Listening to and learning from concerns and complaints

The provider informed us they investigated all formal complaints. We reviewed five complaints logs and one full complaint investigation. Two complaints had been made about the level of staffing during busy periods. Three complaints were made regards medication administration, two of which had been withdrawn and one complaint had been made about staff actions following an incident. In the records we reviewed, we saw a thorough investigation had taken place and that the duty of candour had been observed. The provider identified lessons learnt and recommended actions to improve the quality of the service. However, complaints posters were not displayed on the noticeboards and the clients we spoke with said although they felt able to complain to staff they were not aware of the formal complaints procedure or which external bodies they could contact to raise a complaint. The staff we spoke with were able to describe the process to follow when receiving a complaint and to pass this on to the manger.

Are substance misuse/detoxification services well-led?

Vision and values

The care plus groups vision was 'to be leading care at the heart of our community' through the values:

- putting people first
- taking responsibility
- working together
- delivering quality services
- investing in the local community

These values were embedded as part of the staff appraisal documentation. However, staff we spoke to were unclear of the provider's vision and values.

Staff were aware of the management structure within the provider and could name the senior manager.

Good governance

Staff had completed the providers' induction programme and mandatory training was at 81%. The provider had introduced organisational policies and procedures and the managers were in the process of identifying situations where local operating procedures were necessary to meet the specific needs of the service. Staff could access these policies and procedures through the online portal.

The provider had introduced an audit programme including medication audits and environmental audits. Audit results were collated through the providers' quality and performance department and formed part of the monthly key performance indicator reports used to monitor the performance of the service. Learning from audits was feedback to the manager and incorporated action plans where necessary. The manager shared learning from audits within staff meetings.

Substance misuse/detoxification

Client feedback was collated monthly and presented within the key performance indicator report and a quarterly service user experience report.

The provider was able to demonstrate that where staff performance had been identified as an issue they had taken appropriate action including providing support and training before progressing with disciplinary action.

However, we found evidence in one staff record that a member of staff had commenced work before their disclosure and barring service check had been cleared and the manager had not completed the associated risk assessment in line with the providers' recruitment policy. There was also no evidence of additional recruitment checks being completed by the providers' human resource department including clarification of breaks in employment history.

Leadership, morale and staff engagement

The service had a low absence and turnover rate and many staff had worked for the service for a number of years. The staff we spoke with were aware of the management structure and could name the senior managers within the organisation.

Staff were aware of the whistleblowing process and said they would feel safe to raise concerns if they needed to.

Staff spoken with said the service had been through some difficult times under previous providers and felt the level of investment and support from the current provider was reassuring. Staff stated they felt the provider was here for the future and all felt supported by the manager.

Commitment to quality improvement and innovation

Due to the lack of placements under the recent commissioning arrangements, the service was not required to complete the national drug treatment monitoring system returns. However, the provider had implemented an audit programme and key performance indicators, were being monitored through the providers' quality and performance department.

The service offered a programme of monthly aftercare days and weekly day care sessions, which were available to previous clients to access therapy sessions and peer support. These sessions were free to attend with a nominal charge for meals. The service allowed clients who were travelling long distances to book a room for the evening for a nominal charge to support their attendance.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure clinical areas have appropriate risk assessments and waste streams in place to ensure appropriate infection control measures are in place.
- The provider must ensure appropriate facilities and personal protective equipment are available in clinical areas.
- The provider must ensure medication administration records are completed correctly and contain all relevant medical information including information on allergies.
- The provider must ensure adequate information is sought from other professionals including a client's GP when assessing the risks to the health and safety of service users receiving care or treatment.
- The provider must ensure risk assessments reflect individual risks and management plans are personalised. Clients must have an individual care plan detailing the care and treatment they receive.
- The provider must ensure risk management plans are updated following a change in an individuals' circumstances.

Action the provider SHOULD take to improve

- The provider should ensure that infection prevention and control audits are carried out and recorded to enable staff to learn from the results and make improvements to the service.
- The provider should keep records for the calibration of the blood pressure machine.
- The provider should ensure contingency plans for unplanned discharge are routinely developed as part of the admission process
- The provider should complete a risk assessment to substantiate the providers operating model for managing mixed sex accommodation on the rehabilitation unit.
- The provider should display details of how to make a complaint, including external organisations clients are able to contact. Staff should make clients aware of the complaints process on admission.
- The provider should ensure recruitment procedures are followed and all relevant recruitment checks are completed during the recruitment of new staff.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met There was not a risk assessment for the infectious waste stream and yellow clinical waste systems were not appropriate. There were no risk assessments or procedure for the testing of urine. The facilities in the clinic room on the detoxification unit were not appropriate for the use of the room and personal protective equipment was not available in the room. Over the eight-month period between January and September 36% percent of incidents recorded related to medication errors. However, the medication administration records inspected continued to contain omissions and allergy information was not readily available in the medication records. Risk assessment templates were generic and not personalised to reflect individual risks. We saw two instances where risk assessments had not being updated following clients expressing suicidal ideation. Where clients did not consent to staff contacting their GP or other third party staff would not seek any further information. The meant some clients did not have comprehensive risk assessments creating a potential risk for staff and clients. Regulation 12 (2) (a)(d)(e)(h)(g)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

How the regulation was not being met

Care plans in place did not contain a formal discharge plan or a plan for unexpected exit from the service.

Care plans were not holistic and did not reflect individuals specific support needs.

Regulation 9 (3) (a) (b) (g)