Withersdane

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:

- During our inspection in August 2016, we found the service in breach of regulation 12 of the Health and Social Care Act 2014 concerning lack of call alarms in client bedrooms. The service had installed an alarm in only one bedroom at the time of our inspection.
- It was part of a requirement notice from our comprehensive inspection that the service conducted regular fire drills and had relied on false alarms to conduct drills. The service had recently commenced fire drills and had conducted their first scheduled drill on 3 July 2017.
- At the comprehensive inspection in August 2016, we found that not all staff were competent to administer emergency medicines. During this inspection, three staff told us they did not feel competent or confident to administer this medicine.
- The service stored emergency medicines including naloxone, epipens and buccal midazolam. Buccal midazolam is a prescription only medicine that only

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clinical staff who have agreed to work within the terms of a patient group direction can administer. However, we saw that some staff had been trained to administer buccal midazolam who did not meet the legal framework to do so. Inspectors raised this with the clinical manager who acted on this information.

- Rotas reviewed showed that there had been no nursing cover for part or all of 10 of the 14 days between 26 June and 9 July 2017. The rotas recorded that the service had arranged cover for six shifts between 8pm and 8am during this period. However, there was no nurse available for seven shifts between 8am and 8pm and five shifts between 8pm and 8am. Volunteers from the sober living community were included in night staff numbers. The rotas demonstrated that there were only two health care assistants available after 10pm on four occasions during this period. The Group Clinical Director has confirmed that since the inspection, the service has recruited a nurse and confirmed that there will be three permanent nurses in post from the end of September 2017.
- At the comprehensive inspection in August 2016, we issued a requirement notice that the service should implement a more robust system for incident reporting. During this inspection there was no evidence of a formal process to collate, analyse or share learning from incidents.
- We reviewed 11 prescription and administration charts. Staff had recorded allergies on prescription charts. However, some charts contained a number of administration gaps, which represented missed doses of medicines. This also included medicines which should not be stopped abruptly. Additionally, it was not always possible to tell the reasons for missed doses as staff did not consistently record this information.
- Clinical staff completed a pre admission assessment form and medical assessment for all clients. However, the assessment process did not include questions about children as recommended in the drug misuse and dependence UK guidelines on clinical management and as identified in our report following the comprehensive inspection in August 2016. The assessment process did not formally demonstrate consideration of Wernicke Korsakoff syndrome, which had also been identified at the last inspection. Wernicke's encephalopathy is a disorder that affects the function of the brain. It usually develops suddenly, often after abrupt and untreated withdrawal from alcohol.
- Some people were self-administering medicines but this did not match the service's policy.
- Our inspection in August 2016 identified that staff should receive regular one to one performance management meetings. Only two of the staff interviewed during this inspection said that they received regular performance management meetings.
- The service had updated their admission policy to include exclusion criteria since our last inspection. The policy included information about categories of clients that the service would not provide treatment to and actions for staff where there may be concerns that the service could not meet a client's needs. However, the criteria was basic and did not provide detailed information. For example, it did not include the minimum body mass index for clients with an eating disorder that the service would consider for treatment.
- The service relied on sending information to staff via emails which were not saved on the electronic framework.
- We found that staff had not reported four incidents that required notification to CQC.
- Data provided by the service recorded that six of the 27 volunteers did not have a disclosure barring service check in place.
- After our comprehensive inspection in August 2016, we issued a requirement notice that the service should make sure that their statement of purpose (SOP) contained accurate information. No changes had been made to the SOP reviewed during this inspection.
- The service did not have a Duty of Candour policy. However, since being raised by inspectors, the service was developing a policy.
- However, we also found the following areas of good practice:

Summary of findings

- Risk assessments were comprehensive and detailed. The clinical manager reviewed risk assessments and risk management plans to make sure they were accurate and up to date.
- There was an appropriate range of emergency medicines, including oxygen that were within their expiry dates. Staff checked emergency medicines weekly.
- The service had recruited a doctor who was on site during normal working hours. Staff could contact the doctor outside of normal working hours if required.
- We reviewed 14 client records which were comprehensive and detailed. Care plans were individualised and staff regularly reviewed progress with clients. Staff knowledge of clients was good.
- An external pharmacist visited Withersdane every other week to help screen prescription charts and undertake medicines management audits.
- Staff followed the service's safeguarding policy and knew when a safeguarding referral would be appropriate.
- The clinical manager had introduced guidance of staff responsibilities during a client's treatment journey.
- The process to audit client files was effective. The clinical manager reviewed all client records to make sure that they were accurate and up to date prior to attending the clinical management meeting.
- We observed a clinical management meeting. The meeting allowed staff to contribute in decisions made about the care of clients.
- We found that the service had acted on the following concerns identified during our inspection in August 2016:
- The service had acted on the requirement that staff must have access to emergency medicines quickly and without delay. The service had increased the set of emergency medicines to two and located them in different site areas to allow staff quick access.
- The service had reviewed the process for staff administering medicines since our last inspection. Staff administered medicines in a dedicated area away from the clinic room to avoid interruption.
- At our inspection in August 2016, we issued a requirement notice that the provider must ensure there were robust systems in place to ensure that client records were up to date and stored appropriately. During this inspection, we saw that this had been addressed.
- At the last inspection we identified that the provider should encourage staff to work more as a multi-disciplinary team. We saw that the provider had created one large office for all staff, to encourage multi-disciplinary working. Staff told us that communication between the three different roles had improved since this office had been introduced.

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Background to Withersdane

Withersdane was a residential detoxification and rehabilitation service for people with associated problems relating to substance misuse, eating disorders and other addictive or compulsive behaviours. The accommodation was mixed gender. The majority of clients who used the service had self referred and paid for their own treatment.

Withersdane is registered with the Care Quality Commission (CQC) to provide the following activities:

• Accommodation for persons who require treatment for substance misuse

• Treatment of disease, disorder or injury

Withersdane had a registered manager, although they did not attend the service daily.

The Care Quality Commission carried out a comprehensive inspection of Withersdane in August 2016. Inspectors found the service in breach of regulations 12 and 17 of the Health and Social Care Act 2014. Regulation 12 concerns safe care and treatment and regulation 17 concerns good governance.

This was a follow up inspection to ensure that the service had taken action to address the requirement notices issued after the comprehensive inspection.

Our inspection team

The team that inspected the service comprised; CQC inspector Shelley Alexander-Ford (inspection lead), one inspection manager, one other CQC inspector and one CQC pharmacist specialist.

Why we carried out this inspection

This was a follow up inspection to make sure that the service had taken action to address the requirement notices issued after the comprehensive inspection in August 2016.

During the comprehensive inspection, we found the service in breach of regulations 12 and 17 of the Health and Social Care Act 2014. Concerns included staff competency in administering medication including emergency medication; medicine management; the ability of clients to contact staff in an emergency; staff understanding of reporting incidents and safeguarding alerts; consistency of assessments; maintaining client records; lack of multi disciplinary working and governance.

As this was not a comprehensive inspection we did not pursue all of our key lines of enquiry. We directed our resources towards inspecting the areas of potential concern. This should be considered when reading the report.

How we carried out this inspection

During this focussed inspection we considered areas of the service to make a judgement on the following questions:

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

Summary of this inspection

Before the inspection visit, we reviewed information that we held about the location and data that we held about the service through our intelligent monitoring processes.

During the inspection visit, the inspection team:

- looked at the quality of the physical environment and observed how staff were caring for clients
- reviewed the medicine management of the service
- spoke with 10 clients
- spoke with the clinical manager
- spoke with one nurse
- spoke with 10 other staff members employed by the service provider, including focal therapists, health care assistants, the health and safety lead and a member of the admissions team
- attended and observed a clinical management meeting
- looked at 14 care and treatment records, including risk assessments and care plans
- reviewed 11 medicines records
- reviewed staff training and disclosure barring records
- reviewed the incident reporting records
- reviewed rotas for the two weeks prior to the inspection
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

Feedback from clients was generally positive. Clients spoke highly of staff and the therapy provided. Clients said that staff discussed and reviewed next steps with them during their treatment. Clients told us they felt safe and that staff were always available, although one client said that it was sometimes hard to locate staff to take them to meetings between 6pm and 10pm because of other groups taking place on site. Clients said that staff tailored care to meet individual needs and smaller groups allowed more attention from staff. Clients found the quality of food good, although they had to speak to their allocated therapist if they wanted to change their portion size.

However, there were concerns regarding availability of staff to dispense medicine because staff were not always in the front office. This meant that clients may have to wait to receive their medicine. A client was concerned at the potential lack of security due to staff leaving the door to the client accommodation unlocked. They felt this meant that anyone could potentially walk on site and into the accommodation at any time.

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:

- During our inspection in August 2016 we found the service in breach of regulation 12 of the Health and Social Care Act 2014 concerning lack of call alarms in client bedrooms. At the time of our inspection, the service was in the process of installing alarms, although had only fitted an alarm in one bedroom.
- At time of the last inspection, the service was not undertaking regular fire drills and relied on false alarms to conduct drills. The service had recently initiated fire drills and had completed their first scheduled drill on 3 July 2017.
- Rotas reviewed showed that there had been no nursing cover for part or all of 10 of the 14 days between 26 June and 9 July 2017. The rotas recorded that the service had arranged cover for six shifts between 8pm and 8am during this period. However, there was no nurse available for seven shifts between 8am and 8pm and five shifts between 8pm and 8am. Volunteers from the sober living community were included in night staff numbers. The rotas demonstrated that there were only two health care assistants available after 10pm on four occasions during this period. This was a breach of regulation. You can read more about it at the end of the report.
- The service had introduced a Patient Group Direction (PGD) for Buccal midazolam since our last inspection. However, we were unable to locate records to demonstrate that each nurse had agreed to working within the terms of the PGD. After the inspection, the service confirmed that they had arranged for nurses to sign a new record to confirm this information.
- At the comprehensive inspection in August 2016, we found that staff did not contact a client's GP and other professionals involved in a client's care as part of the admission process. During this inspection, we saw evidence that staff had asked clients for consent to contact their GP but there was no evidence of staff acting on this consent to ensure a comprehensive medical history. Client records contained little evidence of multi-disciplinary working.
- However, we also found the following areas of good practice:

Summary of this inspection

- Risk assessments were comprehensive and detailed. The clinical manager reviewed risk assessments and risk management plans to make sure they were accurate and up to date.
- There was an appropriate range of emergency medicines, including oxygen that were within their expiry dates. Staff checked emergency medicines weekly.
- Staff followed the service's safeguarding policy and knew when a safeguarding referral would be appropriate.
- The service had recruited a doctor who started employment during our inspection. The doctor was on site at the service or a sister service nearby, during normal working hours. Staff could contact the doctor outside of normal working hours if necessary.
- Our inspection in August 2016 found that there was only one set of emergency medicines that staff did not always have immediate access to. The service had increased the number of emergency medicines to two sets and had located them in different areas to allow staff to access them quickly and without delay.
- Our inspection in August 2016 found that there were sometimes delays in administering medicines to clients. The service now had a dedicated area to administer medicines to avoid interruption.

Are services effective?

We do not currently rate standalone substance misuse services.

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

- The comprehensive inspection in August 2016 identified that not all staff had been trained or were competent to administer emergency medicines. During this inspection, three members of staff expected to administer emergency medicine told us they had not received training and did not feel confident or competent to do so. Information provided by the service stated that there would always be a minimum of two trained members of staff on duty.
- The service stored emergency medicines including naloxone, epipens and buccal midazolam. Buccal midazolam is a prescription only medicine that only clinical staff who have agreed to work within the terms of a patient group direction can administer. However, we saw that some staff had been trained to administer buccal midazolam who did not meet the legal framework to do so. Inspectors raised this with the clinical manager who acted on this information.

Summary of this inspection

- We reviewed 11 prescription and administration charts. Staff had recorded allergies on prescription charts. However, some charts contained a number of administration gaps, which represented missed doses of medicines. This was a breach of a regulation. You can read more about it at the end of this report.
- We saw that medicines were not always available for people in a timely manner between medicines rounds.
- The medical assessment form completed for clients did not contain questions about children as recommended in the drug misuse and dependence UK guidelines on clinical management and as identified in our report for the comprehensive inspection in August 2016.
- We saw evidence of the service declining a referral due to the complex needs of a client including Wernicke Korsakoff syndrome. However, the assessment form did not include this information for consideration.
- Staff spoke positively of fortnightly supervision from an independent supervisor. However, the supervision was provided on the same day and time. This meant that not all staff were able to attend due to shift patterns.
- During our inspection in August 2016 we identified that staff should receive regular one to one performance management meetings. Only two of the staff interviewed during this inspection said that they received regular performance management meetings.
- We saw evidence of staff with specialist knowledge, for example, in eating disorders, contributing to a client's care plan. The member of staff with specialist knowledge in eating disorders worked at a sister service. This meant that they were not always on site to give advice and support, although could be contacted by telephone. However, the action plan in response to the comprehensive inspection stated that the permanent chef had enrolled for a Diploma in Diet and Nutrition course. The action plan also stated that the service would purchase the services of a nutritionist as required.
- However, we also found the following areas of good practice:
- We reviewed 14 client records which were comprehensive and detailed. Care plans were person centred and staff regularly reviewed progress with clients.
- Staff knowledge of clients was good. Staff recognised the individual need of clients and tailored care to their needs
- An external pharmacist visited the service every other week to help screen prescription charts and undertake medicines management audits.
- Nurses completed a comprehensive pre admission assessment and doctors completed a medical assessment for all clients.

Summary of this inspection

- We observed a clinical management meeting. The meeting allowed staff to contribute in decisions made about the care of clients.
- The process to audit client files was effective. The clinical manager reviewed all client records to make sure that they were accurate and up to date prior to attending the meeting.
- The clinical manager had developed guidance for staff concerning a client's treatment journey to support a client engaging in treatment.

Are services responsive?

We do not currently rate standalone substance misuse services.

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

- The service had updated their admission policy to include exclusion criteria since our last inspection in August 2016. The policy included information about categories of clients that the service would not provide treatment to and actions for staff where there may be concerns that the service could not meet a client's needs. However, the criteria was basic and did not provide detailed information. For example, it did not include the minimum body mass index for clients with an eating disorder that the service would consider for treatment.

Are services well-led?

We do not currently rate standalone substance misuse services.

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

- Staff were advised of incidents via email and during clinical meetings. However, emails were not stored on the framework and incidents were not part of the clinical meeting agenda.
- There was no evidence of a formal profess to collate, analyse and share learning from incidents. This was a breach of a regulation. You can read more about it at the end of this report.
- Staff had recorded 27 incidents in the service incident book since July 2016. Four of these incidents had met the criteria to report to CQC, however, CQC had not been notified. This was a breach of a regulation. You can read more about it at the end of this report.
- The statement of purpose contained incorrect information concerning staff training and services and activities provided by the service. This was a breach of a regulation. You can read more about it at the end of this report.

Summary of this inspection

- Data provided by the service recorded that six of the 27 volunteers did not have a disclosure barring service check in place. This was a breach of a regulation. You can read more about it at the end of this report.
- Some people were self-administering medicines but this did not match the service's policy.
- Following our inspection in August 2016, we identified that the provider should use key performance indicators and outcome measurements to manage performance and develop and improve the service. This was not in place during this inspection. However, the clinical manager explained that there were plans to collate data to use for this purpose.
- At our previous inspection, we identified that the provider should monitor staff sickness and absence. During this inspection, we saw that sickness and absence was recorded on the staffing rotas. However, we were unable to review if sickness and absence was monitored, as the information was unavailable during our inspection due to staff annual leave.
- However, we also found the following areas of good practice:
- At our inspection in August 2016, we issued a requirement notice that the provider must ensure that there are robust systems in place to ensure that client records are up to date and stored appropriately. During this inspection, we saw that the clinical manager completed a weekly audit of client records. The audit checked risk assessments, care plans and that staff had uploaded all relevant information to client records so that they were accurate and up to date.
- The clinical manager had introduced guidance of staff responsibilities during a client's treatment journey. Information for staff was from the point of a client arriving at the service through to their planned or unplanned exit from treatment.
- At the last inspection, we identified that the provider should encourage staff to work more as a multi-disciplinary team. We saw that the provider had created one large office for all staff, to encourage multi-disciplinary working. Staff told us that communication between the three different roles had improved since this office had been introduced.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

Some of the nursing staff were registered mental health nurses, which meant that they had a good understanding of mental capacity.

Staff completed Mental Capacity Act e-learning training. Staff could refer to the Mental Capacity Act policy for further guidance. Staff monitored capacity throughout a client's detoxification to make sure that they could make informed choices about their treatment.

Substance misuse/detoxification

Safe	
Effective	
Responsive	
Well-led	

Are substance misuse/detoxification services safe?

Safe and clean environment

- The service had opened two more buildings since our last inspection, which meant that three buildings were used for accommodation and group work. The accommodation and level of support was linked to the cost of treatment. The location of client's therapy was dependent upon the fees paid. The Hall was the most expensive treatment programme, Dunstan Skilbeck was the middle and Swanley provided the least expensive treatment option. There were 17 clients in primary and secondary treatment during our inspection.
- Staff told clients that accommodation was mixed gender when they first contacted the service. The bedrooms in The Hall and Dunstan Skilbeck were en-suite. The mixed gender accommodation in Swanley was one long corridor that could be separated by a door. There was a shared bathroom and communal toilets for male clients and another for female clients. Staff used one end of the corridor for male clients and the other end for female clients. This meant that the service complied with Department of Health same sex guidance because clients had access to segregated bathroom and toilet facilities without passing through opposite-sex areas to reach their own facilities.
- At our inspection in August 2016, the service had one set of emergency medicines. The medicines were kept in the nurse's office which was locked when not in use. This meant that staff may not be able to respond appropriately in an emergency. The service had changed the location of and increased the number of emergency medicines to two sets since our previous inspection. This meant that staff in different areas could readily access emergency medicines when required.
- The service had reviewed the process for staff administering medicines since our last inspection. Staff administered medicines in a dedicated area away from the clinic room. This meant that staff did not interrupt an assessment in order to administer client medicines. All staff had access to the medicines cupboard. Controlled drugs (medicines which are more liable to misuse and therefore need close monitoring) were stored securely. Staff completed registers to record handling of controlled drugs. Staff disposed of waste medicines correctly. We were not able to locate records for faulty medicines alerts to check that these were received and acted upon appropriately.
- During our inspection in August 2016, we found the service in breach of regulation 12 of the Health and Social Care Act 2014 concerning lack of call alarms in client bedrooms. The service completed an action plan which stated that the service would install call alarms by 1 June 2017. However, we found that only one bedroom contained a call alarm. The alarm system had been designed and developed by the provider. A volunteer had written the code for the alarm system and was involved in its installation. The alarm did not emit a sound. However, the alarm was set by a pressing a button which locked in place to show that it had been activated. Once activated, the alarm sent an SMS message to two phones carried by staff 24 hours per day. As a backup, the alarm generated an email message to all staff. The message was sent every 60 seconds until staff deactivated the alarm. Since the inspection, the group clinical director has told us that a dedicated laptop has been installed in the clinical office which sounds a klaxon style alarm.
- There was a zoned fire alarm system throughout the site. The system was linked to the main building and showed where the fire was located. At time of the last inspection, the service was not undertaking regular fire drills and relied on false alarms to conduct drills. Fire drills had not been happening until recently. The health

and safety lead had felt it was disruptive to clients to undertake regular drills. Since the completion of the building work, there had been one fire drill on 3 July 2017. Some staff had ignored the alarm and only acted when prompted. Staff had not completed the register for clients in Swanley. The alarm did not sound in the building where the admissions team were located, so they did not go to the assembly point. They had not signed into the visitor's book so nobody was aware they were there. After the drill, the health and safety lead completed a report which detailed conclusions and actions. The report concluded that the drill had been productive and that the actions identified had now been addressed.

- **Safe staffing**
- There were 35 employed members of staff at Withersdane. Staffing included; four permanent nurses; seven focal therapists; nine health care assistants; and three bank nurses. One nurse had recently submitted their resignation and another was on long term absence. There were two doctors on call, although the service had recruited a doctor who started full time employment during the inspection. This meant that there would be clinical cover during normal working hours. The service contracted two consultant psychiatrists, one of which attended the service weekly. The clinical manager told us there were 17 volunteers in the sober living community. However, data provided by the service recorded 24 volunteers.
- Rotas reviewed showed that there had been no nursing cover for part or all of 10 of the 14 days between 26 June and 9 July 2017. The rotas recorded that the service had arranged cover for six shifts between 8pm and 8am during this period. However, there was no nurse available for seven shifts between 8am and 8pm and five shifts between 8pm and 8am. Volunteers from the sober living community were included in night staff numbers. The rotas demonstrated that there were only two health care assistants available after 10pm on four occasions during this period.The Group Clinical Director has confirmed that since the inspection, the service has recruited a nurse and confirmed that there will be three permanent nurses in post from the end of September 2017.
- The recent recruitment of a doctor meant that there was clinical cover during normal working hours. The lack of nursing cover meant that there may not always be clinical staff on site outside of normal working hours, although staff could contact the doctor if required. We visited the service during an evening and found that there had been no nurse on site since the previous day. Staff told us that the service had arranged nurse cover but they had not returned after working a few shifts.
- The service employed volunteers on a zero hours contract and paid volunteers when they worked over 30 hours. Some volunteers worked and were paid as night staff. Volunteers were recorded as health care assistants on the staffing rota. The training matrix provided during the inspection recorded that two volunteers who covered regular night shifts had only completed standard child safeguarding training. A further matrix provided after the inspection recorded that one volunteer had completed all mandatory training and the other had completed 16 of the 17 mandatory training modules. However, the matrix recorded that a member of staff who worked regular night shifts had only completed two of the 17 mandatory training modules.
- Mandatory training included e-learning first aid training. Training data provided by the service during the inspection showed that seven of 34 eligible staff had not completed this training. However, the matrix provided after the inspection recorded that all staff except one had completed the training. Course content provided from the comprehensive inspection in August 2016 showed that the first aid awareness training included cardio pulmonary respiratory training. Only four of the 24 volunteers had completed first aid awareness training.
- Data provided by the service during the inspection showed that five of 26 eligible members of staff had not completed mandatory e-learning training in the safe administration of medicines and only six members of staff had received a competency assessment for administering medicines. Competency assessments help provide assurance that staff are able to administer medicines safely. Information provided after the inspection recorded that all staff had completed training in the safe administration of medicines and seven staff had completed a competency assessment.

Substance misuse/detoxification

- Data provided by the service showed that only four of the 24 volunteers had completed some or all of the online training. However, the group clinical director confirmed that volunteers involved in the care of clients had completed the training.
- **Assessing and managing risk to clients and staff**
- The assessment process began at first point of contact when the admissions team completed an initial screening tool. The admissions team explained the services available, pricing structure and proposed length of stay. The team arranged an appointment for the client to meet with the clinical manager, attend a comprehensive medical assessment and complete paperwork.
- At the comprehensive inspection in August 2016, we found that staff did not contact a client's GP and other professionals involved in a client's care as part of the admission process. The service action plan said that this would be in place by June 2017. We saw evidence that staff had asked clients for consent to contact their GP as part of the nursing assessment. However, there was no evidence of staff contacting GPs to gather information. This meant that the service did not have a full and comprehensive history of a client's physical and mental health.
- The comprehensive inspection in August 2016 identified that not all staff had been trained or were competent to administer emergency medicines. In November 2016, the provider confirmed that training had been provided for all available staff, that there would always be two trained members of staff available at any time and further training would be provided to staff who had been unable to attend the original training. The training matrix provided by the service did not include information about this training. Three members of staff expected to administer emergency medicines told us they had not received this training and did not feel competent or confident to administer emergency medicines. They told us that they would not know the correct medicine to administer in the event of an emergency. However, they said they would place a client in the recovery position and call an ambulance if a nurse was unavailable. It is good practice for a service to have emergency medicines on site, and if it is kept for life-saving purposes, staff must be competent to use it.
- We reviewed eleven prescription and administration charts. Staff had recorded allergies on prescription charts. Some charts contained a number of administration gaps, which represented missed doses of medicines. This also included medicines which should not be stopped abruptly. Additionally, it was not always possible to tell the reasons for missed doses as staff did not consistently record this information.
- All clients were seen by a psychiatrist whose assessment included a mental state examination. This included an assessment of cognition / coordination to time, place and person. This examination would be useful in assessing the risk of Wernicke's encephalopathy. The comprehensive medical assessment document did not specifically invite doctors to consider this despite being a requirement from the comprehensive inspection. However, we saw evidence of the service assessing a client as unsuitable for treatment during their initial assessment, because of their level of need which included alcohol induced dementia.
- The action plan sent by the provider in response to previous concerns stated that risk assessment, management and contingency planning training had been delivered to staff in January and February this year. Three members of staff reported not having received this training.The training matrix provided by the service did not include this information.
- The clinical manager reviewed client's risk assessments and management plans prior to attending the clinical management meeting. We saw client involvement in risk assessments which were comprehensive and detailed. There was evidence that staff regularly reviewed identified issues which were discussed during therapy sessions. Staff took appropriate action for identified risks, for example arranging a psychiatric assessment for a client where staff had identified mental health concerns. Risk assessments included evidence of progression with identified risks such as eating and isolation. Only one of the 14 risk assessments reviewed was overdue a review.
- Staff followed the service's safeguarding policy and knew when a safeguarding referral would be appropriate. There were contact details for the local safeguarding team in the nurse diary. We saw examples of staff contacting the local safeguarding team for advice.

Substance misuse/detoxification

- Staff followed the service's medicines policy, although it contained the name of another clinic. This had been reviewed and had a date for future review.
- There was an appropriate range of emergency medicines, including oxygen that were within their expiry dates. Staff checked emergency medicines weekly. Some staff told us they had received training on emergency medicines. The training matrix did not include this training or information about competency assessments.
- During our inspection in August 2016, we found that the service did not have a Patient Group Direction (PGD) for Buccal midazolam We saw that there was now a PGD in place to allow nurses at the service to administer Buccal midazolam 10mg pre-filled syringes (used to treat prolonged seizures in an emergency). We were unable to locate records to demonstrate that each nurse had agreed to working within the terms of the PGD. However, we received confirmation after the inspection that the service had implemented a new sign off sheet to demonstrate nurse's agreement.
- Some healthcare assistants and counsellors had been trained to administer Buccal midazolam using a PGD. Our specialist pharmacist explained to the clinical manager that healthcare assistants and counsellors are not able to administer this medicine under the legal framework of a PGD. The clinical manager said that he would act on this information.
- **Reporting incidents and learning from when things go wrong**
- Staff had recorded 27 incidents in the service incident book since July 2016. Four of these incidents had met the criteria to report to CQC, however, CQC had not been notified.
- Staff discussed incidents as part of the client review during the clinical meeting. However, incident reporting was not a dedicated agenda item. Staff did not record formal minutes of the clinical management meeting which meant that there was no formal process to share information with staff who did not attend the meeting apart from reading client records or the record of clinical management meeting notes.
- Staff sent a summary email to colleagues at the end of each shift which included information about incidents. However, emails were not stored on the electronic framework. Staff were unable to give examples where changes had been implemented following incidents, to mitigate risk and improve and develop the service. There was a lack of clear evidence that the service collated and analysed incidents to identify themes and share learning.
- Staff recorded medicines errors in an incident book. However, there was no evidence that analysis of incident trends and sharing of lessons learned had been undertaken to support staff learning to reduce the risk of future reoccurrences.
- We saw a recent incident involving non clinical staff administering incorrect medicines to a client. The manager showed us what actions had taken place in order to minimise the recurrence of future incidents with this member of staff.
- The action plan submitted by the provider said that all staff received training in incident reporting in January and February 2017. The training matrix provided by the service did not include information about this training.
- **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 service did not have a Duty of Candour policy. However, we saw evidence in client records of staff regularly contacting relatives and carers. The clinical governance manager told us that the service was now preparing a Duty of Candour policy.

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)

- Clinical staff completed a comprehensive pre admission assessment form for all clients. However, the

form did not contain questions about children as recommended in the Drug misuse and dependence UK guidelines on clinical management as identified in our report for the comprehensive inspection.

- The pre admission assessment did not include consideration for Wernicke Korsakoff syndrome as identified during our inspection in August 2016.
- All staff had access to client records, including volunteers, if it was relevant to their role. Volunteers who had access to client records had completed a disclosure barring check.
- We reviewed 14 client records which were comprehensive and detailed. Care plans were individualised and staff regularly reviewed progress with clients.
- Records included assessment tools including Becks Depression Inventory, Clinical Opiate withdrawal scale, severity of alcohol dependence questionnaire and clinical institute withdrawal assessment.
- The clinical manager had developed guidance for staff concerning a client's treatment journey. The guidance included preparing a room to meet with the client for the initial assessment, responsibilities of staff during a client's treatment and staff actions for planned or unplanned exits.
- **Best practice in treatment and care**
- An external pharmacist visited the service every other week to help screen prescription charts and undertake medicines management audits. The pharmacist also noted on charts when to undertake blood tests for people taking certain medicines that need close monitoring. However, in one case, we were not able to see that clinical staff had acted on this.
- During the inspection, we saw that medicines were not always available for people in a timely manner between medicines rounds.
- **Skilled staff to deliver care**
- Most staff told us that they had received an induction when they joined the service. We saw a new member of staff receiving an induction during our inspection.
- An independent supervisor provided fortnightly supervision for staff who worked with clients. However, the supervision was provided on the same day and time. This meant that not all staff were able to attend due to static shift patterns.
- Our inspection in August 2016 identified that staff should receive regular one to one performance management meetings. Only two of the staff interviewed during this inspection said that they received regular performance management meetings. This meant that staff did not have the opportunity to discuss their development and training needs. Records were unavailable for review during our inspection because of staff annual leave.
- We received mixed responses concerning non-mandatory training. Some staff told us how the service supported their continued professional development whilst others reported not receiving any face to face training or professional development.
- Appraisal notes were unavailable for review during our inspection because of staff annual leave.
- **Multidisciplinary and inter-agency team work**

  We observed a clinical management meeting. The clinical manager reviewed all client records to make sure that they were accurate and up to date prior to attending the meeting. The meeting allowed staff to contribute in decisions made about the care of clients. However, the meeting was on the same day and time each week, which meant that not all staff could attend.
- Staff did not record formal minutes from the meeting. However, staff completed a record of clinical management meeting to record notes. We reviewed five records, which showed that staff had not completed all information, for example the client's 'status and progress' or 'other relevant information'. Records from the meeting were saved onto the framework that all staff had access to.
- We saw evidence of staff with specialist knowledge, for example, in eating disorders, contributing to a client's care plan. However, the member of staff with specialist knowledge in eating disorders worked at a sister service. This meant that they were not always on site to give advice and support, although staff could contact them

by telephone. The action plan submitted by the service stated that the permanent chef had enrolled for a Diploma in Diet and Nutrition course. The service purchased the services of a nutritionist as required.

- Client records contained little evidence of multi-disciplinary working. However, one care plan included staff arranging for a client to visit the dentist. Clients were registered with a local GP if they were in long term treatment.
- Staff told us that multi-disciplinary working within the service had improved since staff shared one office.

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

Access and discharge

- The service had updated their admission policy to include exclusion criteria since our last inspection. The policy included information about categories of clients that the service would not provide treatment to and actions for staff where there may be concerns that the service could not meet a client's needs. However, the criteria was basic and did not provide detailed information. For example, it did not include the minimum body mass index for clients with an eating disorder that the service would consider for treatment.
- The exclusion criteria explained that it could be applied at any stage of the referral process.

Are substance misuse/detoxification services well-led?

Good governance

- At the time of our inspection, the members of staff responsible for information relating to governance, human resources, training and qualifications were on annual leave. The registered manager and clinical manager did not have direct access to much of the information requested during our inspection. This meant that this information was unavailable to review. The service provided information after the inspection.
- The service relied on the use of emails to communicate information to staff. The service did not save the emails in a dedicated area future reference.
- There was a quarterly clinical managers meeting which reviewed clinical and non-clinical aspects of the service. We reviewed the minutes of two meetings which were limited in their detail although did record action points to review at the next meeting.
- At the comprehensive inspection in August 2016, we issued a requirement notice that the service should implement a more robust system for incident reporting. We reviewed the incident reporting book during this inspection. We found incidents recorded that staff should have reported to CQC, but had not done so. Although staff discussed incidents during the clinical management meeting, no minutes were taken. There was a lack of clear documentary evidence that incidents had been discussed openly with staff or clients. There was no evidence of a formal process to collate, analyse and share learning from incidents.
- Staff followed the service medicines policy, although it contained the name of a sister clinic. The policy had been reviewed and had a date for future review. Staff recorded information about medicines errors in the incident book.
- Staff completed a significant event report in the event of a medicines error. The member of staff and the clinical manager reviewed the report together to identify learning and avoid recurrence. Staff had to repeat the safe administration of medicines training and complete a new competency assessment if they were involved in medicine errors. However, there was no evidence of analysis of incident trends or sharing of lessons learned with other members of staff.
- Some people were self-administering medicines. However, the practice of self-administration did not match the service's policy.
- Information concerning staff qualifications was unavailable at the time of our inspection because of staff annual leave. Staff provided this information on their return from annual leave, after the inspection.
- Data provided by the service recorded that six of the 24 volunteers did not have a disclosure barring service check in place.

Substance misuse/detoxification

- During our inspection in August 2016, we found that the statement of purpose (SOP) contained inaccurate information.The action plan completed by the service said that they were seeking advice and hoped that this would be updated by 1 May 2017. However, we found the SOP still contained incorrect information about staff training and the services provided. The SOP recorded that all staff would complete a level 2 Diploma within two years of appointment. We received confirmation that no staff had completed or were in the process of completing this training. The SOP recorded that the service provided a diagnostic and / or screening service. The service is not registered with CQC to provide this service.
- During our inspection in August 2016, we identified that the provider should use key performance indicators and outcome measurements to manage performance and develop and improve the service. This was not in place during this inspection. However, the clinical manager explained that there are plans to collate data to use for this purpose.
- Client records were stored on the service electronic framework. All staff, including volunteers had access to client electronic records. This meant that volunteers in stage three treatment in the sober living community had access to client records, dependent on their volunteer role.
- The clinical manager completed a weekly audit of client records. The audit checked risk assessments, care plans and that staff had uploaded all relevant information to client records so that they were accurate and up to date.
- We saw that sickness and absence was recorded on the staffing rotas. However, we were unable to review if sickness and absence was monitored, as the information was unavailable during our inspection due to staff annual leave.
- **Leadership, morale and staff engagement**
- At the last inspection, we identified that the provider should encourage staff to work more as a multi-disciplinary team. We saw that the provider had created one large office for all staff, to encourage multi-disciplinary working. Staff told us that communication between the three different roles had improved since this office had been created.
- Staff feedback about morale was generally positive. Some staff told us they felt supported including continued professional development. However, other staff told us that they felt that although the therapy provided by the service was good, the overall management and governance aspect of the service could be improved. Some staff told us that they did not receive appropriate support from senior managers.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must implement a robust system to report, collate, analyse and share learning from incidents, including medicine incidents.
- The provider must ensure there is sufficient competent staffing at all times, that is in line with their rota's.
- The provider must make sure they keep accurate records to demonstrate that they have completed relevant checks for staff, including disclosure barring checks.
- The provider must make sure that medicine records are accurate and include all relevant information.
- The provider must make sure that they inform the Care Quality Commission of all required incidents.
- The provider must make sure that their statement of purpose contains accurate information.
- The provider must make sure that staff complete the training identified in the statement of purpose to ensure staff are competent within their role.

Action the provider SHOULD take to improve

- The provider should make sure there are effective call alarms in clients bedrooms so that clients can alert staff in the event of an emergency.
- The provider should ensure staff are trained and competent to administer emergency medicines.
- The provider should ensure they can demonstrate consideration of Wernicke Korsakoff during the assessment process.
- The provider should include questions about children in their assessment process, as recommended in the Drug misuse and dependence UK guidelines on clinical management and as identified in our report for the comprehensive inspection.
- The provider should provide regular performance management meetings to support staff development.
- The provider should act on client consent to liaise with professionals involved in their care.
- The provider should include more detail of exclusion criteria for clients.
- The provider should ensure that staff follow the service policy for self –administration of medicines.
- The provider should ensure that clients receive their medicines in a timely manner.
- The provider should make sure that staff with specialist knowledge are regularly available for support.
- The provider should make sure that clinical supervision is available for all staff.
- The provider should have a Duty of Candour policy in place.
- The provider should use key performance indicators and outcome measurements to develop and improve the service.
- The provider should ensure that records are available in the event of staff sickness or absence.
- The provider should ensure that all training is recorded to ensure records reflect accurate and up to date information.
- The provider should monitor sickness and absence rates.
- The provider should ensure that regular fire drills take place.

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 17 HSCA (RA) Regulations 2014 Good governance There was no system in place to collate, analyse, identify themes and share learning from incidents. The service did not demonstrate that all relevant checks had been completed for all staff and volunteers. The provider did not make sure that medicine records were accurate and included all relevant information The service had not informed CQC of all required incidents. The statement of purpose contained incorrect information concerning staff training and services and activities provided by the service. Regulation 17(1)(2)(a)(f)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff had not completed the training identified in the statement of purpose to ensure competence. There was not always sufficient competent staff cover at night. The service were not proactive in ensuring nurse cover as per their rotas. Regulation 18(1)(2)(a)