Aspinden Wood Centre

Quality Report

Aspinden Wood Centre
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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:

- The service did not have an effective model of care in place. The service stated that they were following a harm reduction model of care. However, there was no clear service model in place which included what the aims and objectives were of the service and how harm reduction was going to be achieved. There were no clear procedures in place which stated how the harm reduction approach would work in practice. Clients did not have contracts or agreements in place as to how to support them with harm minimisation.
- A stable leadership team was not in place. The registered manager had been away from the service for nearly six months and whilst an acting manager was in place the long term plans were not clear. The provider had not ensured that the manager was appropriately supported to maintain the safety and quality of services.
- The provider did not have established systems in place that provided assurance that the service was appropriately meeting the needs of the clients, following up concerns raised by other stakeholders and using audits to maintain standards within the service.
- The service did not have clear criteria for admission. The service was not ensuring that comprehensive

Summary of findings

assessments were undertaken before admission. This meant that clients were at risk of receiving care that was not safe or appropriate and did not meet their needs.

- There was not sufficient staff to ensure there was safe care and support for clients. We saw from client's records that some clients required support from two staff for their personal care needs. Staff shifts were unfilled; there were some night shifts where there had only been one member of staff working. The service did not have a system in place to be able to measure staffing levels to ensure they were safe.
- Robust safeguarding processes were not in place. The provider did not have records to show if staff had completed mandatory safeguarding training or not. The service did not have safeguarding information on display about how to make a safeguarding referral. Not all staff were able to tell us how to make a safeguarding referral. Safeguarding was not discussed as a regular agenda item at staff meetings or at the senior management incident sharing meeting. The incident form did not record if a safeguarding referral had been made.
- Risk assessments were not updated following changes in clients' needs and did not always contain all the relevant information regarding clients' risks. The service had not raised serious incidents following safeguarding alerts being made by the local hospitals regarding the potential neglect of clients .The provider held a meeting to discuss incidents; however the actions from these meetings were unclear. There was not a process in place to discuss feedback from incidents with staff or clients. There was not a system in place to ensure that learning from incidents occurred.
- There were significant fire safety concerns at the service. The service had not implemented an action plan put in place after the London Fire Brigade had been called to the service in March 2017. Significant areas for action to ensure fire safety remained outstanding, including the development of personal evacuation plans for clients with mobility issues or who may have been drinking. The service had not recorded that a fire drill had been carried out during the previous year. Fire alarm tests had not been carried out regularly during 2017
- At the previous inspection in September 2016 we found that the service did not have appropriate systems in place to manage medicines. There was no controlled drug register, risk assessments for client's self-administration or completed medication audits. At the current inspection we found that the service still did not have the appropriate systems to manage medicines. There was a controlled drug register in place. However, the service did not carry out risk assessments for clients self-administering medication or complete medication audits. The service did not have records of staff completing training in medicines management.
- At the previous inspection in September 2016 the service manager was not clear on the training needs of the staff and the service did not have an efficient system in place to record mandatory training compliance rates or specialist training rates. At the current inspection we found that the service still did not have a system in place to record mandatory training compliance rates or specialist training rates. This included safeguarding and mental capacity act training.
- At the previous inspection in September 2016 we found that staff did not always ensure clients had comprehensive care plans to address all identified needs. Clients with epilepsy did not have specific care plans or risk assessments in place for the safe management of their epilepsy. At the current inspection in June 2017 we found that staff did not always ensure that clients had comprehensive care plans to address all identified needs. Clients with epilepsy did not have specific care plans in place for the safe management of their epilepsy. Clients did not have care plans for their individual needs such as their personal care needs, moving and transferring needs or how to support them with ensuring their rooms were clean. Clients did not have a copy of their care plans which were in an accessible format.
- At the previous inspection in September 2016 we found that the service did not document agreed decisions made with clients around restricting their alcohol and finances. At the current inspection in June 2017 we found that there had been no improvement and the service was still not implementing a robust process for supporting clients to manage their alcohol misuse and documenting agreed decisions with clients around restricting their alcohol.

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- The provider was not ensuring that that the physical health care needs of clients were met. The provider did not ensure that risk assessments and care plans were updated to include information regarding physical health care when client's needs changed. The provider did not ensure that visits from health care professionals were clearly documented with the agreed actions and outcomes of these visits.
- The service was not able to ensure the safety of the clients in the communal areas of the building. The service did not have appropriate security at the front entrance and it was not possible to accurately know who was entering or leaving the building. Staff could also not observe communal areas. Staff were not observing clients using the 'wet room', which was the communal living area where clients were able to drink and smoke. We observed clients who had been drinking heavily in this room. This meant clients were at risk of injury and abuse.
- The service did not have a same sex accommodation policy in place and had not considered separation of bedroom and bathroom facilities according to gender.
- The provider did not respond appropriately when clients' needs changed and the service was no longer able to meet their needs.
- The service was not using the Mental Capacity Act appropriately. Staff did not document when there were concerns regarding capacity, there were no capacity assessments in place. There were no records that staff had completed mental capacity training.
- The service did not support staff by ensuring that they had regular supervision. The service did not supply staff with personal alarms so that they could call for support if needed.
- The service did not support clients to clean their rooms on a regular basis.

Following the inspection a notice of proposal was served proposing that no more clients were admitted to the service until the issues of concern were addressed. This was voluntarily accepted by the provider who has stopped admissions. In addition two warning notices were served relating to regulations 12 safe care and treatment and 17 good governance.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Substance misuse services		

Summary of findings

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Location name here

Services we looked at
Substance misuse services

Summary of this inspection

Background to Aspinden Wood Centre

Aspinden Wood Centre provided accommodation and 24 hour care and support for up to 26 men and women who have long term issues with alcohol, mental ill health or homelessness. The service operated a harm minimisation approach that allowed clients to drink agreed amounts of alcohol. The aim was for the service to promote stabilisation and a recovery focus.

At the time of the inspection there were 23 clients using the service. Three clients were in hospital and were not returning to Aspinden Wood. Nine clients had complex needs, this included clients requiring support with activities of daily living, personal care, mobility issues or disability and risk of falls. One client had their personal care provided by an external agency that went into Aspinden Wood daily to provide the care needed.

Clients were placed at Aspinden Wood by local authorities and clinical commissioning groups from all over the country.

Aspinden Wood is registered to carry out the regulated activity of accommodation for persons who require treatment for substance misuse.

At the time of the inspection the registered manager was on sabbatical leave and there was an acting manager.

Our inspection team

The team that inspected the service comprised a lead CQC inspector, two inspection managers, one other CQC inspector, a CQC pharmacist specialist and a specialist advisor who was a psychiatrist specialising in substance misuse.

Why we carried out this inspection

We undertook this focused inspection due to concerns that had been raised regarding the safety and welfare of clients at the service.

CQC had received concerns from the following individuals and organisations:

- In December 2016 a member of staff contacted CQC as a whistle blower raising concerns regarding staff culture, poor standards of care and medication errors. This followed a joint grievance that had been raised by staff members which they did not feel had been resolved. CQC made a safeguarding alert to the local authority regarding the concerns, which the local authority investigated. The provider investigated the concerns and developed an action plan from their findings.
- In March 2017 the London Fire Brigade contacted CQC to raise concerns after being called to Aspinden Wood following a flood in a client's room. They were concerned as the client appeared to be intoxicated and not able to move from his room or have an awareness of the flood. They also noted burn marks in the clients bedding. CQC raised a safeguarding alert to the local authority after receiving this information. Aspinden Wood developed an action plan to action all the concerns raised by the London Fire Brigade.
- In April 2017 CQC received three safeguarding notifications regarding three clients who had been admitted to local hospitals. The local hospitals had then raised safeguarding alerts due to concerns they had regarding the physical condition of the clients on admission. The local authority held a

Summary of this inspection

safeguarding meeting on 2 June 2017 where there was a fourth client discussed who also had a safeguarding alert raised after being admitted to hospital.

We also focused on the requirement notices following our last comprehensive inspection, which took place in September 2016, to see if the service had made any improvements since that inspection.

Following the September 2016 inspection, we told the provider that it must make the following actions to improve the service.

- The provider must ensure that all clients have comprehensive care plans that address all identified needs. For example, the provider must ensure that clients with epilepsy have a risk assessment and care plan in place for this specified need. The provider should ensure care plans are provided in an accessible format, for example for clients who are numerical and literacy illiterate.
- The provider must ensure that there were systems in place for the proper and safe management of medicines. The provider must have a controlled drugs book, review the organisations medication policy and adhere to it, carry out medication administration audits and medication stock checks. The provider must have a medication refrigerator for medicines requiring cold storage.
- The provider must ensure that there is an effective system in place to record and monitor staff compliance with mandatory and specialist training.

These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

Regulation 12 Safe Care and Treatment

Regulation 9 Person Centred Care

Regulation 17 Good Governance

Following the September 2016 inspection, we told the provider that it should make the following actions to improve the service.

- The provider should ensure that staff update client's risk assessments following incidents.
- The provider should ensure that clients are supported to clean their rooms on a regular basis.
- The provider should ensure that appropriate systems are in place for reporting safeguarding alerts. The provider should report safeguarding alerts internally and externally to the appropriate agencies including CQC and local authority.
- The provider should ensure that staff are aware of their responsibilities under the duty of candour and there is a policy in place around this.
- The provider should ensure that staff have completed Mental Capacity Act (MCA) training. The provider must ensure clients are aware of their rights to access an independent mental capacity advocate under the MCA and know how to support a client to access this.
- The provider must ensure that staff document agreed decisions made with clients around restricting alcohol and finances.
- The provider should ensure that staff are not using a dual care record system.

This was an unannounced inspection.

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location, we attended a safeguarding meeting held by the local authority and gathered feedback from other professionals at that meeting.

Summary of this inspection

During the inspection visit, the inspection team:

- visited the location, looked at the quality of the physical environment, and observed how staff were caring for clients
- spoke with three clients
- spoke with the acting registered manager and the clinical lead for Equinox Care
- spoke with six other staff members employed by the service provider, including recovery workers, recovery assistants, a cook and a domestic
- attended and observed one hand-over meetings
- looked at 7 care and treatment records, including medicines records, for clients
- observed medicines administration
- looked at seven staff files
- looked at policies, procedures and other documents relating to the running of the service
- met with the senior management team

What people who use the service say

We spoke to three clients who currently live at Aspinden Wood Centre. All three clients told us that they like living at Aspinden Wood and that the staff are kind to them, treating them with respect. All three clients told us that they felt safe at Aspinden Wood.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

- At the previous inspection in September 2016 we found that the service did not have appropriate systems in place to manage medicines. There was no controlled drug register, risk assessments for client's self-administration or completed medication audits. During this inspection we found that the service still did not have the appropriate systems to manage medicines. There was a controlled drug register in place. However, the service did not carry out risk assessments for clients self-administering medication or complete medication audits. The manager informed us that staff had completed training and competency assessments for the administration of medication however the service could not find any evidence to show that staff had completed this training.
- At the previous inspection in September 2016 the service manager was not clear on the training needs of the staff and the service did not have an efficient system in place to record mandatory training compliance rates or specialist training rates. During this inspection we found that the service did not have a system in place to record mandatory training compliance rates or specialist training rates.
- At the previous inspection in September 2016 we found that clients were not always supported to clean their rooms on a regular basis. During this inspection we found that clients were not supported to clean their rooms or there was no record of where this had been offered and refused. The service did not have care plans in place addressing how staff should support clients and what to do if they refused support. There was no record of when bed linen was changed or offered to be changed. The service had not ensured that all communal areas were clean.
- The service did not have appropriate security at the front entrance and it was not possible to accurately know who was entering or leaving the building. Staff could also not observe communal areas and requests for CCTV in communal areas had not been put into place.

Summary of this inspection

- Staff were not observing clients using the 'wet room', which was the communal living area where clients were able to drink and smoke. We observed clients who were intoxicated in this room. This meant clients were at risk of injury and abuse.
- There were significant fire safety concerns at the service. The service had not implemented an action plan put in place after the London Fire Brigade had been called to the service in March 2017. Significant areas for action to ensure fire safety remained outstanding, including the development of personal evacuation plans for clients with mobility issues or who may have been drinking. The service had not recorded whether fire drills had been carried out during the last year. Fire alarm tests had not been carried out regularly during 2017.
- Robust safeguarding processes were not in place. The provider did not have records to show if staff had completed mandatory safeguarding training or not. The service did not have safeguarding information on display about how to make a safeguarding referral. Not all staff were able to tell us how to make a safeguarding referral. Safeguarding was not discussed as a regular agenda item at staff meetings or at the senior management incident sharing meeting. The incident form did not record if a safeguarding referral had been made.
- The provider held regular meetings to review incidents across all its services. The minutes of these meetings did not clearly show what actions were being taken following the discussion of each incident. There was not a process in place to discuss feedback from incidents with staff or clients or to ensure that learning from incidents occurred. The service had not raised serious incidents when safeguarding alerts had been made to the local authority by hospitals due to concerns regarding possible neglect of client's personal care and physical health care needs.
- There were not sufficient staff to ensure there was safe care and support for clients. We saw from client's records that some clients required support from two staff for their personal care needs. Some staff shifts were unfilled, with only one or two staff members on duty.
- Clients did not have comprehensive risk assessments in place. Staff did not update risk assessments following deterioration in client's health. Risk assessments were not person centred or supportive of positive behaviour. Clients who required support with moving and transferring, including those who used a hoist, did not have moving and transferring risk assessment and management plans in place.

Summary of this inspection

- The service did not have a same sex accommodation policy in place. Clients' bedrooms were not separated according to gender and clients shared bathroom facilities.
- Staff had not completed monthly health and safety checks during 2017. The service had two first aid boxes. These had not been checked since December 2016 and some equipment was out of date.

Are services effective?

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

- At the previous inspection in September 2016 we found that staff did not always ensure clients had comprehensive care plans to address all identified needs. Clients with epilepsy did not have specific care plans or risk assessments in place for the safe management of their epilepsy. During this inspection in June 2017 we found that staff did not always ensure that clients had comprehensive care plans to address all identified needs. Clients with epilepsy did not have specific care plans in place for the safe management of their epilepsy.
- At the previous inspection in September 2016 we found that clients with literacy and numeracy difficulties did not have care plans in an accessible format. During this inspection in June 2017 we found that there had been no improvement and clients with literacy and numeracy difficulties still did not have care plans in an accessible format.
- At the previous inspection in September 2016 we found that the service used a dual recording system of paper and electronic records which were inefficient. Staff did not always update risk assessments when updating the electronic versions. During this inspection in June 2017 we found that that the service was using a single system of electronic records however the risk assessments were not always updated on this system following changes in client's needs.
- At the previous inspection in September 2016 we found that the service did not document agreed decisions made with clients around restricting their alcohol and finances. During this inspection in June 2017 we found that the service was not implementing a robust process for supporting clients to manage their substance misuse and documenting agreed decisions with clients around restricting their alcohol and finances.

Summary of this inspection

- The provider was not assessing clients thoroughly and ensuring they could meet their needs before they were admitted to the service.
- Staff were not supported to receive an induction, on going supervision and access to specialist training.
- The provider was not working effectively with other healthcare professionals and ensuring there was good communication to meet the on going complex physical and mental health care needs of the clients.
- The provider was not using the Mental Capacity Act appropriately to support the clients with specific decisions.

Are services caring?

We did not inspect this domain at this inspection.

Are services responsive?

We did not inspect this domain at this inspection.

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:

- At the previous inspection in September 2016 we found that the service did not have an efficient system in place to record mandatory training compliance rates or specialist training rates. During this inspection in June 2017 we found that the service did not have an efficient system in place to record mandatory training rates.
- The provider did not have governance processes in place that provided assurance that the service was appropriately meeting the needs of the clients, following up concerns raised by other stakeholders and using audits to maintain standards within the service.
- A stable leadership team was not in place. The registered manager had been away from the service for nearly six months and while an acting manager was in place the long term plans were not clear.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

At our last inspection in September 2016 we found that not all staff had received Mental Capacity Act training. At the current inspection we looked in eight staff files and found no records of staff completing Mental Capacity Act training. The service gave us a list of core courses and non-core courses for staff to attend. Mental Capacity Act training and Deprivation of Liberty Safeguards was not on these lists.

One client was identified as having possible cognitive functioning concerns which may have influenced their capacity. The client had had several incidents where they had been reported missing by the service and had been returned by the police. The service had not included any references to possible impaired capacity within their care plan or risk assessment. No conversations or communication with their social worker were recorded regarding their capacity and whether a capacity assessment and a Deprivation of Liberty order may be required.

We looked at seven client records, during the inspection. We did not see any references to capacity or fluctuating capacity in any of these records.

Staff assumed that all clients had capacity to make decisions regarding their personal care, medical care and cleaning of their bedrooms. Where clients refused support there were no discussions recorded regarding their capacity to consent or discussions with their social workers regarding capacity.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Summary of findings

Are substance misuse services safe?

Safe and clean environment

- Aspinden Wood Centre was a large building over two floors. There was a staff office which was downstairs next to the entrance. The entrance was unlocked and people could enter and leave the building without ringing a bell. Staff in the front office could see through the window or office door who was entering or leaving the building. However staff were not always in the office or observing the entrance. This lack of security at the front door potentially compromised the safety and security of people living and working in the home.
- The service had a living area called the 'wet lounge'. This was a communal area downstairs where clients could sit and watch television. Clients were able to smoke and drink in this room if they wanted to. Staff told us that they looked into the 'wet room' every 30 minutes but there was no rota for this or record of this being done.During the inspection we saw that four clients were intoxicated and were continuing to drink within this room. The staff could not observe clients within this room as there was no visibility from outside of the room and staff could not stay in the room due to the levels of cigarette smoke. This meant that clients were potentially at risk within this room. We were concerned that the service did not fully understand potential situations where clients could be at risk of exploitation or abuse. This meant that safe levels of observation were not occurring to protect clients who were at risk.
- There was no CCTV available in the service to help improve the observation of communal areas of the home. The acting manager informed us that a request for CCTV to be installed within the communal areas had been made but no date was available for this work to take place.

Substance misuse services

- The service accommodated female and male clients. The service did not have a same sex accommodation policy in place and client's bedrooms were not separated according to sex. Clients shared bathroom facilities.
- The service had a full time housekeeping staff member who worked in the week and a part time domestic who worked at weekends. The domestic workers cleaned the communal areas of the building. We found that the communal areas were generally clean. However in the toilet near the laundry there was a large white bin with a lid, inside it was very soiled with dried excrement on it. This was an infection control risk for clients and staff.
- At the previous inspection in September 2016 we found that clients were not always supported to clean their rooms regularly. During this inspection we found that staff did not always support clients to clean their rooms. Staff did not record if clients had been offered or refused. The domestic workers did not clean the client's bedrooms. The clients had individual responsibility to clean their rooms or to accept staff support with this. During the inspection we looked at seven client bedrooms. We saw that four of these bedrooms were dirty. The rooms smelt strongly and the sheets appeared dirty. Two clients had no sheets on their bed. One client had out of date milk and cream in their fridge and one client had a cup with mould in on their bedside table.The service did not have care plans in place addressing how staff should respond if clients did not clean their rooms or refused support to clean their bedrooms. There was no system in place to ensure that clients had changed their bed linen regularly. The service did not prevent, detect or control the spread of infection, including those that were health care related.
- The service had not ensured that the monthly health and safety checks were being completed. Staff had not completed the monthly check of the bedrooms in March 2017. Also the checks carried out by the cook of the kitchen area had been completed for January and February 2017 but the form had not been signed off by the manager. There were no records of health and safety checks being carried out in April or May 2017.
- The service had yellow bags for clinical waste, these were collected weekly.
- There was no clinic room on site. Physical examinations took place in client's bedrooms or in health care settings away from the premises.
- Hoists, to safely move and transfer clients, were available if required.
- Staff did not carry personal alarms. There were alert buttons or cords in each of the client's bedrooms and communal rooms. There was a panel located in the staff office which showed where the alarm was being activated.
- The London Fire Brigade was called to the service on 21 March 2017; this was as a result of a flood which caused damage to the fire alarm panel. Following their visit the fire brigade raised concerns with the CQC and there was a subsequent safeguarding referral made. In response, the service had developed a fire action plan, dated 28 March 2017. We examined documentation relating to this action plan and general fire safety measures in place at the location. We saw that the fire action plan had not been reviewed or updated since its implementation. Significant areas for action to ensure fire safety remained outstanding, for example, personal evacuation plans for clients with mobility issues or who may be intoxicated had not been developed.
- The service had a fire risk assessment completed in 2013, with no record of this being reviewed or updated since. The fire safety folder available on site showed that the required weekly fire alarm tests had not been carried out in 2017. A fire drill had not been carried out during the previous year.
- The service had two first aid boxes, one was in the kitchen and one was in the office. Staff had not signed to say that the first aid boxes had been checked since December 2016. The first aid box in the office had a plastic bag inside containing out of date equipment, these were removed at the time of inspection.

Safe staffing

- There were not sufficient staff to provide safe care and support to clients. At the time of inspection the service had 23 clients, nine of which were identified as having complex needs with high support needs. The service had four substance misuse recovery workers and four recovery assistants in post. The service also had a manager and deputy manager.

Substance misuse services

- At the time of inspection, the service had recognised that the clients needed more support. There were vacancies for four substance misuse workers, two personal recovery assistants and a nurse. The service had undergone a recent recruitment drive for a nurse but had been unsuccessful. Since the inspection the service informed us that they have taken on staff redeployed from another service to fill some of these vacancies immediately.
- The service used bank and agency staff. At the time of inspection there were two long term regular agency members of staff and four bank relief workers.
- There were not enough staff to ensure that one to one sessions with clients always took place.
- At the previous inspection in September 2016 we found that there was not an effective system in place to record and monitor staff compliance with mandatory and specialist training. We found at the current inspection that this had not improved and there was still not an effective system in place to record and monitor staff compliance with training.
- The provider had identified 20 core courses as mandatory for staff to complete. In addition there were 23 non-core courses. We asked to see the services training matrix, however the manager informed us that we had to look in staff folders for evidence of training certificates. We looked at eight staff files. Two staff files had some training certificates for 2016. The other six files did not have any certificates of training including a new member of staff who had started this year. There were no certificates for the safe moving and transferring of clients with mobility issues. There were no certificates for safeguarding or Mental Capacity Act training. The service did not have an oversight of what training had been completed by staff.
- The registered manager told us that staff who administered medicines had received training although we did not see any evidence of this as the training certificate had not yet arrived from the external trainer. None of the staff who administered medicines had completed any competency assessment in medicines administration. This meant that the manager may not have a good clinical oversight of medicines management which could potentially undermine the safe management of clients' medicines.

Assessing and managing risk to clients and staff

- Staff had not completed comprehensive risk assessments for clients. One client had not had their risk assessment updated following deterioration in their physical health which had led to a hospital admission. The hospital had raised a serious concern following this admission regarding the client's tissue viability; staff had not reflected this in their risk assessment. Staff had not updated a previous risk assessment where it had been stated that a hoist needed to be used, and this had then not been recorded in the subsequent four risk assessments. The risk assessment did not state clearly if the client did need a hoist or not. Another client had a risk of seizures noted in their risk assessment; it stated that staff should observe for signs of seizures and staff should monitor them after a seizure. However there was no further detail in either the risk assessment or the care plan about what the signs of a seizure would be or how to monitor the client after a seizure. The service did not ensure that care and treatment was being provided in a safe way and failed to assess the risks to the health and safety of clients or updating risk assessments after a change to risk.
- Clients' risk assessments were not person centred and did not support positive behaviour. For example, one client was identified as having behaviour that challenged, which could lead to verbal or physical aggression to staff. However, their risk assessment and risk management plan did not include information on possible triggers to these behaviours, based on what had happened just before them, information on de-escalation or diversion strategies that may be beneficial, or client input about the strategies they found most helpful in these situations. For the same client, their risk assessment included several incidents of absence from the home, quite often to their previous address. There was some concern that the client may become disorientated while in the community. The clients risk management plan identified that the client should be given a card with their address and that they should be reported to the police as missing after three hours. Neither the risk assessment or risk management plan explored why the client may be returning to their former address or other strategies to minimise or mitigate risk, for example an agreement for support staff to accompany them on community visits they wished to make.

- Some clients were wheelchair users or experienced other mobility issues and required support with moving and transferring, in some cases using a hoist. We examined the care records of two clients, who were identified from their available care records as requiring support with moving and transferring. We saw that a moving and transferring risk assessment and management plan had not been completed. This put clients and staff at risk as a result of unsafe moving and transferring practice.
- During the inspection staff identified 18 clients as smokers. Clients who were smokers were permitted by the service to smoke in their rooms. Some of these clients also had mobility problems. We looked at the risk assessments of three clients who were all identified as smokers with mobility issues, who smoked in their bedrooms. We saw that there were cigarette burn marks on the bedding of three clients. The risk assessments did not have information around risks associated with their smoking. There were no personal emergency evacuation plans in place in the event of their being a fire at the service. The London Fire Brigade were called to the service in March 2017 following which the provider put an action plan in place to mitigate identified risks. Part of the action plan was to ensure that personal emergency evacuation plans were developed for clients with mobility issues. The service had failed to implement this action. The service was not ensuring that care and treatment was being provided in a safe way by failing to assess the risks associated with clients smoking in their bedrooms.
- Not all staff were able to tell us the safe guarding procedure. The provider did not have records to show if staff had completed mandatory safeguarding training or not. The service did not have safeguarding information on display for service users or staff. The services safeguarding policy and procedure did not give information as to how to contact the local safe guarding team. The lack of visibly displayed safeguarding information for staff and clients to see and the lack of information regarding how to make a safeguarding referral was bought to the attention of the provider during the inspection, the provider was asked to ensure that this was rectified immediately by the end of that day. The provider sent us evidence to show that this had been put in place that day.
- At the previous inspection in September 2016 we found that the service did not have appropriate systems in place to manage medicines. At that inspection there was not a controlled drug register in place. During this inspection the service had a controlled drug register and controlled drugs were kept in an appropriate cupboard. Registers were in place to record the handling of controlled drugs and we saw evidence of regular balance checks.
- At the previous inspection in September 2016 we found that the service did not have a medicines refrigerator. During this inspection the service had a refrigerator for medicines that required cold storage.
- At the previous inspection in September 2016 we found that service did not carry out risk assessments for clients self-administering medication. This included prescribed creams and ointments. During this inspection we found that the service still did not carry out any self - administration risk assessments for clients who were self-administering medication to ensure that it was being done safely.We saw a number of residents that administered some of their own medicines such as inhalers, nebulisers and topical creams.
- Clients had a locked medicine box in their bedroom. Staff had keys to unlock the medicine boxes at the times clients needed to take their medication.
- During the inspection the CQC pharmacist inspector reviewed the medicines management audit. We were told that at the end of every medication administration record (MAR) cycle, staff would reconcile the amount of medicines received with what was ordered. The service had not carried out an audit since February 2017. The audit tools the service used were to monitor the receiving, returning and destroying of medication. The service did not have an audit in place which would effectively identify medicine related errors. The medicines policy recommended weekly medication audits not only looking at medicines received or returned but administration records on MAR charts, as well as client's medication cabinets. The service had failed to carry out these audits.

Track record on safety

- The service had not raised any incidents as serious incidents during 2017. However we had been advised prior to the inspection that three clients had been

admitted to hospital during 2017 with pressure sores and leg ulcers. Local hospitals had made safeguarding alerts to the local authority concerning client's potential neglect as their personal and physical health needs did not appear to have been met by the service. The service had not raised these as serious incidents.

Reporting incidents and learning from when things go wrong

- The service recorded 69 incidents between the beginning of December 2016 and the end of May 2017. The majority of these incidents were regarding physical health issues or slips, trips and falls. The service graded these incidents as either low, medium or high. The service did not have clear guidelines in place regarding the grading of incidents. Senior managers were made aware of this at the time of our inspection.
- The service did not report all incidents as needed to the local authority as safeguarding referrals or to the CQC as notifications. The service had four recent safeguarding referrals made by local hospitals. The service had not made safeguarding referrals themselves when clients were self-neglecting and refusing support. When looking through client records we found an incident where a client had fallen and broken their leg. The client had later alleged that they were pushed. The service did not make a safeguarding referral to the local authority following this allegation or notify CQC of the incident.
- The service kept a spreadsheet of all incidents that had been reported, however the spreadsheet did not show if a safeguarding alert has been raised or not.
- The provider met fortnightly to discuss incidents, accidents and near misses. Incidents were discussed across the whole service, which included a discussion on actions that were taken and how they would follow up on the incident. We looked at the minutes for this meeting for the week ending 1 June 2017. The minutes showed that twelve incidents from Aspinden Wood were discussed. They gave an overview of the incidents and an update since the incident; however, there were no clear actions of how the incident was being responded to or how lessons could be learnt from incidents.
- Staff in the service did not receive feedback regarding incidents and learning from incidents was not discussed within team minutes.

Are substance misuse 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 did not have a comprehensive assessment undertaken by the service before admission. During the current inspection, we reviewed the available care and treatment records for a client who had recently been admitted to the service. The information contained within the assessment was brief and did not include information from the comprehensive needs assessment submitted by commissioners as part of the referral. The assessment did not outline how the service would meet the client's personal care needs or concerns relating to possible mental health issues. There was no clear decision-making process documented prior to admission or subsequently, on how the service had understood their complex needs and had assured itself these could be met. This meant that this client was at risk of receiving care that was not safe or appropriate and did not meet their needs. We were told by the shift leader that two other clients had been admitted to the service in January and February 2017 respectively. Both these clients had been admitted to hospital just before the inspection took place, and were not expected to return. We were advised by the local authority safeguarding team, prior to the inspection that safeguarding alerts had been raised regarding both clients potential neglect as their personal and physical health needs did not appear to have been met by the service. While the safeguarding alerts were subject to ongoing investigation, the short timescale between admission to the service and subsequent admission to hospital for treatment of complex personal care and physical health care needs indicated that a robust assessment and consideration of how the service would meet these client's needs had not been carried out prior to their admission. Three staff members informed us that they thought that clients who had recently been admitted were not appropriate for the service.
- The service did not have systems in place to ensure that clients intimate personal care needs and moving and transferring needs were met. We reviewed the available care and treatment records of six clients who required

support with personal care and support. We saw that the service had not developed systems to ensure that clients who required support with intimate personal care had these needs met safely and in a way that reflected their personal preferences. There were no care plans for personal care, to detail which clients required support with which personal care tasks at which times. There was no system to monitor that support with personal care had been provided at these times, or if the client had declined this support. Client care records and observation of staff handover meetings demonstrated that staff did not routinely share or record information relating to the support of clients with their personal care needs.

- Some clients accommodated at the service were identified as having mobility issues, including the need to use wheelchairs and hoists when transferring. We looked at the care records for two clients who were identified as having mobility issues. There was no detailed personal care plan in place for them. Staff told us that they refused to shower or accept support with personal care. We saw that there was a document for each client entitled 'service user's preferences to manage personal care and rooms'. We were told that staff referred to this chart for each client when providing their personal care. However, this chart had the same information for each client, regardless of their personal care needs. For example, for each individual client the chart stated 'encourage and support to have a shower'. Charts had not been personalized to reflect individual client needs and did not include information on how clients with mobility issues who were not able to weight bear should be supported with showering. This meant that clients were at risk of receiving support with personal care that was not safe or appropriate and did not meet their needs.
- The service was not meeting the physical and mental health needs of clients effectively. There was no system in place to ensure that effective communication took place after district nurse or community mental health team visits. We spoke with support staff on shift during the inspection and were given conflicting information on which clients were currently receiving district nurse support. There was little communication in a book that was used for community nurses to record their visits. After a delay of some hours, staff confirmed that at the time of our inspection no clients were receiving district nurse support. For one client with recent tissue viability concerns, staff were unclear how this was now being monitored. It was suggested that the visiting GP would be monitoring this, however this was not reflected in communication note books or the clients care records. Some clients received support from community psychiatric nurses and were administered regular depot medicines by injection to treat their mental health conditions. We examined the care records for one client and they did not include information that detailed visits by community psychiatric nurses or the dates when depot medicines for mental health conditions had been administered or were due again. We were unable to locate this information in the nurse's communication book.
- The GP visited once a week, the service had recently introduced a new system for recording client outcomes and follow up actions when seen by the GP on site. However, we saw that robust systems to ensure that this information was systematically reviewed and necessary actions taken were not in place, which put the health and safety of clients at risk. For example one client had been reviewed by the GP and had been advised to commence prescribed calorie fortified drinks. There was no recorded evidence to show that this had been actioned.

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Best practice in treatment and care

- The service did not have a clearly stated and implemented model of care or clear criteria for admission.The service stated that they were following a harm reduction model of care. However there was no clear service model in place which included what the aims and objectives were of the service and how harm reduction was going to be achieved. There was not a clear criteria for admission or clear procedures in place which stated how the harm reduction approach would work in practice.
- The service did not have processes in place to effectively manage the alcohol consumption of the clients using the service. During the inspection we observed clients who were drinking heavily and were intoxicated. We asked staff how the service supported people to stabilize their drinking to achieve harm minimisation. Staff told us that they tried to ration drink to four spaced

out cans a day but some clients were not part of this approach and drank when they wanted to. Staff told us that some clients, independently left the service and went to the shops to buy alcohol for other clients. In the seven care plans that we looked at we did not see any agreements or contracts in place as to how clients would be supported to manage their alcohol intake. We asked a staff member if staff were required to record whether clients have been drinking in the daily records, the staff member replied that they did not always record it. We asked staff how they monitor alcohol consumption. Staff informed us that some clients kept alcohol in the staff office and were given this alcohol at agreed times during the day. However, staff could not be certain that this was the only alcohol that these clients had access to as they could purchase more themselves and keep it in their rooms, or obtain additional alcohol from other clients. The absence of clear processes to reduce the harm to clients from their alcohol consumption, including incomplete records, meant that the service was unable to monitor what clients purchased or what clients drunk.

- Client's nutrition and hydration needs were not always met by the service. The full time cook had a good understanding of the client's nutritional requirements and their intake; however this was not always recorded by staff or passed on in handovers. Clients who were unwell or in their bedrooms did not have food taken to their rooms. We did not see evidence of how bedbound clients nutritional and hydration needs would be monitored.

Skilled staff to deliver care

- Staff were not receiving regular supervision. At this inspection we looked at eight staff supervision records. We found that seven out of the eight staff had not received formal supervision during 2017.
- Staff did not receive the necessary specialist training for their role. We looked at eight staff files where training certificates were kept. We did not see evidence that staff had undergone any specialist training to support their role in the last year. An example of this was that there were no records of staff receiving training in moving and handling for clients with mobility issues, including the use of hoists.
- Staff received an induction which included an initial week not at the service, where staff completed the basic induction training. New staff then shadowed established staff in Aspinden Wood for a period of time before they were placed on the rota. We looked at the staff file for one member of staff who started in January and there were no records of induction or training in their file.
- Staff told us that there were monthly team meetings; we saw that these were more frequent if needed. There were plans in place to develop reflective practice meetings for staff.

Multidisciplinary and inter-agency team work

- The clinical lead for Equinox Care, the parent organisation, informed us that they are currently discussing a new contract with the GP; the new contract would ensure that the GP was involved in decisions regarding future admissions as well as giving greater support to existing clients at Aspinden wood.

Good practice in applying the MCA

- At the last inspection in September 2016 we found that not all staff had received Mental Capacity Act training. At the current inspection we looked at eight staff files where training certificates were kept. We found no records of any of these staff completing Mental Capacity Act training; one staff member had completed Deprivation of Liberty Safeguards training in May 2016.
- During the inspection one client was identified as having possible cognitive functioning concerns which may have been influencing their capacity. They had had several incidents where they had been reported missing by the service and had been returned by the police. There were no references to possible impaired capacity within his care plan or risk assessment. No conversations or communication with his social worker was recorded regarding his capacity and whether a capacity assessment and a Deprivation of Liberty Safeguard may be required.
- During the inspection we looked at seven client records. We did not see any references to capacity or fluctuating capacity in these records.

Are substance misuse services caring?

We did not inspect this domain at this inspection.

Substance misuse services

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

We did not inspect this domain at this inspection.

Are substance misuse services well-led?

Good governance

- The provider was systemically failing as there were no processes in place to effectively manage the alcohol consumption of the clients using the service. There were no governance systems in place to ensure that agreed processes were being followed. The absence of clear processes to reduce the harm to clients from their alcohol consumption, including incomplete records, meant that the service was unable to monitor what clients purchased or what client's drank.
- During the inspection we asked to look at internal audits that had taken place to monitor the quality of care the service was providing and provide assurance to your senior team. An example of this might be an audit of the completion of essential care records. There were no records of any audits since March 2016.
- Systems were not in place to ensure staff received the supervision and training they needed to work safely and effectively in the service.
- The provider had been aware of the concerns that had been raised about care and support at Aspinden Wood but had not taken necessary measures to ensure that identified actions had been implemented. The provider had been aware that concerns had been raised in December 2016 through a whistle blower which had resulted in the local authority taking safeguarding action. The provider was aware that the London fire brigade had been called to the service in March 2017 and had raised concerns regarding the safety of the building and clients. The provider had been aware that during April and May four safeguarding alerts had been made by local hospitals due to clients from Aspinden Wood being admitted to hospital, two of whom had pressure sores, one a leg ulcer and one with malnutrition.The provider had failed to make sure that systems and processes were established and operated effectively to ensure the quality and safety of the service.

Leadership, morale and staff engagement

- The Registered Manager of the service was on sabbatical leave at the time of inspection. CQC was notified of this in December 2016. The sabbatical leave was originally for three months but had been extended and the acting manager did not know if the registered manager would return. The provider had not applied for the acting manager to become registered manager.
- Staff we spoke to were very committed to the clients and to the service. Staff informed us that the current team worked well together, however there were currently not enough staff.
- Staff we spoke to acknowledged that there had previously been some bullying at Aspinden Wood. They informed us that the staff that had been involved in this were no longer working there. Staff felt that the new local managers for the service were open and approachable.
- Staff we spoke to were aware of the whistle blowing policy and would feel able to raise concerns with the manager.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve
Action the provider MUST take to meet the regulations:

- The provider must have a clear service model in place that clearly states how they will support the clients to manage their substance misuse issues.
- The provider must ensure that governance processes are in place to provide assurance that all aspects of the service are operating well.
- The provider must ensure that they have clear admission criteria in place. They must ensure that comprehensive assessments are carried out prior to admission to ensure that they can meet the needs of the clients; they must outline how they will meet the client's needs within the assessment.
- The provider must ensure that there are sufficient staff on duty to meet client's needs. They must ensure that there is a system in place to be able to accurately measure the staffing requirements needed to safely meet the needs of the clients.
- The provider must ensure that all clients have comprehensive care plans and risk assessments that are updated when their needs change and address their holistic needs, including assistance with personal care and moving and transferring.
- The provider must ensure that that the physical health care needs of clients are met. The provider must ensure that risk assessments and care plans are updated to include information regarding physical health care when client's needs change. The provider must ensure that visits from health care professionals are clearly documented with the agreed actions and outcomes of these visits.
- The provider must respond appropriately when clients' needs change and the service may no longer be able to meet their needs.
- The provider must ensure that there are systems in place for the proper and safe administration and management of medicines. Staff who administers medicines must be competent to do so. The provider must ensure that where clients administer their own medicines the associated risks are assessed and appropriately mitigated or managed.
- The provider must ensure that serious incidents and recorded and reported. The provider must ensure that there are clear actions in pace following incidents. The provider must ensure that learning from incidents occurs and outcomes are discussed both with staff and clients.
- The provider must ensure that the manager is appropriately supported to maintain the safety and quality of services.
- The provider must ensure there is an effective system in place to record and monitor staff compliance with mandatory and specialist training. The provider must ensure that staff receive regular supervision.
- The provider must ensure that clients are supported to clean their rooms on a regular basis.
- The service must ensure that clients are safe when they are using the 'wet room'.
- The provider must ensure that fire regulations are adhered to. They must ensure that the fire action plan is implemented and that regular fire checks are carried out.
- The provider must ensure that robust safeguarding processes are in place. The provider must ensure that all staff have completed safeguarding training and understand their responsibilities to keep clients safe.
- The provider must ensure that feedback from safeguarding concerns are reviewed, lessons learnt and where appropriate changes in policy and practise made.
- The provider must ensure that the Mental Capacity Act is used appropriately. They must ensure that all staff have completed Mental Capacity Act training.

Outstanding practice and areas for improvement

Action the provider SHOULD take to improve

- The service should ensure that appropriate security is in place to ensure that they know who is in the building. The provider should ensure that communal areas can be observed appropriately.
- The provider should ensure that there is a policy in place regarding same sex accommodation. The provider should ensure that consideration is given to where bedrooms and bathrooms used by female residents are located.
- The provider should consider if safety of staff and clients would be enhanced if staff had access to personal alarms.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014 Person centred care** The care and treatment of service users must be appropriate, meet their needs and reflect their preferences. • Care plans were not comprehensive and did not reflect clients' needs or their preferences for support. **This was a breach of regulation 9(1)(a)(b)(c)**

Regulated activity	Regulation
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment must be provided in a way that is safe for service users. • The provider did not have clear admission criteria in place. • The provider had not ensured that clients who were administering their own medicines were safe to do so. • The provider had not ensured that there were clear actions in place following the review of incidents. It had not ensured that learning took place following incidents and that outcomes of incidents were discussed with both staff and clients. • The provider had not ensured that fire regulations were followed and appropriate fire checks and required actions were completed.

This section is primarily information for the provider

Requirement notices

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

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 Person centred care** Deployment of sufficient numbers of competent, skilled staff. • The provider had not ensured that there was sufficient staff on duty to safely meet the needs of the clients. • The provider had not ensured that staff had completed mandatory training, including medicines administration. Mental Capacity Act and safeguarding and were able to support clients safely and appropriately. • The provider had not ensured that all staff had received appropriate specialist training required for their role. • Staff did not receive regular supervision. **This was a breach of Regulation 18(1)(2)(a)**

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment** Care and treatment must be provided in a safe way for service users. • The provider did not appropriately assess potential risks for each client relating to their care and treatment, or ensure appropriate measures to manage or mitigate these risks were in place. • Risk assessments were not updated following incidents or changes in client needs. • Moving and transferring risk assessment and management plans were not in place for clients who required support from staff with moving and transferring. • Personal emergency evacuation plans were not in place for clients with mobility issues. • Clients referred to the service did not have their needs appropriately assessed to ensure the service could safely meet their needs. • Clients did not receive appropriate support to ensure that their bedrooms were safe and clean. • Appropriate levels of staff supervision were not maintained in the “wet room” to ensure that clients were kept safe. **This was a breach of regulation 12(1)**

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Accommodation for persons who require treatment for substance misuse

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 Good Governance, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems or processes must be established and operated effectively to ensure compliance with the requirements of the Act.

- The service was not operating a clearly defined model of substance misuse treatment.
- The service did not have systems in place to monitor clients alcohol intake and take appropriate steps to minimise harm from alcohol consumption.
- Audits to monitor the safety and effectiveness of the service were not carried out.
- Appropriate systems to manage medicines reconciliation, the receipt and return of medicines and monitoring of medicines errors were not in place.
- Effective systems to identify and respond to concerns regarding the safety and quality of services were not in place.
- The manager of the service was not appropriately supported to carry out their role.

This was a breach of Regulation 17(1) & (3).