Linwood House

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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.

Summary of findings

Overall summary

we rated Linwood House as good because:

- All client records contained a risk assessment which staff reviewed daily.
- There were effective procedures in place for the administration of medication.
- Clients were admitted through a robust admission assessment process.
- Staff demonstrated a thorough knowledge of clients' individual needs.
- The service could respond promptly to requests to access support and had a flexible approach treatment options available.
- The service had effective governance processes in place incorporating client feedback in to key performance indicator reports.

However:

- Actions identified in the ligature policy had not been completed.
- A sharps bin in the clinic room had not been returned in the required timeframe.
- Best interest decisions to admit clients who temporarily lacked capacity or the rational and risk mitigation to admit clients who did not give consent for the service to contact their GP were not recorded.

Summary of findings

Contents

Good

Linwood House

Services we looked at

Substance misuse detoxification and rehabilitation

Summary of this inspection

Background to Linwood House

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

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

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

- the accommodation for persons who require treatment for substance misuse
- diagnostic and screening procedures
- treatment of disease, disorder or injury.

The service received referrals through the local drug and alcohol services, referral agencies or directly from people funding their own treatment. Framework agreements had also been agreed with both Manchester and Tameside clinical commissioning groups. However, at the time of the inspection no referrals had been received through these contracts.

The service had previously been inspected in September 2017. At the time of the previous inspection the Care Quality Commission did not rate standalone substance misuse services. This is the first inspection which will rate the service.

Start here...

Our inspection team

The team that inspected the service comprised two CQC inspectors, an inspection assistant, a nurse specialist and a social worker specialising in substance misuse.Start here...

Why we carried out this inspection

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

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

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

Summary of this inspection

Before the inspection visit, we reviewed information that we held about the location and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited both the detoxification unit and the rehabilitation unit, looked at the quality of the environment and observed how staff were caring for clients;
- spoke with seven clients who were using the service;
- spoke with the registered manager and the head of operations;
- spoke with nine other staff members; including nurses, therapists and support workers;
- spoke with the advanced nurse practitioner;
- attended and observed two admissions and one group therapy session;
- collected feedback from one client using comment cards;
- Looked at nine care and treatment records of clients;
- carried out a check of the medication management on the two units; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

Start here...

What people who use the service say

We spoke with seven clients who all said staff treated them with dignity and respect. Clients said the staff were always available and approachable some said staff would 'go extra mile' to provide the support they needed. One client told us he chose to access the service despite it been some distance from home as he felt the staff cared about the welfare of the clients.

Client feedback received between July and September 2018 indicated 98% of clients rated their experience of the service as good or excellent and 91% would recommend the service to others.

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?

Good

we rated safe as good because:

- Clinic rooms were fully equipped with appropriate equipment to enable staff to perform their role.
- Staffing levels in the service could be increased based on the level of occupancy and the needs of the clients.
- All clients had a risk assessment on admission and these were reviewed daily.
- Medication administration records were completed appropriately and did not contain any gaps or missed doses.

However:

- Actions identified in the ligature policy had not been completed.
- Admission records did not clearly record the rational and risk mitigation when a client was admitted without consenting to the service contacting their GP.

Are services effective?

Good

we rated effective as good because:

- Clients were admitted through a three-staged admission assessment.
- The service followed best practice guidelines.
- Clients could access a range of individual and group therapy sessions as recommended by National Institute for Health and Care Excellence.
- The service held monthly team meetings to share learning within the team.

However:

- Best interest decisions made to admit clients who temporarily lacked the capacity to consent to treatment had not been recorded.

Are services caring?

Good

we rated caring as good because:

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

Summary of this inspection

- Clients in the rehabilitation unit were actively involved in developing and writing their own recovery plans.

Are services responsive?

Good

we rated responsive as good because:

- The service could respond promptly to requests for support offering clients an admission date and time to suit their needs.
- The service offered flexible treatment options and clients could choose to stay for detoxification, rehabilitation or both.
- Transfers from the detoxification unit to the rehabilitation unit were planned and clients could spend time on the unit before transfer.
- Formal complaints were investigated, and lessons learned were identified.
- There were a range of facilities available for clients including therapy rooms for one to one or group therapy and craft rooms.

Are services well-led?

Good

we rated well-led as good because:

- The provider had a clear governance process in place including a programme of regular audits.
- The provider collected feedback from all clients and incorporated these in to their monthly key performance indicators.
- Staff felt valued and supported by the provider and all staff received regular supervision.
- Policies and procedures were available to all staff via an online portal, this ensured staff could always access current and up to date procedures.

However:

- Some staff felt isolated from the provider and told us they felt they were employed by the location and not the provider.

Recent infection control audits had not identified a sharp box had not been returned and the clinic room bin did not have a lid.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

The service had 96% compliance with Mental Capacity Act training. The staff we spoke with could demonstrate an awareness of the principles of the Act and the need to assess a clients' capacity before obtaining their consent.

When a client was intoxicated on admission to the detoxification unit and did not have the capacity to consent to their treatment the decision would be made to complete the admission and obtain their consent later in the day or the next day depending on the time of admission. However, we did not find any recording of best interest decisions where a decision had been made to prescribe medication in the patients' best interest when this was required to support a clients' withdrawal.

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

Good

Substance misuse/detoxification

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Are substance misuse/detoxification services safe?

Good

Safe and clean environment

Staff completed regular environmental risk assessments and audits including a fire risk assessment and an environmental audit/workplace inspection. The layout of the building meant that there were blind spots on corridors and that staff could not see where all clients were within the building. Staff managed this through individual risk assessment and management plans.

We observed potential ligature points throughout the service. The service had completed an initial ligature audit in October 2016, and had a ligature policy dated August 2017. However, actions outlined in the ligature policy regard completing a regular ligature risk assessment identifying the severity of identified risks had not been completed. The manager accepted this was an oversight and provided assurance the risk assessment would be completed as a priority. The service had a programme of refurbishment. Where possible ligature risks identified in the ligature audit completed in 2016 were identified to be removed as part of the refurbishment programme. Ligature cutters were available. Although, staff we asked were unaware where they were kept.

Each room including communal areas had a call alarm and there were two panels on each unit to identify where the call had been made. Staff did not have access to a call alarm to summon help in an emergency. However, there was a system in place where staff could use a short-range walky-talky if necessary. This was generally used by the night staff on the rehabilitation unit to maintain contact with staff on the detoxification unit. There were plans in place as part of the refurbishment plan to install a staff call system.

The layout of the building enabled separate male and female corridors on the detoxification unit however, this was not replicated in the rehabilitation unit, and staff managed this through risk based bed management process. Bedrooms were all ensuite, providing clients with a toilet and washbasin. Bathroom facilities were communal and all had locking doors. Although the service did not provide separate female only lounge facilities clients could access their bedrooms at any time outside of therapy sessions and were able to access the therapy room as an additional lounge if required. At the time of the inspection a draft protocol for the management of the mixed sex environment was due to be ratified.

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

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

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

The provider had completed a waste management audit in September 2018, which included infection control. Effective procedures were in place for the storage and collection of

clinical waste. However, we found the bin in the clinic room was a regular open top waste paper bin containing a yellow clinical waste bag and not a bin with a lid as recommended in the Department of Health and Social Care technical memorandum 07-01: safe management of healthcare waste.

Sharps bins were available for the safe storage of used of syringes and there were procedures in place for the collection and disposal of these. However, one sharps bin in the rehabilitation medication room had been assembled on the 16 March 2018 and not been sealed or returned following the three-month period recommended in the Department of Health and Social Care technical memorandum 07-01: safe management of healthcare waste. The staff on duty sealed the sharps bin for collection immediately. We raised these issues with the manager and received assurance they would be addressed as a priority.

The clinic room on the detoxification unit was fully equipped with a couch, a phlebotomy chair weighing scales, a height measure and blood pressure monitors. The service utilised portable battery powered blood pressure monitors. Stock levels were well maintained. However, we found some syringes which had expired the previous month, these were disposed of immediately.

Appropriate personal protective equipment was available for staff including aprons and gloves.

Safe staffing

Linwood house employed 29.2 whole time equivalent staff made up of:

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

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

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

Linwood House operated a rota comprising a nurse and support worker on the detoxification unit and a support worker on the rehabilitation unit. Therapy staff were available on both units between 9am and 5pm. The provider calculated staffing levels using a task based approach and recognised there were key times when staff may be busy if the unit was full. The manager would increase staffing levels if necessary depending on occupancy levels and individual needs of the clients.

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

Mandatory training comprised of eighteen courses including the provider's induction programme, safeguarding adults, safeguarding children, conflict resolution and the Mental Capacity Act. The average mandatory training compliance rate for staff was 81%. However, this included the moving and handling of people which had recently been added as mandatory training. All staff had been booked on the course and were due to attend over the following month; discounting the newly added course the average compliance was 83%. However, three courses fell below the care quality commission benchmark of 75% these were conflict resolution (74%), Health and Safety (74%) and safeguarding adults level 1 (24%). The manager informed us there had been some difficulty in accessing the safeguarding training which had recently been resolved and that the provider was in the process of commissioning a new conflict resolution training programme for all staff.

There were lone working protocols in place to ensure the safety of staff whilst lone working. The service provided call buttons in rooms and staff used two-way radios as a means of raising and maintaining contact during lone working.

Good

Substance misuse/detoxification

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

Assessing and managing risk to patients and staff

We looked at nine clients' records. These included pre-admission and admission information taken by the service and information taken by the medical practitioner during the clinical admission. The files of clients who were admitted through referral from the local drug and alcohol service for detoxification contained a comprehensive risk assessment and referral information. For self-funding clients staff relied on them to be open and honest about their history and potential risks during assessment. This process relied on clients understanding the impact of non-disclosure of medical risk issues including double prescribing, allergies and interactions, history of complicated withdrawals, poly drug use or prescriptions of benzodiazepines.

The initial assessment form allowed the client to consent to sharing information with their GP. Where clients did not consent, the medical practitioner would make a clinical judgement based on their professional judgement and the information provided. They could decide to override the clients request and contact their GP in the clients' best interest if it was felt there was a serious medical risk or cancel the admission and refuse to prescribe treatment in line with guidance from the general medical council. However, where the decision was made to admit a client without consent to contact their GP, admission records did not demonstrate the medical practitioner's rationale and risk mitigation in continuing treatment without contacting the clients GP as recommended in the general medical council's good practice in prescribing and managing medicines and devices 2013.

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

The service did not use a recognised risk-screening tool and had instead incorporated risk-screening questions within their assessment documentation. In all the records we reviewed, staff had used the information gained through the admission to identify potential risks and complete a risk assessment. Risk management plans were based on set pro forma interventions to manage these risks. For example, there were management plans for epilepsy, allergies and diabetes, which contained a set of processes that staff, should follow if the risk was present. Risk assessments, especially for patients progressing to or accessing rehabilitation could be more personalised and include interventions specific to the individual needs of the client. We saw evidence that risk assessments were reviewed daily, where new risks had been identified the management plans were added to the clients file. However, we saw some instances where risks had reduced and management plans had remained in the clients' file. For example, where a patients' mobility had improved following the completion of their detoxification.

Staff completed hourly observations of clients as standard regardless of their assessed level of risk. Where higher risks were identified staff would complete observations more frequently depending on the risk identified.

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

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

Safeguarding

All staff accessed online training on safeguarding adults awareness and class based training on safeguarding children level one. Care staff also accessed class based training on safeguarding adults level one. Both class based courses were provided through the local authority safeguarding team. At the time of the inspection 97% of staff had completed the online course, 85% had completed the safeguarding children training and 24% of identified

Good

Substance misuse/detoxification

staff were in date for safeguarding adults level one training. However, all staff who required the training had been booked to attend future courses. The manager advised us that there had been some difficulty accessing the training through the local authority and they could only request three spaces for each course.

All the staff we spoke to were able to outline areas where abuse may occur and the procedure they would follow to raise a concern including where they could seek support and guidance from either the local authority safeguarding team or the providers lead nurse. Between 30 June 2017 and 30 June 2018 the service had not made any safeguarding referrals to the local authority. One concern had been raised with the local authority safeguarding team which was investigated and found to be unfounded.

Staff access to essential information

Client records were paper based. Client files contained all the information relevant to their stay including their admission assessment, risk assessment and care plan information. Files were stored in a locked cupboard in the staff office which was locked when not in use. Medication records were stored in a locked cupboard in the medication room and were only accessible to the staff administering medication.

Medicines management

We reviewed the medication administration records for clients on both the detoxification and rehabilitation units. All records were completed appropriately and indicated the correct dose and frequency for medication. Medication administration records did not have any gaps in recording.

There were appropriate systems and processes in place for the storage and administration of controlled drugs including a controlled drugs book used to record the receipt, administration and disposal of controlled drugs. However, the standard operating procedures did not contain a list of the controlled drug key holders in line with best practise guidance.

The service stocked Naloxone and epinephrine injections for use in emergencies. Naloxone is a medication used to block the effects of opioids, especially in overdose. Epinephrine can reverse the symptoms of an allergic reaction. There was an automated external defibrillator in the nurses' office on the detoxification unit. All staff had received training in basic life support and had watched the manufacturers instructional DVD on the use of the automated external defibrillator. Staff who had completed the more advanced first aid at work training had received additional training about the use of automated external defibrillators as part of the course.

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

Track record on safety

In the twelve-month period, before the inspection there had not been any serious incidents.

Reporting incidents and learning from when things go wrong

The provider used an electronic incident reporting system, 84% of staff had received training on using the system. Staff spoken with knew how to report incidents and we saw a copy of the incident log report produced by the incident reporting system.

In the six months between April 2018 and September 2018 there had been 27 incidents recorded of which 10 (37%) related to the rehabilitation unit and 17 (63%) the detoxification unit. The log demonstrated incidents were investigated and actions taken to address learning.

There was a system for sharing learning following incidents through the team meetings. We saw evidence of incidents being discussed in the team meeting minutes we reviewed.

Are substance misuse/detoxification services effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

Clients were admitted to the detoxification unit in a three staged approach covering clients social, medical and psychological health; nursing staff completed a pre-admission assessment with the client and their referring agency if appropriate before admission. On admission support staff completed the initial admission and orientation to the unit, nursing staff then completed an

admission assessment and completed physical observations. Finally, the duty medical practitioner would complete a clinical assessment and prescribe the treatment regime to support the detoxification.

We reviewed nine care records, six on the detoxification unit and three from the rehabilitation unit. On the detoxification unit staff utilised generic care plans, these included prepopulated actions, which were not specific to the need of individual clients or holistic in nature. Care plans on the detoxification unit generally focused on the medical detoxification regime the client was following and the physical interventions required to support this.

Care plans did not reflect clients emotional, mental or physical health support needs. For example, one care plan identified a client required support with personal care but not how the client preferred to receive this. Staff told us due to a clients' health during their initial treatment they were not able to engage fully in the care planning process until they had overcome their initial withdrawal. Staff would therefore ask what support clients required during each intervention to promote independence.

When the client progressed from the detoxification unit to the rehabilitation unit their care plan transferred with them and an additional assessment took place with one of the therapists demonstrating greater client participation. Clients developed a more comprehensive recovery plan based on the first three stages of the twelve steps programme, clients were encouraged to write the plan themselves using their own words and identifying their own goals. Staff told us where a client was referred from the local drug and alcohol service they would come with a plan for discharge which helped focus the patients' recovery.

Best practice in treatment and care

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

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

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

The medical practitioner working for the local health provider completed clinical assessments and subsequent treatment plans. Detoxification medication and reduction plans were based on the NICE guidelines.

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

A GP or advanced nurse practitioner from the local health provider was available to provide telephone advice if staff had concerns regarding a client's detoxification. Clients could register as a temporary resident with the local GP for the duration of their stay. Staff would seek support via the emergency services for clients suffering with a physical health or mental health crisis.

Skilled staff to deliver care

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

Support workers completed NVQ level 2. Training was available to all staff specific to drug and alcohol misuse. All staff had received training on alcohol use over the last year and more recently staff had received training on 'the addicted brain' and self-harm.

All staff received regular supervision and appraisals from an appropriately qualified supervisor.

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

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

Multi-disciplinary and inter-agency team work

Good

Substance misuse/detoxification

Nurses and therapists held daily meetings with the manager and shared information as necessary between teams or recorded details in progress notes. Staff from the local health federation visited the service regularly and informed us they had a good relationship with the staff and staff would contact them to discuss concerns about a patients' wellbeing or to request a review of a client's care if necessary.

Where a client was receiving support from another agency staff would involve the third party in the persons care planning and inform them of progress made.

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

Good practice in applying the MCA

The service had 96% compliance with Mental Capacity Act training which was a mandatory course. However, the course did not have a frequency for refresher training and staff told us it had been a long time since they had completed the course. The staff we spoke with could demonstrate an awareness of the principles of the Act and the need to assess a clients' capacity before obtaining their consent. Staff told us where they had concerns the would raise these with the nurse on duty.

When a client was intoxicated on admission to the detoxification unit and did not have the capacity to consent to their treatment the decision would be made to complete the admission and obtain their consent later in the day or the next day depending on the time of admission. Where it was identified that a patient would begin to withdraw during this period and would be at risk without their detoxification medication the medical practitioner and the nurse in charge would make a best interest decision to prescribe the medication in the patients' best interest and to review this when completing the admission and obtaining the clients consent. However, we did not find any recording of this best interest decision in the admission notes of the clients we reviewed where this had been the case.

Advocacy support was available through the local advocacy service for clients who required additional support. Although the service had not required to access this.

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

Are substance misuse/detoxification services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

We observed one group therapy session and general interactions between staff and clients on both units. We saw caring interactions between staff and clients throughout the service, staff engaged clients in a respectful manor. We spoke with seven clients who all said staff treated them with dignity and respect. Clients said the staff went the extra mile and were caring. Staff demonstrated an ability to gain an understanding of the individual clients and their support needs within a short period of time.

Involvement in care

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

We reviewed nine care records and saw clients on the detoxification unit had not always signed their care plans. However, we saw evidence of staff obtaining a second signature after clients completed detoxification and progressed on the rehabilitation unit. We saw clients were more involved in their care on the rehabilitation unit and were encouraged to develop and write their own recovery plans.

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

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

Good

Substance misuse/detoxification

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

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

Good

Access and discharge

The bed occupancy rate for the service was low, between 29% and 41%. At the time of the inspection, there was one client in the rehabilitation unit, with another client attending day care and nine clients in the detoxification unit. Four clients were admitted over the course of the inspection.

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

Clients could be admitted at a time which suited them including in the evening.

The service was flexible in the treatment options provided; clients could choose to stay for detoxification, rehabilitation or both. Alcohol detoxification was completed over seven days; the average stay for opiate detoxification was three weeks. Where clients were transferred from the detoxification unit to the rehabilitation unit this was planned with the individual and they could spend time on the unit and attend therapy sessions or social time with the current residents to help their transition.

The facilities promote recovery, comfort, dignity and confidentiality

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

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

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

There was space for clients to engage in both group and 1:1 therapy sessions on each unit and both units had an art room for clients to engage in arts and craft activities.

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

The service provided meals for the clients who could choose from a range of options daily. The service could cater for a range of dietary requirements on request. A range of snacks were readily available in both the lounge and dining areas and clients could help themselves to hot or cold drinks at any time.

Patients' engagement with the wider community

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

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

Meeting the needs of all people who use the service

The service was accessible and had a lift to enable access to the detoxification unit. Bathrooms on the detoxification unit were accessible for clients in wheelchairs. There was no accessible bathroom on the rehabilitation unit, this meant clients in wheelchairs would need to be supported

Good

Substance misuse/detoxification

to access the facilities on the detoxification unit. There was an on-going refurbishment plan in place that included a redesign of the bathroom facilities and would address this issue.

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

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

Listening to and learning from concerns and complaints

Formal complaints were reported centrally and could be investigated by the manager or an independent investigator depending on the complaint. We reviewed six complaints, two complaints had been withdrawn and four had been partially upheld identifying lessons learnt and recommended actions to improve the quality of the service. Complaints posters were displayed on the noticeboards and leaflets were available on leaflet stands and in patients' bedrooms. However, posters and leaflets did not identify external bodies clients could also contact to raise a concern. The staff we spoke with could describe the process to follow when receiving a complaint and to pass this on to the manger. The clients we spoke with said they felt able to complain to staff and felt they would respond to their concerns. However, we received a comment card from a client who was not happy with the outcome of a complaint they had raised previously.

Are substance misuse/detoxification services well-led?

Good

Leadership

The staff we spoke with were aware of the management structure and could name the senior manager. The manager had worked for the provider for over ten years and had been the manager of the service for three years. Staff told us they found the manager to be accessible and approachable and would spend time on the units talking to staff and clients.

The manager and the operations manager could describe the improvements made at the service since their last inspection and the developments planned for the future to improve the service and provide opportunities for staff development.

Vision and strategy

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

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

These values were embedded as part of the staff appraisal process. Although staff we spoke to were not able to list the values as they were written they could describe them in their own words and actions.

Culture

The service had a low absence and turnover rate and many staff had worked for the service for several years.

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

Staff we spoke with said they felt respected and valued by their managers and that the managers were supportive and would respond to concerns raised by the team. Staff also said the level of investment in to the property from the provider was reassuring and demonstrated a level of commitment. However, some staff said that due to the service's location and the type of service provided they felt isolated from the head office and saw themselves as 'Linwood house staff' rather than 'care plus' staff.

Governance

Staff had completed the providers' induction programme and mandatory training was at 83%. The providers' policies and procedures were all available on the intranet. Staff could access these policies and procedures through the online portal.

There was an audit programme including medication audits and environmental audits. Audit results were

collated through the providers' quality and performance department and formed part of the monthly key performance indicator reports used to monitor the performance of the service.

However, recent infection control audits had not identified a sharps bin had not been returned within the required timeframe in line with Department of Health and Social Care guidance on the management of clinical waste.

Learning from audits was fed back to the manager and incorporated in to action plans where necessary. The manager shared learning from audits and action plans within staff meetings.

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

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

Staff files demonstrated recruitment checks were completed in line with organisational policies and checks were completed to ensure qualified staffs' registrations were up to date.

Management of risk, issues and performance

Staff could raise concerns to the manager who maintained a local risk register which fed into the provider risk. The manager told us the register was regularly reviewed through governance processes within the organisation.

Contingency plans were in place across the provider identifying actions to take in the event of an emergency. The provider completed an annual assessment of their emergency planning.

All staff had received training in the providers incident reporting system and were aware of their role to report incidents. There were effective governance procedures in place to review and investigate incidents.

Governance processes were in place and the service reported on key performance indicators monthly. The governance process was two way and provided the manager with monthly compliance reports identifying if any areas required action to achieve compliance.

Information management

All staff had access to the providers intranet and organisational policies and procedures. Staff could also access a service specific portal containing service specific policies and procedures. Staff could access an online human resources portal providing links to their individual training records to request training and identify when training were due to expire.

The manager could access the system and was able to produce a report for the team to monitor compliance with mandatory training.

Client records were paper based and were stored in locked cabinets within the staff office. Records over 12 months old were archived in a secure area for an identified retention period where they could be accessed if a client returned during that period.

Engagement

Both the provider and the service had an internet site providing information about the services provided. Staff could access information, guidance and policies on both the providers intranet and the service specific portal on the intranet. All clients were asked to complete a feedback form following their stay. These were collated centrally by the provider and regular reports produced summarising the feedback for the period. The service offered a programme of monthly aftercare days and weekly day care sessions, which were available to previous clients to access therapy sessions and peer support. These sessions were free to attend with a nominal charge was made for meals. The service allowed clients who were travelling long distances to book a room for the evening for a nominal charge to support their attendance. Friends and family could provide feedback through the providers internet site.

Learning, continuous improvement and innovation

Due to the lack of placements under commissioning arrangements, the service was not required to complete the national drug treatment monitoring system returns. However, the provider had implemented an audit programme and key performance indicators, were being monitored through the providers' quality and performance department. Learning from incidents and complaints was discussed at team meetings and staff were involved in discussions around addressing the learning and developing the service.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure actions identified in the ligature policy including a ligature risk assessment identifying the severity of identified risks are completed and updated regularly.
- The provider should ensure the medical practitioner record their rationale and any risk mitigation when admitting clients who do not consent to the service contacting their GP.
- The provider should ensure best interest decisions to admit clients who temporarily lack capacity are recorded in the admission records.
- The provider should ensure controlled drug standard operating procedures contain a list of all key holders in line with best practise guidance.
- The provider should ensure audits effectively identify areas of noncompliance with best practise guidance.