Equinox Care

Brook Drive

Inspection report

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Date of inspection visit: 20, 21, 22, 23 and 26 July 2021
Date of publication: 10/02/2022

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Good
Are services responsive to people's needs?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Overall summary

Our rating of this location went down. We rated it as inadequate because:

Our rating for this service has been limited by the enforcement action we have taken. We imposed urgent conditions on the registration of this service under section 31 of the Health and Social Care Act 2008. This means the service can only admit clients when there are experienced, qualified and suitable medical staff always available. The service can only admit clients whose needs it can safely meet. We also served two warning notices on the provider, concerning safeguarding clients and governance.

We found:

- The service admitted clients with serious and significant physical and mental health problems, which the service could not safely provide care and treatment for. There was no inclusion and exclusion criteria for the service. Since the beginning of 2021, 13 clients had been transferred by emergency ambulance from the service to hospital.
- Staff did not have an understanding of safeguarding and did not know how to make a safeguarding referral. No staff had undertaken safeguarding children training and only 25% had recently undertaken safeguarding adults training. Two incidents which should have prompted a safeguarding referral had not.
- Not all medical staff had qualifications to safely treat clients with complex problems in the service. Medical staff did not receive supervision for their substance misuse work. Clients' mental health and cognition was not adequately assessed on admission. There was no psychiatrist working in the service to assess and support clients with mental health problems. Out of hours medical cover consisted of medical staff who did not have specific experience in substance misuse treatment and detoxification.
- There were frequent occasions when there were not enough staff on shift. It was common for there to be a shortage of registered nurses on shift. There was no system for assessing how many staff were required to support clients.
- The governance system for the service was ineffective. Safeguarding and complaints were not standard agenda items at meetings, there was a lack of clinical audits and limited learning from incidents. There were no prescribing protocols. The service risk register did not include the risks we identified during the inspection. There was no single document or system for managers to have oversight of staff mandatory training. Almost without exception, less than 50% of staff had undertaken mandatory training.
- Staff did not understand the Mental Capacity Act 2005. When clients were intoxicated on admission their capacity to consent to admission and treatment was not assessed.
- Clients' care plans did not identify their specific needs during treatment.
- The service did not notify the CQC of incidents which it was legally required to. These incidents concerned serious injury to clients and alleged abuse.

However:

- Staff treated clients with compassion and kindness. Staff were supportive, developed good relationships with clients and treated clients as individuals. Clients said that staff were very helpful and understanding.
- Eighty per cent of clients completed treatment and had a planned discharge from the service.
- Staff were positive regarding the manager of the service and their leadership style. They said that the culture of the service had improved during the previous year.
- Staff in the service had undertaken an audit of clients who had alcohol withdrawal seizures. The number of clients having seizures had reduced.

Summary of findings

- When clients were unable to obtain support for their pet during their detoxification treatment, they could bring their pet into treatment with them.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Residential substance misuse services	Inadequate 	See overall summary.

Summary of findings

Contents

Summary of this inspection

Background to Brook Drive

We undertook this unannounced comprehensive inspection of Brook Drive following information of concern regarding the treatment of clients in the service.

The service provides residential drug and alcohol detoxification treatment to all adults. It has 26 beds.

Brook Drive is registered to provide Accommodation for persons who require treatment for substance misuse and Treatment of disease, disorder or injury.

There was a registered manager in post at the time of the inspection.

We last inspected Brook Drive in November 2018. At that time, we rated the service as Good in all areas and Good overall.

What people who use the service say

The five clients we spoke with were very positive regarding the support they received from staff. Clients said that staff were very helpful and understanding. Staff were supportive, developed good relationships with clients and treated clients as individuals. Clients also said that staff were good at motivating them to remain abstinent from substances and responded when clients needed support.

Two clients specifically mentioned that the cook was good and the food was very good.

How we carried out this inspection

The inspection team for this inspection consisted of two CQC inspectors and a specialist advisor who is a consultant psychiatrist in addictions.

This inspection involved on-site visits on two days. We also undertook interviews by teleconference and telephone due to COVID-19.

During this inspection, the inspection team:

- visited the service and observed the environment and how staff were caring for clients
- spoke with the registered manager
- spoke with nine staff including the nurse team leader, a registered nurse, the deputy manager, a recovery worker, the psychosocial lead, organisational clinical lead, director of operations, head of service and the director of governance
- spoke with two GPs and the addictions consultant who worked with the service
- spoke with five clients
- reviewed twelve clients' care and treatment records
- reviewed other documents concerning the operation of the service.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Summary of this inspection

Outstanding practice

None identified.

Areas for improvement

Action the service MUST take to improve:

- The service must ensure that a lead addictions psychiatrist works in the service, and other medical staff providing input are appropriately qualified and experienced in substance misuse, including out of hours medical cover.
- The service must ensure that the service has a suitable inclusion and exclusion criteria.
- The service must ensure that all staff undertake safeguarding adults and safeguarding children training and that staff can identify risks to clients and others and know how to make a safeguarding referral.
- The service must ensure that the governance system is further developed, operates effectively, and provides a consolidated view of risk, quality and performance.
- The service must develop a system to assess staffing requirements which meets the demand and support needs of clients. The service must ensure there are a sufficient number of registered nurses deployed on shifts in the service.
- The service must ensure that staff understand the Mental Capacity Act 2005 and that capacity assessments of clients take place when indicated.
- The service must ensure that clients' care plans reflect their assessed needs.
- The service must ensure that all staff complete mandatory training.
- The service must ensure that notifications are sent to the CQC, as required by law.

Action the service SHOULD take to improve:

- The service should consider the use of a tool to assess the severity of clients' dependency on alcohol, such as the severity of alcohol dependence questionnaire (SADQ).
- The service should ensure that easy read leaflets are available for clients.
- The service should consider if a ligature risk assessment is required, and if so, that it accurately reflects all environmental ligature risks and includes actions to minimise such risks.
- The service should ensure that medicines are stored properly.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Residential substance misuse services	Inadequate	Inadequate	Good	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Good	Inadequate	Inadequate	Inadequate

Inadequate

Residential substance misuse services

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

Are Residential substance misuse services safe?

Inadequate

Our rating of safe went down. We rated it as inadequate. Our rating is limited to Inadequate by the enforcement action we have taken.

Safe and clean environment

The environment was visibly clean. Furniture was in good condition and and the building was well maintained.

Clients with mental health needs and increased risks were accommodated on the ground floor so staff could observe them more closely. An up to date ligature risk assessment was in place and accessible for staff. However, the ligature risk assessment did not include all ligature risks. Pipes, taps, soap dispensers and light fittings were not included in the ligature risk assessment. On the first floor, door closers were included in the ligature risk assessment. However, pipes, cables, chairs, tables and a sofa were not included. Clients with a history, and at risk, of self harm or suicide attempts were admitted to the service.

The service had a small female only area, with bedrooms, bathroom facilities and a dedicated lounge. Clients with more complex needs or increased risks were accommodated on the ground floor. This applied to male and female clients and enabled staff to supervise clients more closely.

The service had a wall alarm system fitted in communal areas and all bedrooms.

There were clear procedures for people entering the service so that COVID-19 guidance was followed. All staff, clients and visitors had a COVID test on entry to the service. Staff used personal protective equipment and observed social distancing. Other infection control measures included hand wash basins had lever taps and the clinic room being cleaned four times per day.

Safe staffing

There were shortages of nursing and substance misuse workers on shifts and no structured system for matching staffing with the level of demand. There were no full time medical staff working in the service. A part time psychiatrist was available remotely. Less than 50% of staff had undertaken almost all types of mandatory training.

There were 11 posts for registered nurses, of which three were vacant posts (27%). Two of the vacant posts were senior nurse posts. There were seven recovery worker posts which were all filled.

There were three registered nurses on shift during weekdays and two at night and during the weekends. There were two recovery workers during the day and one at night. The service used agency staff to cover vacant posts and shifts on the rota. The nurse team leader also covered gaps in the rota during the day, when required. However, there had been no systematic review of staffing levels against demand and taking account of the environment. Staffing levels were historical. For example, on the first day of the inspection, four clients were being admitted for detoxification treatment. Staff would need to undertake their physical observations frequently throughout the night. There were another 12 clients in the service that night. Staffing was unchanged, with three staff working across the three floors in the service. The manager said that additional staff could be brought in to work a shift. However, there was no guidance regarding when this would be appropriate to meet clients' needs. Three of the five clients we spoke with said that the service was short staffed, at least some of the time.

In the three months before the inspection there were 19 day shifts and 13 night shifts when the service was below minimum staffing levels. All of these shifts involved a shortage of registered nurses. During the day, for seven shifts, a student nurse was used as a replacement for a registered nurse. On two day shifts, the service was short of two registered nurses. The nurse team leader worked the shift undertaking nursing duties.

A doctor attended the service each weekday morning and on Tuesday and Thursday afternoons. This was one of the three GPs who reviewed referral information and assessed and treated clients in the service. A GP trainee would also attend the service regularly. The GPs were also available by telephone until 6.30pm each weekday. In the evenings, and at nights and weekends, staff could contact the out of hours GP service for the area. There had been one recent incident involving a client withdrawing from a novel psychoactive substance. The client's physical health was deteriorating. As there were no medical staff on-site at the weekend, a decision was taken to call an ambulance for the client to be transferred to hospital. A further incident occurred at 5pm on a weekday when staff could not speak with a GP. An ambulance was called to transfer the client to hospital.

Clients with significant mental health problems, and associated risks, were admitted to the service. However, there was no psychiatrist available on site.

Staff were required to complete 22 types of mandatory training. Apart from basic life support training, less than 50% of staff had undertaken other types of mandatory training. Seven staff (44%) had undertaken fire training. Thirty-seven per cent of staff had undertaken Mental Capacity Act, autism awareness, health and safety, equality and diversity and General Data Protection Regulations (GDPR) training. Four staff (25%) had undertaken safeguarding adults training and less than 20% of staff had undertaken nutrition and hydration training. None of the staff in the service had undertaken safeguarding children, lone working or principles of communication training.

Assessing and managing risk to people who use the service and staff

Assessment of client risk

The service did not effectively assess actual and potential risks of clients before admission to the service. Clients were admitted when the service was unable to meet their needs or safely manage their risks.

We reviewed 12 clients' care and treatment records. Staff screened clients before admission. There was no inclusion or exclusion criteria describing clients who were or were not suitable for the service to admit. GPs working with the service

reviewed referral information. Referral information included information about the clients' use of substances, mental health and physical health. This included the results of a blood test undertaken in the previous three months. The GPs requested additional information on clients' physical or mental health appropriately. The GPs also consulted an addictions consultant when clients' had complex healthcare needs. However, the addictions consultant did not work in the service and was only able to provide advice remotely. As a result of the COVID-19 pandemic, the addictions consultant had never visited the service .

When clients came to the service to be admitted they were assessed by a registered nurse and one of the GPs. Clients' physical and mental health were assessed. Whilst a tool to assess cognition was available, this had not been completed, where appropriate, for the clients whose care and treatment records we looked at. Clients did not have a mental state examination when they had significant mental health problems. Potential risks related to clients' mental health were not fully assessed. The severity of clients' alcohol dependence was not assessed using a validated tool, such as the Severity of Alcohol Dependence Questionnaire (SADQ). This did not follow best practice (Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence, National Institute for Health and Care Excellence, 2011). This meant that staff monitored clients' response to detoxification medicines without objective baseline information on the severity of clients' dependency. A client with a history of sexual offending was admitted without staff obtaining any information about the offending, to assess potential risks to other clients. Risks to or from clients were not properly understood. Staff decided that clients with multiple health problems and potentially significant risks could be admitted to the service. These included clients with cirrhosis, recent self harm and suicide attempts, and multiple physical health problems. On admission, GPs noted that clients had complex physical health needs and indicated transferring the client to hospital may be required. Three staff, including senior staff, told us that the service rarely, if ever, refused a client admission. However, admissions had been refused in the past.

Management of client risk

The service did not manage individual client risks well.

Clients' risk management plans were largely generic, focusing on clients' withdrawal symptoms and treatment. This included monitoring clients for seizures, when appropriate. When clients had specific potential risks identified, such as self harm, falls and physical health concerns, these were not always included in clients' risk management plans. When they were included, only a brief description of the risk was included, with no detail regarding ways the potential risks could be minimised.

During 2020, the service only admitted clients for detoxification treatment for seven months due to the COVID pandemic. However, during that year, ten clients experienced seizures during detoxification treatment. One client experienced two seizures in one day. Seven of these clients had experienced seizures before being admitted for treatment. In 2021, a client experienced three seizures during detoxification treatment. Three months before the inspection, a further client experienced a seizure. The procedure in the service, in summary, was to treat and monitor a client if they had one seizure and to transfer them to hospital after two seizures or a prolonged seizure. The service was not equipped to provide full care to these clients, such as blood testing. Managers and staff did not recognise that a client having a seizure should be treated as an emergency requiring hospital care.

Since January 2021, the service had called an emergency ambulance to take clients to hospital on 13 occasions. On one occasion, a client did not have physical observations recorded for more than 24 hours. When their observations were recorded, the client had a very rapid pulse. The client's pulse rate did not lower when they had additional medicines. With another client, staff observed they had developed signs and symptoms of severe fluid retention. The doctor was only alerted to this when the client had a fall.

A falls policy and risk assessment was in place for clients at risk of falls. However, GPs did not refer to a falls risk assessment being completed when they assessed clients as having reduced mobility or being unsteady. In the previous three months, clients had fallen or slipped over on seven occasions. Clients were assessed after the fall and had not fallen again. On two occasions clients' falls were related to them being intoxicated on admission to the service.

GPs, in discussion with the wider team, determined where clients should be located in the building during their treatment. Clients with complex or high risk physical or mental health needs were located on the ground floor. Staff were better able to observe clients on the ground floor. For some clients assessed with complex physical health needs and high potential risks, a staff member could observe and supervise them continuously.

Some clients chose to self discharge from the service before their detoxification treatment was completed. Staff informed clients of the risks of using, or abstaining, from alcohol or drugs after their discharge. Naloxone was available for clients dependant on opiate drugs and information on naloxone was readily available in the ground floor staff office.

To maintain safety and to minimise distractions from the therapeutic day programme there were some blanket restrictions in the service. Clients were not allowed to bring knives or laptops into the service and were not allowed to keep their mobile phones. There were restricted times in the evening when clients could make phone calls. There were exceptions when clients wanted to speak with their children using internet videocalls. Clients agreed to these restrictions when they were admitted to the service.

Safeguarding

Very few staff were trained in safeguarding adults and children. Only some staff could identify people at risk of abuse or neglect. Staff and managers in the service did not make safeguarding referrals when they should have been made.

Four of the sixteen staff (25%) had undertaken recent safeguarding adults training. No staff had undertaken safeguarding children training. The provider's policy directed staff to report safeguarding matters to the manager and directors. Four staff we spoke with did not know the safeguarding process or how to make a safeguarding referral. This did not follow national best practice guidance (Adult safeguarding: roles and competencies for healthcare staff, Intercollegiate document, 2018). Two of the four staff had little or no knowledge of safeguarding adults.

Whilst all incidents were reviewed at clinical governance and team meetings, safeguarding was not a standard agenda item for these meetings. We identified two incidents where staff had not responded appropriately to deterioration in clients' physical health. There was no record that either incident had been considered by staff or managers to be a safeguarding issue.

Staff access to essential information

Staff used a mix of electronic care and treatment records and paper records.

The provider had recently installed a new system for electronic care and treatment records. This system included all assessment information, risk information and care plans for clients. Incident reports were also available on the system. Bank staff could make entries on the system. However, when bank nurses undertook admission assessments for clients they did not always record their name. This meant it was not immediately possible to know who had undertaken the assessment.

Paper records were used to record clients physical observations. The dates and times of observations were not always able to be read. In addition, the spaces on the form were small and were sometimes difficult to read what staff had written.

Medicines management

The management of medicines did not follow best practice.

Medicines were stored in a room on the ground floor and in a clinic room on the floor above. There was no system for checking the temperatures of either room. Medicines may become ineffective if they are stored above 25 degrees. On the first day of inspection both rooms were very hot and the outside temperature was above 27 degrees. Medicines stored at room temperature may not have been fully effective. The temperature of the medicines fridges in both rooms were checked. However, the recording sheet stated that the temperature for refrigerated medicines should be two to 25 degrees. This was incorrect and did not reflect the provider's medicines policy. Refrigerated medicines should be stored between two and eight degrees. In the ground floor room, the refrigerator temperatures had not been checked for seven days in the previous month. In the clinic room the fridge temperatures had not been checked for five days in the previous month. The medicines fridge in the clinic room was not locked when we inspected.

Stock medicines and client's own medicines were appropriately labelled and within their expiry dates. The controlled drugs cupboard in the clinic room was locked. Controlled drugs were recorded appropriately in the controlled drugs book. Stock and administration of medicines which could be addictive, such as diazepam and oxazepam, were also recorded in a separate document.

Emergency medicines were available and within their expiry dates. They were stored with resuscitation equipment in the ground floor room and clinic room. Weekly checks were undertaken on the emergency medicines and resuscitation equipment, including the oxygen and the defibrillator in the clinic room. Other medical equipment, such as blood pressure machines, had been calibrated.

Clients were prescribed high doses of diazepam in some circumstances and the medicine flumazenil can be used to reverse the effects of over sedation. Flumazenil was not stocked in the service and there was no risk assessment regarding whether it should be.

We were told that medicines audits had been carried out daily during the previous three months. The audit form did not include an audit of clients' prescription charts. An audit of prescription charts had not taken place during the COVID pandemic.

Five medicines errors were recorded in the previous three months. Each medicine error had been reviewed, causes for the error established, and action taken to prevent repetition.

Track record on safety

Inadequate

Residential substance misuse services

The service did not have a good track record on safety. There were a high number of serious patient safety incidents and clients were frequently transferred by ambulance to hospital.

A number of incidents in the previous year involved clients' detoxification treatment and physical health needs. These included clients having seizures and, in 2020, a client experiencing delirium tremens whilst receiving treatment for gammahydroxybutyrate (GHB) dependence. Delirium tremens has a significant mortality rate. There were a range of incidents involving clients' physical health deteriorating and necessitating transfer to hospital. Since January 2021, the service had called an emergency ambulance to take clients to hospital on 13 occasions.

There were frequent incidents of clients having falls or slipping, in some cases immediately after admission when they were intoxicated.

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report. Reviews of incidents were not systematic and learning from incidents was inconsistent. Learning from incidents was not embedded in the service.

Staff reported a wide range of incidents. These included clients self-discharging from the service, falls, accidents and when clients' physical health deteriorated.

We reviewed 31 incident forms. All of them, except two, had further actions recorded in response to the incident, such as the GP assessing the client or the client requiring more frequent physical observations. Every medicine error was reviewed and action taken to prevent repetition. Staff had a debriefing after serious incidents.

The clinical governance meeting minutes for the three months before the inspection showed that whilst incidents were noted there was no in-depth review of incidents. Themes, trends and root causes of incidents were not discussed in detail. There were few actions to minimise future incidents. It had been suggested that in future, the clinical governance meeting would not review all incidents, only serious ones. The minutes of team meetings also did not include a systematic review of incidents and learning. Five staff we interviewed could not identify specific learning following any incidents.

Following an audit of client seizures in 2020, the service had remote input from an addictions consultant. This had led, in some cases, to higher doses of detoxification medicines being prescribed and a decrease in the number of seizures. However, staff had not considered any other changes which could further reduce the risks of seizures.

Are Residential substance misuse services effective?

Inadequate

Our rating of effective went down. We rated it as inadequate. Our rating is limited to Inadequate by the enforcement action we have taken.

Assessment of needs and planning of care

Clients had a comprehensive physical assessment on admission but the assessment of their mental health was very limited. Clients' care plans did not reflect their assessed needs and were not holistic.

Inadequate

Residential substance misuse services

We reviewed twelve clients' care and treatment records. Clients physical health needs were assessed on admission by a registered nurse and by one of the GPs. Clients had a thorough and comprehensive physical health assessment. Clients had a very limited assessment of their mental health, including when they had known mental health problems. Clients' cognition was not assessed. For clients' receiving treatment for alcohol misuse, a cognitive assessment is best practice (NICE, 2011) to identify existing and emerging memory problems. Clients had a urine drug screen and alcohol breathalyser as part of their admission assessment.

All clients in the service had care plans. Clients' care plans were divided into three parts, covering physical health, psychological and mental health, and social support. Although the care plan template prompted care plans to be SMART (specific, measurable, achievable, realistic and time-limited), they were not. Only the physical health section of clients' care plans was completed. This contained clients' views and expectations of treatment and their aims and goals. It was not limited to clients' physical health needs. Clients' assessed physical health needs were not included clients' care plans. The psychological and mental health, and social support, parts of the care plan were not completed. This included when clients had been assessed with specific needs in these areas. Clients' care plans did not describe actions staff would take to meet clients' needs. They did not include how clients' care and treatment needs could be monitored to identify if staff interventions had been successful in meeting clients' needs.

Clients had an initial care plan within 48 hours of admission to the service. Clients had one further care plan one day prior to their planned discharge. Clients' second care plan did not evaluate the success of interventions to meet clients' needs during treatment. Clients' second care plan contained clients' views on the further actions and support they needed after discharge from the service. This information was contained in the physical section of the care plan, with the other sections blank. Clients' second care plan was, effectively, a discharge plan for the client. If clients' assessed needs changed during their treatment in the service, their care plan was not updated.

Best practice in treatment and care

Managers and staff did not recognise that the service could not safely treat clients' having alcohol withdrawal seizures. Managers and staff were not undertaking clinical audits. However, staff provided a range of care and treatment interventions suitable for the client group and consistent with national guidance on best practice. Staff used recognised rating scales and recorded client outcomes.

Clients with alcohol dependence had seven to 10 days of detoxification treatment. There were no protocols identifying different prescribing regimes for clients with moderate or severe alcohol dependence, as recommended by best practice guidance (NICE, 2011). Clients with alcohol dependence were initially treated depending on their withdrawal symptoms. Staff assessed clients withdrawal symptoms using the alcohol withdrawal scale (AWS) and national early warning score 2 (NEWS2). This reflected best practice recommendations. After the first two or three days, clients had fixed dose detoxification treatment based on their initial symptoms and treatment. Pabrinex was prescribed and administered to clients at risk of cognitive problems, as recommended by best practice guidance (NICE, 2011).

Incidents of clients having withdrawal seizures during treatment had reduced following advice and input from the addictions consultant. However, clients did continue to have seizures and the service had a policy for staff to manage these. Managers and staff had not recognised that a client having a withdrawal seizure should be rare and could not be safely managed in the service. In the previous year, one client had two seizures on the same day and another client had three seizures during their detoxification treatment, on different days. Managers and staff did not understand that a client having a seizure should have prompted an immediate transfer of the client to hospital.

Inadequate

Residential substance misuse services

Clients having opiate detoxification treatment were admitted to the service for up to 28 days. Clients opiate substitution treatment (OST) was gradually reduced during detoxification. Staff monitored clients withdrawal symptoms using the clinical opiate withdrawal scale (COWS), as recommended by best practice guidance (Drug misuse and dependence: UK guidelines on clinical management, Department of Health, 2017). Naloxone was stored on-site in the event a client had an opiate overdose.

Clients also had treatment at the service for novel psychoactive substances. This treatment included GPs prescribing medicines to minimise clients' withdrawal symptoms.

The service operated as a psychologically informed environment (PIE). PIE ensures staff focus on clients' emotional and psychological needs. PIE was developed in the homeless sector and has an evidence base for it's effectiveness.

Therapeutic groups took place daily as part of clients' treatment. In addition to the daily 'check in' meeting, groups covered areas such as relapse prevention and managing difficult emotions. A new psychosocial lead post had been developed to review and enhance the psychosocial treatment programme. Massage was available twice per week, in addition to acupuncture sessions. Mutual aid organisations attended four evenings per week.

Clients' physical health was monitored by staff throughout clients' detoxification treatment. GPs were available during weekdays. Twice per week, blood borne virus screening was available to clients. Clients' weight was closely monitored during treatment.

The outcomes of clients' treatment were recorded by the service. The service submitted information regarding outcomes to the national drug treatment monitoring system (NDTMS). The service also monitored how many clients successfully completed detoxification treatment.

Since the easing and ending of COVID restrictions, managers and staff had not recommenced clinical audits. There had been no care plan audits. We were told that an audit of clients' risk assessment and risk management had been undertaken but had not used the audit template. Similarly, we were told that daily checks of medicine charts had not been documented. A clinic room audit was completed regularly.

Skilled staff to deliver care

The service did not have the full range of specialists required to meet the needs of clients.

One of the three GPs who worked with the service had undertaken parts one and two of the Royal College of General Practitioners' certificate in substance misuse. The other two GPs, and the trainee GP, working with the service had undertaken part one, but not part two, of the certificate. National guidance states that only GPs who have undertaken both parts of the certificate, or addictions consultants, should provide care and treatment for clients with the most severe and complex needs (The role of addictions specialist doctors in recovery orientated treatment systems, Public Health England, 2014). Clients being treated in the service, such as those with mental health problems, significant and multiple physical health needs, and clients withdrawing from novel psychoactive substances, were clients with the most severe and complex needs. The addictions consultant providing advice and support to the service worked remotely and had not visited the service. Only one of the GPs had the recommended qualification to be treating the type of clients being treated in the service.

Inadequate

Residential substance misuse services

The service treated clients who had complex mental health problems in addition to their substance misuse problems. Detoxification treatment can affect clients' mental health problems. The service had previously worked with a local mental health trust and a psychiatrist worked at the service. Since this arrangement ended, there was no psychiatrist based at the service. Clients with mental health problems did not receive an appropriate assessment and ongoing support during detoxification treatment.

The service had one adult-trained registered nurse working in the service. The remaining nurses were mental health trained.

A community based pharmacist worked with the service. There were no pharmacy audits available to review during the inspection.

A range of training was available for staff to undertake. Staff uptake of training had been affected by the COVID pandemic and had been restricted to online training for a considerable period. Training included diabetes awareness, dementia awareness and epilepsy awareness. Each of these non-mandatory trainings had been undertaken by less than 40% of staff. Staff had received training on how to manage clients who were considering self discharging.

GPs working with the service did not receive supervision for the substance misuse work they undertook. This did not follow best practice guidance (NICE, 2011).

Staff received regular supervision. Areas of staff development were identified and staff received feedback regarding their work and performance.

Multidisciplinary and inter-agency team work

Staff from different disciplines worked together as a team to benefit clients. The team had effective working relationships with relevant services outside the organisation

Nursing staff attended shift handover meetings to discuss clients' treatment, risks and needs. During weekdays, multidisciplinary clinical meetings also took place. Staff and GPs worked collaboratively and had effective working relationships.

The service had developed a protocol with a local out of hours GP provider. This protocol included a range of treatment interventions for clients, should staff contact the out of hours service. However, the GPs working in the out of hours service were not substance misuse specialists. Typical scenarios were included in the protocol which involved the out of hours service providing remote advice or prescriptions.

The service had close links with the local acute hospital trust. When clients were transferred to hospital staff would contact the alcohol liaison team at the acute hospital. Staff would also liaise with acute hospital staff if clients were stabilised and safe to return to the service. Some of the policies used by the acute hospital trust were used in the service.

Good practice in applying the MCA

Some staff had undertaken Mental Capacity Act training. Staff did not know how to lawfully support clients who lacked mental capacity.

Inadequate

Residential substance misuse services

Six staff (38%) had undertaken Mental Capacity Act training. Staff, including senior staff, were not knowledgeable about mental capacity. Some clients attended the service when intoxicated and others had cognitive problems. Clients' mental capacity was not assessed on admission, when there was a good reason to do so. Staff could not describe the process of assessing clients' mental capacity. Staff could not describe how they could continue to provide care and treatment for clients who lacked capacity, within the law.

Are Residential substance misuse services caring?

Good

Our rating of caring stayed the same. We rated it as good.

Kindness, dignity, respect and support

We observed and received feedback, that staff treated clients with compassion and kindness.

The five clients we spoke with were very positive regarding the support they received from staff. Clients said that staff were very helpful and understanding. Staff were supportive, developed good relationships with clients and treated clients as individuals. Clients also said that staff were good at motivating them to remain abstinent from substances and responded when clients needed support.

Staff supported clients to access other services. For example, at the time of the inspection, staff were assisting one client to be able to go to residential rehabilitation following their detoxification treatment.

The involvement of people in the care they receive

Clients' were shown around the service when they were admitted. They were also introduced to other clients and provided with a welcome pack.

Clients' views and hopes about treatment and their recovery were described in detail in their care plans. Clients said that staff explained things to them in ways they could understand. This included the medicines that clients were prescribed and possible side effects. However, clients' involvement with their own risk assessment and risk management was limited or absent.

Clients were able to provide feedback about the service each morning during the 'check in' meeting. Staff responded to resolve clients' concerns the same day if this was possible.

Client feedback was not collected and collated consistently. Recent client feedback consisted of five feedback forms from clients since November 2021. There was no formal monitoring of themes and trends from client feedback.

Inadequate

Residential substance misuse services

Are Residential substance misuse services responsive?

Inadequate

Our rating of responsive went down. We rated it as inadequate.

Access and discharge

The service admitted clients with serious and significant physical and mental health problems, which the service could not safely provide care and treatment for. There was no inclusion and exclusion criteria for the service. Since the beginning of 2021, 13 clients had been transferred by emergency ambulance from the service to hospital. On two occasions there had been a delay in transferring clients by ambulance.

Transfers to hospital had occurred at various stages in clients' treatment, including when a client attended the assessment for admission. Concerns regarding clients' health were reviewed with GPs during the day, wherever possible, and clients were transferred to hospital during the day and early evening. On some occasions, clients were transferred to hospital for a few days until their physical health was stabilised. They were then transferred back to the service to complete treatment.

In the three months before the inspection, 29 clients had an unplanned discharge from the service. This involved them self-discharging or being transferred to hospital.

In the three months before the inspection the average bed occupancy was 13 clients per night. This ranged from seven clients to 23 clients per night. Clients were admitted on four days per week. Between one and four clients were admitted on each of those days. Clients were admitted for a fixed period of seven to 28 days, depending on their treatment needs.

The facilities promote recovery, comfort, dignity and confidentiality

The service had a range of rooms to support clients with their care and treatment. In addition to the dining room there were three lounges, one of which was females only. There were activity spaces for groups and a large outside space. Clients had their own bedrooms and shared communal bathroom facilities. There was a female only area with bedrooms and bathroom facilities.

Clients had a safe in their bedroom to store valuables.

There were no communal telephone facilities. As part of clients' contract when they were admitted, clients agreed to make phone calls at a specific time in the evening. Clients could make phone calls in private but they could only last for ten minutes maximum.

Clients had access to drinks and snacks throughout the day and night. Two clients specifically mentioned that the cook was good and the food was very good. There was enough food so that clients could regain weight lost through substance misuse.

Meeting the needs of all people who use the service

Inadequate

Residential substance misuse services

The service met the needs of clients with a protected characteristic or with communication support needs.

The service was accessible for clients who were wheelchair users. The service had an ensuite bedroom suitable for a wheelchair user. The service also had a lift.

Leaflets were available for clients. However, there were no easy read leaflets. The provider had recently introduced a policy regarding the accessible information standard. This policy was not being followed at the time of the inspection. Leaflets were only available in English. Staff used online translation programmes and face-to-face or telephone interpreters when required.

Clients individual faith needs were catered for in a number of ways. Prayer mats were available and group times were changed to accommodate prayer times. Clients' religious or other dietary requirements were accommodated.

When clients were unable to obtain support for their pet during their detoxification treatment, they could bring their pet into treatment with them.

Listening to and learning from concerns and complaints

Clients had made two complaints to the service in the three months before the inspection. One complaint was not upheld. The other complaint did not have an outcome at the time of the inspection.

The provider had a comprehensive complaints policy in place. The policy included an appeals mechanism. If a complainant was unhappy with the outcome of their complaint, or how it was investigated, they could appeal the decision.

Complaints about the service had previously been reviewed during the service clinical governance meeting. At a recent clinical governance meeting there had been discussion regarding complaints being part of the clinical governance standard agenda.

Are Residential substance misuse services well-led?

Inadequate

Our rating of well-led went down. We rated it as inadequate. Our rating is limited to Inadequate by the enforcement action we have taken.

Vision and values

The provider had values of ambition, empowerment, inclusivity and transparency. The PIE model of care and how the service operated followed these values.

The provider's vision for the service had been affected by a number of factors. The incremental increase in the complexity and risks of clients, together with less clinical support, meant that the provider and managers had been conditioned to complexity and risk. Their vision did not reflect the increasing risks to operating the service safely.

Inadequate

Residential substance misuse services

The service had been treating clients with more complex needs for some time. The previous arrangements with a local mental health trust had included a clinical nurse specialist and a psychiatrist working in and with the service. When this arrangement had ended, the provider had not adapted to the additional risks this would bring with an increasingly complex client group. Wider pressures within the substance misuse sector in London added to the challenges the service had with providing care and treatment to clients in a safe way.

Good governance

Governance processes did not work effectively and there were gaps in the governance system. Performance and risks in the service were not managed well.

Items such as safeguarding and complaints were not standard agenda items for clinical governance or team meetings. There was no evidence that these areas were discussed at these meetings. Learning from incidents was not embedded and lacked a structured approach to identify root causes of incidents and to implement and monitor a range of actions to minimise repetition.

Policies for detoxification treatment did not include prescribing protocols. There was a lack of clinical audits. Basic standards for audits such as using objective tools and templates and documenting audits undertaken were not followed.

The governance system was not structured. Individual elements, such as audits, training and learning from incidents were not collated into overarching systems so that performance, themes and trends could be monitored and proactively addressed. The risk register for the service did not identify any of the risks to safety which we identified during the inspection.

We identified seven incidents in May and June 2021, when the provider was legally required to send notifications to the CQC of those incidents. Six incidents concerned serious injury and the seventh required a notification for either alleged abuse or serious injury.

Leadership, morale and staff engagement

There was a lack of appropriate clinical leadership within the service. No consultant psychiatrist was available on site, as a result of the pandemic and medical input was provided by GPs, some of whom did not have the relevant specialism in substance misuse.

Staff described the providers' senior leaders being absent during the Covid pandemic. Senior managers had not been visible or attended the service and some staff did not know who the senior managers were. Staff did not feel engaged with the senior management team.

Staff were positive regarding the manager of the service and their leadership style. They said that the culture of the service had improved during the previous year. Previous tensions between registered and non-registered staff had eased. The manager sought staff views on areas of change in the service.

Staff morale had improved. Staff believed that their work was important and got satisfaction from seeing clients discharged after treatment, with improved physical and mental health.

Commitment to quality improvement and innovation

Inadequate

Residential substance misuse services

The provider and managers were committed to improving the quality of the service and client outcomes. However, they were not using any formal quality improvement methodology or structured approach to quality improvement.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Care and treatment of service users was not always provided with consent or in accordance with the Mental Capacity Act 2005. **Regulation 11(1)(3)**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were not a sufficient number of staff deployed at all times in the service. Staff did not receive appropriate training for them to carry out their duties. Rates of mandatory training were low. **Regulation 18(1)(2)(a)**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Staff did not design care or treatment with a view to ensuring service users needs were met. Clients' care plans did not include care planning for their assessed needs. **Regulation 9(3)(b)**

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The service did not make notifications to CQC as required. **Regulation 18(1)(2)(b)(e)**

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Staff were not able to identify potential safeguarding risks to clients and did not know how to make a safeguarding referral.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance An effective governance system was not in place.