Greig House

Quality Report

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

Overall summary

- Greig House provides residential detoxification, care and support for up to 20 people with alcohol and/or drug dependency. We identified serious concerns about the care and treatment of patients going through alcohol detoxification. We identified less serious concerns about patients undergoing opiate detoxification.
- People at high risk of alcohol withdrawal seizures and delirium tremens were admitted to the service. Such people should have had alcohol detoxification in hospital. The service did not transfer a patient who required treatment in hospital immediately, as they should have.
- Policies and practices regarding the prescribing and administration of medicines were unsafe. National and professional guidelines were not followed. This increased the risks to patients.
- We informed the provider of our serious concerns regarding the safe care and treatment of patients - Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider voluntarily made a commitment to immediately stop all admissions of patients to the service until all areas of non-compliance had been resolved. The provider also produced an action plan. The Care Quality Commission will monitor the progress of the action plan closely.
- We identified concerns regarding other areas of the service. We have issued the provider with a warning notice and taken other action regarding these concerns.
- There were a large number of thank you cards on display from recent patients. They described the staff as caring and kind.

Summary of findings

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Summary of this inspection

Background to Greig House

Greig House is registered to provide residential detoxification, care and support for up to 20 people with alcohol and/or drug dependency.

Greig House 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 for the service.

The service received referrals from various organisations inside and outside of London.

We have inspected Greig House twice since 2010, most recently in July 2013. At that time, Greig House met essential standards, now known as fundamental standards.

Our inspection team

Team leader: Steve George, Care Quality Commission

The team that inspected the service comprised two CQC inspectors, a CQC inspection manager, two CQC pharmacist specialists, and two specialist advisors. The specialist advisors were a consultant psychiatrist in addictions and a senior nurse with experience in substance misuse. The inspection team also included an expert by experience. This is someone who has used, or cared for someone using, a similar service.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

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?

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- visited the service and looked at the quality of the environment and observed how staff were caring for patients
- spoke with three patients who were using the service
- spoke with the registered manager
- spoke with five other staff members; the programme co-ordinator, acting clinical team leader, the doctor, a nurse and a support worker
- received feedback about the service from two commissioners
- attended and observed a patient assessment, a handover meeting and two patient groups
- looked at five care and treatment records of patients
- carried out a specific check of the medication management in the service
- looked at a range of policies, procedures and other documents relating to the running of the service.

We left comment cards for people who were using the service to complete, but did not receive any in response.

Summary of this inspection

What people who use the service say

We spoke with three patients. They said staff were kind, caring and considerate. There were a large number of thank you cards from previous patients supporting this view.

Patients raised concerns regarding the number of one-to-one meetings with staff. These meetings did not always happen shortly after admission. Not all patients had regular one-to-one meetings.

Patients were positive regarding the food in the service.

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?

- The service accepted patients at high risk of withdrawal seizures and delirium tremens. This did not reflect national guidance.
- Staff did not prescribe or administer medicine for alcohol detoxification in a safe way. Medicine was administered without a prescription and important safety checks were not in place. Staff did not follow national and professional guidance.
- Staff did not undertake safeguarding children training and did not always follow best practice.
- The sharps bin was filled to the top. This was an infection control risk. The infection control audits were not effective.
- Eighty three per cent of staff had not received recent training in cardiopulmonary resuscitation. Fifty per cent of staff had not received recent infection control training.
- There were no policies or procedures for patient observations, the disposal of needles and sharp instruments, or for pregnant patients.
- There was no ligature risk assessment for the 'high risk' bedrooms. These were the bedrooms used during the initial stages of patients' detoxification. This was a risk as the service treated people with a history of self-harm or suicide attempts.

However, the service had identified an increased number of patient falls. Action had been taken and the number of falls reduced. Following incidents, staff and patients had a debriefing.

Are services effective?

- The assessment and treatment of patients did not reflect national guidance.
- The quality of patient care plans was variable. Care plans were not personalised or holistic.
- The prescribing and administration of medicines did not reflect national and professional guidance.
- Patients admitted for opiate detoxification were not aware of the risks and benefits of different medicines that could be used. National guidance was not followed.
- Outcome measures for the service were basic and limited.
- The doctor in the service was not a specialist, and did not receive appropriate supervision. Not all staff received regular supervision.
- The system for recording patients' informed consent was not effective.

Summary of this inspection

- An effective training needs analysis had not been undertaken.
- Not all relevant patient information was consistently discussed during staff handover.
- Some senior staff could not describe the five statutory principles of the Mental Capacity Act.

However, one-to-one meetings with patients were recorded in detail. Visiting staff offered art therapy, reiki, massage, aromatherapy and acupuncture. Counsellors would attend the service at short notice, at the request of staff. A mutual aid organisation attended the service weekly to support patients.

Are services caring?

- Thank you cards from former patients described staff as caring and kind. All of the patients told us that the staff were kind and considerate.
- Patients were involved in their care and treatment.
- Patients were involved in interview panels for staff.
- Patients could provide feedback about the service at weekly community meetings. An action plan followed.
- In 2014/2015, 95% of patients were very satisfied overall with their care and treatment.

However, care plans did not reflect patient involvement. Staff had a basic understanding of patients' needs. Safety issues concerning individual patients' treatment were not well understood. Patients' emotional and mental health needs were not always fully understood. There were no specific aspects of the service designed for carers or families.

Are services responsive?

- Patients were usually admitted to the service within 48 hours of referral.
- There was a clear procedure when patients were discharged from the service.
- Each patient was provided with a detailed handbook. The handbook contained a range of useful information. Patients were provided with information on how to complain in their handbook.
- A questionnaire regarding the complaints process was sent with the providers' response to complaints.

However, patients at high risk of having withdrawal seizures or delirium tremens were admitted. There was a lack of information in a range of languages.

Summary of this inspection

Are services well-led?

- Systems and processes in the service were not effective, did not mitigate risks, or improve safety and quality.
- Policies and practices which involved the prescription and administration of medicines were unsafe. Professional guidance and national clinical guidance were not followed.
- Policies and practices regarding alcohol withdrawal seizures and delirium tremens did not follow national guidance. This increased risk to patients.
- The monitoring arrangements for staff supervision were ineffective. The supervision arrangements for the doctor in the service did not reflect national guidance.
- Two clinical audits were undertaken; neither was comprehensive. One of the audits was not undertaken regularly.
- Staff did not have all of the necessary employment checks before working in the service. The providers' own policy was not followed.
- There were no policies or procedures regarding observations, sharps and pregnant patients.
- There were very limited key performance indicators.
- The providers' staff conducting internal quality assurance checks had very limited knowledge of substance misuse services.
- The service was professionally isolated. Wider developments in the field had not been identified and adopted.

However, staff were aware of and understood the providers' vision and values. Patients' feedback was used to address patients concerns. There were low levels of sickness and absence in the service. Staff felt able to raise concerns. The management and staff team were committed to making improvements.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

- Mental Capacity Act (MCA) training was not mandatory. However, nine staff (75%) had undertaken MCA training prior to the inspection.
- Two senior staff members could not describe the five statutory principles of the MCA. One could not describe the two stage test; the other could only describe stage two.
- After admission, some patients may not have had the capacity to make certain decisions. This could be due to intoxication or withdrawal symptoms. All patients were asked to sign their consent to take medicines. This process was repeated the following day.

Substance misuse/detoxification

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse/detoxification services safe?

Safe and clean environment

- The clinic room was clean. However, the medicines refrigerator was dirty. Ice had built up at the back of the refrigerator. This meant medicines were stored at too low a temperature. One medicine in the refrigerator was labelled 'do not freeze'. Refrigerator temperatures were checked most days. We saw staff washing up crockery in the clinic room sink, which was an infection control risk.
- The sharps bin, used to dispose of needles and syringes, was filled above the 'fill line', close to the opening of the bin. This was an infection control risk. The service did not have a sharps policy. This was a breach of the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- A breathalyser was used in the service to measure patients' breath alcohol level. The breathalyser should have been calibrated monthly. However, it had not been calibrated for eight months. This meant incorrect breath alcohol readings could be given. Disposable thermometers were also past their expiry date.
- The service was visibly clean and cleaning staff followed a set cleaning schedule. However, there was a smell of urine near the unisex bedrooms.
- Monthly infection control audits were undertaken. The audit was large and had been broken down into separate parts. One part would be undertaken each month. Parts of the audit would not be done for five consecutive months.
- There was a health and safety risk assessment for the service. This included assessing risks in the building. Two unisex bedrooms were for people who presented with a high level of risk during detoxification. However, there was no ligature risk assessment of these rooms. The service treated people who had a history of self-harm, suicide attempts or mental health problems. The risks of using the unisex rooms had not been fully assessed.
- The service had a locked door controlled by staff. Closed circuit television (CCTV) was used inside and outside of the building.
- Fire equipment was maintained, and the fire alarm was tested weekly. Fire drills were conducted regularly.

Safe staffing

- The service had a registered manager, acting clinical team leader and programme co-ordinator. This was the management team for the service. There were also four nurses and seven support workers. The service also had an administrator and maintenance person.
- Two staff had left the service in the previous year (13%). There was one staff vacancy. The majority of the staff had worked in the service for several years. Sickness levels in the previous year were 1.7%.
- During the day one nurse and two support workers were on duty. At night, there was one nurse and one support worker. Additional staff were on shift when a patient required frequent or continuous observation. One of the management team was available by telephone at the weekend. Patients described a lack of one to one meetings. One patient had only one one-to-one meeting in ten days. Another patient had their first one-to-one meeting four days after admission. Patients reported that the service did not have enough staff.
- When there was staff sickness or absence, regular staff could work overtime. Agency staff were also used. Agency staff undertook an induction to the service. A small group of agency nurses and support workers worked regularly at the service.
- Staff were able to contact the doctor in the service at any time of the day or night. The doctor also had other employment. During the inspection, we observed that

staff spent a number of hours attempting to speak with the doctor. Patients were admitted during the daytime and the doctor attended the service in the evening. The doctor could not attend the service at short notice.

- We reviewed the employment records of four staff. The provider had not carried out the appropriate checks before they started working in the service. Two of the staff had no references from previous employers. A further member of staff had one reference rather than the required two. The provider had not obtained evidence of satisfactory conduct in previous employment for all staff. This was not in accordance with the providers' policy. Two staff had not had Disclosure and Barring Service (criminal records) checks against the list of people barred from working with children.

Assessing and managing risk to patients and staff

- Staff carried out a risk assessment of patients on admission to the service. The severity of each risk was scored 0 to 10. The scoring of assessed risks did not always correspond with other information available. One patient who had been using multiple illicit substances prior to admission, was scored as '0' for risk of illicit drugs. This meant some areas of potential risk were not identified. Where risks were identified, a plan was made to reduce the risks. Clinical risk assessment was not classified as mandatory training for staff. Five staff (41%) had undertaken clinical risk training in 2012. There was no record that other staff had received such training or learnt about clinical risks. This meant that some staff would not be able to safely assess and manage patients risks.
- Alcohol detoxification was not being provided in a safe way. Patients were admitted to the service in the morning or afternoon and were assessed by a nurse. Shortly after being admitted, most patients experienced alcohol withdrawal symptoms. These symptoms can become serious, and include seizures and delirium tremens, which can result in death. The doctor did not attend the service until the evening. Following a telephone conversation with the doctor, nursing staff administered medicines to newly admitted patients. During the inspection, a new patient developed withdrawal symptoms. They had been assessed to be at high risk of withdrawal seizures. It took some hours before staff could speak with the doctor and administer medicine to the patient. This patient also had their bedroom on the first floor rather than a ground floor unisex room. As the patient was at high risk of seizures, they should not have needed to climb stairs.
- Some patients had required frequent or continuous observation by staff. There was no observation procedure or policy. Some guidance on observation was provided in the procedure regarding falls. However, this did not relate to when a patient was at increased risk of harming themselves. Different observation skills were required. There was no guidance regarding how long staff should observe the patient. This meant that staff could potentially observe a patient for many hours. The risks, including reduced concentration, had not been assessed. There was also no procedure for providing detoxification to pregnant women. The service had provided alcohol detoxification to a pregnant woman in the previous year. This meant that any specific guidance concerning the health and safety of pregnant women undergoing detoxification was not available to all staff.
- The service had developed a procedure for when patients had a withdrawal seizure. The procedure described how staff should monitor the patient. It also described the medicine to be administered in specific situations. The procedure did not reflect national guidance (Alcohol-use disorders: diagnosis and management of physical complications, National Institute for Health and Care Excellence [NICE], 2010; Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence, NICE, 2011). In the previous year, one patient had an alcohol withdrawal seizure. Several months prior to the inspection, a patient exhibited some symptoms of delirium tremens. The doctor reviewed the patient the same evening and recommended further 'as required' medicine. It was not until the following day that the patient was taken to hospital in an ambulance. The service procedure, and staff, described how medicine would be administered if a patient had symptoms of delirium tremens. This was not in accordance with national guidance (NICE, 2010). In the previous 12 months, three patients had been transferred to hospital with suspected delirium tremens. The service admitted patients who were assessed as being at high risk of withdrawal seizures or delirium tremens. National guidance states that such people should be offered admission to hospital for alcohol detoxification (NICE, 2010).

Substance misuse/detoxification

- When patients left treatment early or took a self-discharge, they were provided with written information. For patients undergoing alcohol detoxification, the information described the risk of alcohol withdrawal seizures. If these occurred, the patient was advised to see their general practitioner (GP). If a person experienced hallucinations, as in delirium tremens, they were advised to go to their GP. The information did not advise patients to attend hospital as per national guidance (NICE, 2010). It did not advise patients how to minimise the risks of seizures or delirium tremens. When patients had successfully completed alcohol detoxification, written information did not alert them to the risk of substituting alcohol with other illicit substances.
- The provider identified mandatory training for staff to undertake. Ten staff members (83%) had not undertaken cardiopulmonary resuscitation training within the last year. Eight staff members (66%) had received training more than two years previously. This was not in accordance with Resuscitation Council (UK) guidelines. Six staff members (50%) had not received infection control training within the last two years. This was not in accordance with The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections (2015).
- One member of staff had not undertaken safeguarding adults training. Another staff member had last received safeguarding adults training in 2009. This meant some staff members might not be aware of signs of abuse. Safeguarding children training was not identified as mandatory training. There was no record of any staff having undertaken safeguarding children training. A staff member said it was not needed in the service. When new patients were admitted, staff asked if the patient had children. However, they did not ask further questions to assess the children's safety. This was not in accordance with national guidance (Drug misuse and dependence: UK guidelines on clinical management [orange book], Department of Health [DH], 2007; NICE, 2011). Staff and patients told us that when children visited they were the responsibility of the adult visitor or the patient. However, when children visited the service, staff did follow the providers' policy. This included undertaking a risk assessment prior to a child visiting. There had been no safeguarding adults or children referrals by the service in the previous year.
- The service had procedures for administering medicines before the doctor had assessed the patient. This involved 'verbal orders' and was routine practice. This had occurred with a patient who had recorded liver impairment. Patients with liver impairment require a full assessment before receiving medicines. This is because medicines may over sedate such patients. In some circumstances, staff could administer medicine without speaking with the doctor. None of the nurses in the service were able to prescribe medicines as a 'non-medical prescriber'. There was no patient group direction or patient specific direction in place. These are approved and safe ways for staff to administer some medicines without a doctors' prescription. A pharmacist had not been involved with the development of medicines procedures. The procedures and practices were not safe and did not follow guidance from professional regulatory bodies (General Medical Council, 2013; Nursing and Midwifery Council [NMC], 2010). The provider conducted a medicines audit. This was meant to take place every two weeks. However, the medicines audit had been carried out nine times in the previous ten months. For five months, no medicine audit had been undertaken. The audit did not include checking the temperature of the medicine room. The expiry date of medicines was not checked. During the inspection, we found five medicines in the medicines cupboard were past their expiry date. Two medicines had expired more than five months previously. This meant the medicines may not have the effect they should have. Liquid medicines did not have the date the bottle was opened recorded. Five previous patients' 'patients own' medicines were being used as stock medicines. This was not in accordance with the service procedure, or with professional guidance (NMC, 2010). Medicine administration records (MAR) contained 11 pre-printed medicines. One of the pre-printed items was for 'oxazepam/chlordiazepoxide'. Either medicine can be used for alcohol withdrawal symptoms. On some MARs, one of the medicines had been crossed through. On two MARs, neither medicine had been crossed through. This was unsafe as either medicine could be administered by different staff at different times. Controlled drugs were administered for opiate detoxification. A nurse and support worker would administer and check these medicines. There was no evidence of checks on the competence of staff to administer medicines safely.

Substance misuse/detoxification

Track record on safety

- There had been no serious incidents in the service in the previous year.
- In the previous year, three patients were transferred to hospital with suspected delirium tremens. One patient had an alcohol withdrawal seizure. There was no evidence that these incidents had been investigated, or that any action had been taken to prevent them happening again.
- Nine patients had experienced falls. The management team had identified the increasing frailty of patients and the increased number of falls. A new falls procedure and falls risk assessment had been introduced. Staff had received training regarding the new procedure and risk assessment. This had resulted in a decrease in falls. In the three months prior to the inspection, there had been no incidents of patients falling.

Reporting incidents and learning from when things go wrong

- There were 14 accidents and incidents recorded in the previous year. Four different types of incident or accident were recorded. There were no reports of medicine errors, contraband items, contract breaches or aggression. There were no reports of 'near misses'.
- Where a mistake was made, the manager was informed. The manager understood their responsibilities under the duty of candour.
- When incidents had been investigated, the outcome was discussed in the team meeting and following handover. The discussion included how such incidents could be minimised in future.
- Following incidents staff had a debriefing. Patients also had a debriefing.

Are substance misuse/detoxification services effective?
(for example, treatment is effective)

Assessment of needs and planning of care

- Referral information, completed prior to a patients' admission, was comprehensive and detailed. However, one patient was admitted to the service when blood results for liver function were not available. This meant there was a risk of the patient being over sedated if they had unrecognised liver impairment. Each patient was assessed by a nurse shortly after they were admitted to the service. Patients' height and weight, blood pressure and pulse were taken. The patient also had a urine sample tested for illicit drugs. Later the same day, the doctor assessed the patient. This included the patients' medical history and current health problems. Patients also provided a breath alcohol level by using a breathalyser. Each patient had a thorough physical examination. Although some patients complained of low mood and panic attacks, their mental health was not assessed in detail. This meant the possible severity of symptoms was not always understood by staff. Patients admitted for alcohol detoxification did not have a brief cognitive assessment. This included patients with reported memory or orientation problems. This was not in accordance with national guidance (NICE, 2011). The assessment of patients for alcohol detoxification did not include the use of validated tools, such as the Severity of Alcohol Dependence Questionnaire (SADQ) or Alcohol Problems Questionnaire (APQ). It is recommended that such tools are used when assessing patients for alcohol detoxification (NICE, 2011). Using these tools would assist in the decision of the doses of medicine required for the patients' alcohol detoxification. There was a risk that patients would not receive the correct dose of medicine, leading to alcohol withdrawal symptoms.
- Patients had care plans for alcohol detoxification, opiate detoxification, or both. The quality of care plans varied. Some care plans described the frequency of physical observations during the initial stages of detoxification. Other care plans made general statements for staff to monitor the patient for withdrawal symptoms and to 'offer support.' Care plans did not describe how the patient wanted to be supported. Patients' views and preferences were not included in the care plan. There were no care plans addressing patients mental health problems, spiritual needs, or of them leaving treatment early. As care plans covered detoxification treatment only, they were not personalised or holistic.
- Patients' care records were stored securely. Their day to day progress was clearly documented. The recording of individual one to one sessions was very detailed.

Best practice in treatment and care

- National guidance was not followed for people undergoing alcohol and opiate detoxification. There was no record of discussions with patients regarding the choice of medicine for opiate detoxification. The

discussions should include the risks and benefits of each medicine and the patients' preference (Methadone and buprenorphine for the management of opioid dependence, NICE, 2007). All of the patients undergoing opiate detoxification received the same medicine. There was no protocol or procedure describing how medicine would be titrated to the needs of the patient. Titration is when a dose of medicine is increased until it achieves the desired effect. For people undergoing opiate or alcohol detoxification the desired effect would be control of withdrawal symptoms. National guidance (DH, 2007) recommends the use of local protocols. For patients undergoing alcohol detoxification there were five medicine detoxification regimes. None of the regimes were signed, dated or had a review date. There was no protocol for the lofexidine and oxazepam detoxification regimes. All of the regimes involved a fixed dose reduction of medicine over a period of seven days or less. Medicine was not titrated before detoxification, to ensure patients' withdrawal symptoms were controlled. The duration of the detoxification was fixed and could not be extended according to patient need. This meant there was an increased risk that patients would experience withdrawal symptoms. A symptom-triggered detoxification regime should have been used by the service (NICE, 2010). The service used the Clinical Institute Withdrawal Assessment – Alcohol, revised (CIWA–Ar) scale to measure patients' withdrawal symptoms. The use of this scale was in accordance with NICE guidance (NICE, 2010; NICE, 2011). However, staff did not always use the CIWA-Ar scale before the doctors' assessment. Some of the service procedures authorised staff to administer medicines before being assessed by the doctor. The procedures described how this was dependent on the patients' withdrawal symptoms, or a patients' breath alcohol level. However, national guidance states 'breath alcohol should not usually be measured for routine assessment and monitoring in alcohol treatment programmes' (NICE, 2011). Patients undergoing alcohol detoxification were also prescribed an injectable medicine. This medicine reduces the risk of memory and cognitive problems resulting from alcohol dependency. Patients at the service were routinely prescribed the medicine for three days. National guidance recommends the medicine is administered for five days (NICE, 2010). Following successful alcohol detoxification, patients should be considered for one of three medicines to assist with abstinence (NICE, 2011). The service was able to offer one of the medicines.

- One patient signed a consent form for one medicine and was administered another. Another patient consented to medicine for alcohol detoxification. There was no record of their consent for opiate detoxification, which they were also undergoing. The document for alcohol detoxification described alternative medicines that could be prescribed. Patients were asked to sign their consent. It was unclear if patients were providing informed consent in these circumstances.
- The service offered a structured programme of psychological interventions. Relapse prevention groups used cognitive behavioural techniques. Motivational groups also took place using motivational interviewing techniques. These psychological treatment approaches are recommended (NICE, 2011; DH, 2007).
- Outcome measures for the service were basic. The key performance indicators measured successful completion of treatment and patients' self discharge.
- Clinical audits were undertaken by the acting clinical team leader. Audits were limited to the medicines audit and clinical records audit. The clinical records audit reviewed the presence of certain documents in patients' records, rather than the quality of them.

Skilled staff to deliver care

- The staff team at the service included nurses, support workers and a doctor. There was no input from a pharmacist.
- The doctor at the service had worked in substance misuse services previously. However, they had not received specialist training. They did not receive supervision from a substance misuse specialist doctor. This was not in accordance with national guidance (Public Health England, 2014; Royal College of Psychiatrists, 2012). All staff had significant experience in the substance misuse field. Support workers roles had been matched to the Drug & Alcohol National Occupational Standards (DANOS). This meant that support workers' skills and competency levels had been matched to national standards.
- Staff were due to receive supervision every six to eight weeks. Two support workers and the administrator had

not received supervision for three consecutive months in the previous year. Two nurses and three support workers had received supervision four times in the previous 10 months.

- Seventy five per cent of staff had received an appraisal within the previous 12 months. The remaining 25% of staff had received an appraisal within the previous 18 months.
- Staff undertook specific training, such as on 'legal highs' and blood borne viruses. Some staff were trained to give auricular acupuncture. However, an effective training needs analysis had not been completed. This meant that the range of staff training required to meet patients' needs had not been assessed. Although patients being admitted were more frail than previously, only one member of staff had undertaken any physical health training recently. This training was on diabetes.
- The service had a range of qualified visiting staff. These staff offered art therapy, reiki, massage, aromatherapy and acupuncture.

Multidisciplinary and inter-agency team work

- Regular team meetings took place in the service. However, the doctor did not attend these meetings.
- Handover meetings took place when staff started their shift. All of the staff team could contribute to the handover. We saw that the handover was focussed on patients' physical healthcare and medicines. Mental health support for patients was not always discussed during the handover. Patients' observation levels were not always discussed. This was also the case with newly admitted patients who had not been assessed by the doctor. The handover did not consistently ensure that all relevant information was communicated to the next shift. At the end of the handover, we observed that duties were not allocated to staff for the next shift. This meant that care could be disjointed and important duties delayed or missed.
- The service maintained excellent links with other services offered by the provider. Specific religious support was provided weekly and was optional for patients. One of the providers' counsellors attended the service at short notice, at the request of staff.
- A mutual aid organisation (alcoholics anonymous) attended the service weekly to support patients. The service had a good relationship with the local pharmacist. As patients kept their own GP from where they lived, there were no links with local GP services. If a patient required physical healthcare, staff would escort them to the emergency department at the local hospital. This was not always necessary, and in some cases, a GP would have been more appropriate. Links with other agencies varied, due to patients coming from a wide geographical area.

Good practice in applying the MCA

- Mental Capacity Act (MCA) training was not mandatory. However, nine staff (75%) had undertaken MCA training prior to the inspection.
- Two senior staff members could not describe the five statutory principles of the MCA. One could not describe the two stage test; the other could only describe stage two.
- After admission, some patients may not have had the capacity to make certain decisions. This could be due to intoxication or withdrawal symptoms. All patients were asked to sign their consent to take medicines. This process was repeated the following day.

Are substance misuse/detoxification services caring?

Kindness, dignity, respect and support

- Staff were observed to be patient, kind and caring. They were polite, and treated patients with dignity and respect.
- There were a large number of thank you cards on display from recent patients. They described the staff as caring and kind. All of the patients told us that the staff were kind and considerate. There were no negative comments regarding the qualities of the staff.
- Staff had a basic understanding of patients' needs. Safety issues concerning individual patients' treatment were not well understood. Patients' emotional and mental health needs were not always fully understood. Identification of, and support with, such needs was limited.
- Staff and patients were fully aware of the need to maintain confidentiality. Patients had information on confidentiality in their handbooks. Patients were able to discuss personal matters openly.

The involvement of people in the care they receive

Substance misuse/detoxification

- Patients were involved in their care and treatment. This was evident in the documentation from one-to-one sessions. However, care plans did not reflect patient involvement.
- There were no specific aspects of the service designed for family members or carers.
- Patients did not have access to advocacy in the service.
- Patients were involved in interview panels for staff. They could also place ideas in a 'suggestion' box.
- Patients could provide feedback about the service at weekly community meetings. There was an action plan attached to the minutes of the meeting to respond to patients' concerns. Changes made following informal concerns included more flexible visiting times and access to mobile phones. Patients were also provided with an evaluation form before they left the service. This form was anonymous and asked the patient about various aspects of their care and treatment. In 2014/2015, 95% of patients were very satisfied overall with their care and treatment. Approximately 75% of patients were very satisfied with the programme, one to one meetings and meals.

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

Access and discharge

- Almost all of the patients being admitted to the service were funded by commissioners. Once a referral was received, the acting clinical team leader reviewed this. Where necessary, further information was obtained. When a patient was assessed as having complex needs, the doctor also reviewed the referral. If referral information was complete, the service admitted people within 48 hours of the referral.
- The provider only excluded people from being admitted to the service on clinical grounds. This meant that the service would be unable to meet their medical needs. However, patients at high risk of having withdrawal seizures or delirium tremens were admitted. Such people should be offered admission to hospital for detoxification (NICE, 2010).
- When patients were discharged from the service, there was a clear procedure to ensure that other agencies were informed. Patients were also provided with written information concerning their safety. However, information for alcohol dependent patients leaving treatment early did not minimise risks to patients.

The facilities promote recovery, comfort, dignity and confidentiality

- The service was in a large building with a number of rooms where patients could meet with staff or visitors.
- Patients did not have keys to their bedrooms. Their bedrooms were left unlocked.
- Each patient was provided with a handbook when they were admitted. The handbook included information about medicines, treatment and withdrawal symptoms. Community living guidelines, and information on confidentiality and complaints was included. There was also information regarding leaving treatment early, and a suggested after care plan. General health advice and relapse prevention techniques were also in the handbook.

Meeting the needs of all people who use the service

- The service was wheelchair accessible. There was a unisex disabled bedroom available.
- Information and leaflets were written in English. There was a lack of information in other languages.
- Patients with different religions and faiths were able to undertake religious observance.
- Interpreters were available for patients whose first language was not English.

Listening to and learning from concerns and complaints

- In the previous year, there had been five complaints about the service. Two complaints were upheld. None of the complaints were appealed through the providers' own appeals process.
- Patients were provided with information on how to complain in their handbook. The outcome of each complaint was provided in writing. Attached to this was a questionnaire regarding the complaints process. A self-addressed envelope was included for patients or relatives to post the questionnaire back.
- Complaints were monitored in the management team meetings. The outcome of complaints was discussed in team meetings. On some occasions, the outcome would be discussed with staff in individual supervision.

Substance misuse/detoxification

Are substance misuse/detoxification services well-led?

Vision and values

- All staff were fully aware of, and understood, the providers' vision and values. Staff shared these values.
- The service objectives fully reflected the organisations' vision and values.

Good governance

- The systems and processes in the service were not effective. They did not effectively assess, monitor and improve the safety and quality of services. Risks were not appropriately identified, monitored and mitigated.
- Policies and practices which involved the prescribing and administration of medicines were unsafe. There were inappropriate or absent detoxification protocols. Professional guidance and national clinical guidance were not followed. Staff had not been assessed as competent to administer medicines. Some medicines were out of date or stored inappropriately.
- Policies and practices regarding alcohol withdrawal seizures and delirium tremens did not follow national guidance. This increased the risk to patients.
- The monitoring arrangements for staff supervision were ineffective. Some staff received regular supervision, other staff did not. The supervision arrangements for the doctor in the service did not reflect national guidance.
- Two clinical audits were undertaken; neither was comprehensive. One of the audits was not undertaken regularly.
- Staff lacked understanding of child safeguarding, although the provider had a child safeguarding policy. Staff did not attend safeguarding children training.
- Staff did not have all of the necessary employment checks before working in the service. The providers' own policy was not followed.
- Patient consent forms were not always used consistently. It was unclear if patients always provided informed consent for treatment.
- Two senior staff members could not describe the basic elements of the Mental Capacity Act. Both staff members had received MCA training. MCA training was not effective.
- There was learning from some incidents but not others.
- There were no policies or procedures regarding observations, sharps and pregnant patients.
- Patients' feedback was used to address patients' concerns. There was systematic collection of patients' views.
- There were very limited key performance indicators. These involved the outcome of treatment but not the quality and effectiveness of care and treatment. The provider maintained limited oversight of the service.

Leadership, morale and staff engagement

- There were low levels of sickness and absence in the service.
- There were no cases of bullying or harassment.
- Staff told us they felt able to raise concerns.
- Overall, morale was good. Staff believed they made a difference to patients. However, some staff were unhappy with changes to their contracts and terms and conditions. This had involved reduced pay and changes to breaks and subsistence.
- There were opportunities for leadership development and courses for senior staff.
- If a mistake or error was made, this was referred to the manager. The manager was fully aware of their responsibilities in terms of apologising when things went wrong.

Commitment to quality improvement and innovation

- The provider had their own internal quality assurance team. The service was checked regularly. However, the staff conducting the checks had very limited knowledge of substance misuse services.
- The management and staff team in the service were committed to making improvements. However, the service was professionally isolated. Wider developments involving care and treatment, risk management and governance had not been identified and adopted.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must follow national guidance regarding the risk profile of patients admitted to the service.
- The provider must ensure that medicines policies and practice are in accordance with national and professional guidance.
- The provider must ensure that all aspects of care and treatment for patients undergoing alcohol detoxification are in accordance with national guidelines.
- The provider must ensure that comprehensive and effective clinical audits are undertaken on a regular basis.
- The provider must ensure that all staff undertake safeguarding children, safeguarding adults, and cardiopulmonary resuscitation training on a regular basis.
- The provider must ensure that the service has policies or procedures for sharps, observation of patients and pregnant patients.
- The provider must ensure that all of the employment checks required for staff are obtained for existing and new staff.
- The provider must ensure that patients are involved in care planning and can express their views and preferences. Care plans must reflect all of the patients' needs.
- The provider must ensure that the doctor in the service has the appropriate skills, competence and supervision to undertake their role. The provider must ensure all staff receive regular supervision.
- The provider must ensure that there is an effective system for recording patients' informed consent. Staff must be able to assess if patients are providing informed consent.

Action the provider SHOULD take to improve

- The provider should ensure that a ligature risk assessment and management plan is conducted for the 'high risk' rooms in the service.
- The provider should ensure that patients undergoing opiate detoxification are able to discuss the risks and benefits of different medicines with a professional.
- The provider should undertake a training needs analysis to identify the training required to meet patients needs. Staff should receive the identified training.
- The provider should ensure that key performance indicators effectively measure the quality and effectiveness of treatment.
- The provider should ensure that all relevant patient information is communicated during handover.
- The provider should ensure that all staff understand when and how the Mental Capacity Act may be required.
- The provider should review the level and type of support provided for family members and carers.
- The provider should ensure information is available in the most common languages.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The care and treatment of service users was not always appropriate, or did not meet their needs and preferences. Patients were not enabled or supported to understand care and treatment choices or to discuss with a competent health care professional or other competent person, the balance of risks and benefits involved in any particular course of treatment. Care plans for each patient related to alcohol or opiate detoxification. There were no care plans for any other health or social care needs of patients. There was no record that patients had expressed their views and preferences regarding their care plan. There was no record that patients undertaking opiate detoxification had discussed the risks and benefits of different types of medicines with staff. This was a breach of Regulation 9(1)(a)(b)(c)(3)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse 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 the consent of the patient. Some patients received different medicines to those they had consented to take. When multiple medicines were listed on consent forms it was unclear if the patient had provided informed consent. This is a breach of Regulation 11(1)

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not ensure that all staff received appropriate support and training. Some staff members had not received recent safeguarding adults training. Staff had not undertaken safeguarding children training. Most staff had not undertaken recent training in cardiopulmonary resuscitation. This was a breach of Regulation 18(1)(2)(a)

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The provider was unable to provide information specified in Schedule 3 for each person employed at the service. The provider had failed to obtain two references from former employers for each staff member. The provider had failed to ensure that all staff members were not listed on the Barred List for working with children. This was a breach of Regulation 19(3)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had not established, or did not operate effectively, systems and processes to assess, monitor and improve the quality and safety of the service and to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users The infection control, medicines and clinical records audits were not effective. The system for monitoring staff competence, training and supervision was not effective. There was an absence of necessary policies or procedures. Procedures regarding medicines and seizures did not reflect national and professional guidance. This was a breach of Regulation 17 (1)(2)(a)(b)