Ravenscourt

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

We do not currently rate independent standalone substance misuse services.

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

- The majority of mandatory training was delivered during monthly staff meetings, by members of the staff team. We were concerned that the quality of the training provided was unsatisfactory due to insufficient skill on the part of the in-house facilitators (who were not professional trainers) and an insufficient amount of time to properly cover the subject area.
- Risk assessments were of poor quality, lacking necessary details of identified risks. Furthermore, none of the client records we examined contained a plan to manage/mitigate the identified risks.
- There were no policies in place in relation to safeguarding children, duty of candour or mental capacity.
- There was no dedicated system for the recording or investigation of incidents. Notes present in the daily records book were excessively brief. There was no system in place for the auditing of incidents by type or number. There was a lack of clear documentary evidence that incidents had been discussed openly with staff or clients, and so there was no way of evidencing that information had been appropriately shared or that learning had taken place.
- The report resulting from the internal investigation into the death of a client during 2015 was very poor. Although senior personnel were able to communicate their findings and subsequent actions verbally, they were not clearly evidenced in written form.
- Staff occasionally used physical restraint although they had not been trained how to carry it out safely or appropriately. No records were kept on the number of instances of restraint or the type of restraint used.
- The GP assessment for new detox clients was brief, primarily consisting of the GP asking the client to confirm the accuracy of the information they had received from the client's own GP. The GP did not conduct a test to check for the presence of opiates. The prescription written for methadone only cited the total amount of methadone needed for the forthcoming week, rather than stipulating how much methadone was to be administered each day. No record of the information from the client's own GP or the assessment from the detox GP were forwarded to Ravenscourt. None of the six care records we examined contained details of a medical assessment.

Summary of findings

- Medicine records were confusing, since each client had a separate recording sheet for each medicine and there was no differentiation between charts for regularly administered medicines and those for 'as needed' (PRN) medicines. Some entries on the medicines charts had been amended using correction fluid. Medicines were administered by unqualified members of care staff whose training had only consisted of a brief session delivered by one of their colleagues, during the course of a staff meeting.
- There were no formal arrangements in place for structured clinical supervision of the two nurses employed by the service. Staff did not receive an appraisal. Instead, they merely completed a self-assessment questionnaire. Personal development plans were not completed and there was no evidence of a discussion between the members of staff and their line manager, resulting from the questionnaire.
- The minutes of monthly staff meetings were not recorded.
- None of the six care records we examined were signed by the client.
- Some clients perceived that the regime imposed by the service was inflexible and lacked a common-sense approach. As a result, they felt that their dignity had sometimes been infringed.
- Some clients felt that the daily programme was very repetitive, and said there was a shortage of physical activities on offer. The financial contribution expected from clients to attend a weekly swimming session discouraged some clients from attending.
- Audits were infrequent, with some aspects of the service not audited within the last 12 months. The service did not use a risk register; nor did it use key performance indicators (KPIs), to gauge the performance of the team; or, improvement methodologies. There were no clear systems in place for explicitly inviting feedback from clients, or for providing information on how the service had been adapted as a result of comments and suggestions received.
- The general state of the décor and furnishings within the premises was poor and in need of updating.
- The use of twin rooms and lack of gender segregation did not adequately safeguard the privacy and dignity of clients.

However, we also found the following areas of good practice:

- The staff team had no vacancies and a low level of turnover and sickness. The service did not use agency staff, so clients benefitted from being cared for by workers familiar with them and the service.
- Staff had improved the pre-admission assessment process, following a serious incident in 2015, by introducing a list of medical exclusion criteria for admission to the detox service.
- The service had strong links with two local GPs, local charities, and their local community mental health team.
- Three members of staff received specialist advice and support for the counselling and group therapy aspects of their work from an external professional.
- We observed staff treating clients in an appropriate, respectful and supportive manner.
- The facilities contained a range of rooms and spaces that could be flexibly used to meet the needs of clients, including large areas for group sessions, and smaller rooms for individual meetings. Clients had unrestricted access to the kitchen and garden.
- Staff we spoke with did not raise any concerns relating to bullying or a fear of victimisation and there had not been any whistleblowing concerns raised during the period 17 January 2014 to 04 March 2016.

Summary of findings

Contents

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Background to Ravenscourt

Ravenscourt Trust is registered by the CQC to provide the following specialisms/services:

- Accommodation for persons who require treatment for substance misuse
- Substance misuse problems.

Ravenscourt Trust is a registered charity. It has offered a residential rehab service at Ravenscourt since 1990. It began to also offer a residential detox service in 2012.

There is a registered manager for the service.

The service offers residential detoxification (commonly known as 'detox') and rehabilitation (commonly known as 'rehab') services in respect of dependence on alcohol, opiate or prescription medicines, to males and females aged 18 and over.

According to the provider, between 5 and 10% of clients are self-funded. The remaining 90-95% of placements are funded by public monies. Detox placements were generally commissioned for up to three weeks' duration, and rehab placements were generally commissioned for up to 12 weeks' duration. There was some flexibility to extend placements if justified on clinical grounds.

We inspected Ravenscourt in January 2013 and January 2014. There were no outstanding compliance actions (now known as requirement notices) associated with this service.

Our inspection team

Team leader: Steven McCourt, Inspector, Care Quality Commission.

The team that inspected the service comprised two Care Quality Commission inspectors, one assistant inspector and one specialist advisor who was a consultant psychiatrist with experience in substance misuse.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- looked at the quality of the physical environment, and observed how staff were caring for clients
- spoke with five people who were using the service
- looked at care records for six clients, and medicines records for five clients

Summary of this inspection

- spoke with the director and the registered manager
- spoke with two other staff members employed by the service provider
- attended and observed one weekly care review meeting and three therapeutic group sessions
- collected feedback using comment cards from five clients
- looked at policies, procedures and other documents relating to the running of the service

What people who use the service say

- We spoke with five people who were using the service. They were generally positive about the services delivered by the provider and the way in which staff treated them. However, one client told us that staff could be judgemental at times.
- Some clients we spoke with told us that the daily programme was very repetitive, and there was a shortage of physical activities on offer. A weekly trip to a local swimming pool was on offer, however, clients told us the personal financial contribution they were obliged to make discouraged them from attending.
- The five comments cards we collected had consistently positive feedback about the service and the staff.
- Two clients spoke of their anxiety surrounding their impending discharge. They said that there not been any community work incorporated into their recovery programme.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We do not currently rate standalone substance misuse services.

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

- There were no measures in place to cover periods of absence of the two qualified members of nursing staff.
- The majority of mandatory training was delivered during monthly staff meetings, by members of the staff team. We were concerned that the quality of the training provided was unsatisfactory due to insufficient skill on the part of the in-house facilitators (who were not professional trainers) and an insufficient amount of time to properly cover the subject area.
- Risk assessments were of poor quality, lacking necessary details of identified risks. Furthermore, none of the records we examined contained a plan to manage/mitigate the identified risks and none of the records contained a copy of any medical assessment conducted either prior to, or following admission.
- Medicine records were confusing, since each client had a separate recording sheet for each medicine and there was no differentiation between charts for regularly administered medicines and those for 'as needed' (PRN) medicines. Some entries on the medicines charts had been amended using correction fluid, including a chart pertaining to the client who had died within the first 24-hours following admission for detox treatment. Medicines were administered by unqualified members of care staff whose training had only consisted of a brief session delivered by one of their colleagues, during a staff meeting.
- Staff occasionally used physical restraint, although they had not been trained how to carry it out safely or appropriately. No records were kept on the number of instances of restraint or the type of restraint used.
- There was no policy in relation to safeguarding children.
- The report resulting from the internal investigation into the death of a client during 2015 was very poor. Although senior personnel were able to communicate their findings and subsequent actions verbally, they were not clearly evidenced in written form.

Summary of this inspection

- There was no policy in relation to duty of candour and there was a lack of clear, ongoing documentary evidence that the service was transparent with stakeholders.
- There was no dedicated system for the recording or investigation of incidents. Notes present were excessively brief, and had no summary of the event or subsequent investigations. There was no system in place for the auditing of incidents by type or number. There was a lack of clear documentary evidence that incidents had been discussed openly with staff or clients. This meant that there was no way of evidencing that information had been appropriately shared or that learning had taken place.
- The use of twin rooms and lack of gender separation within the building did not safeguard the privacy and dignity of clients.
- The general décor and furnishings within the premises was poor and in need of updating.
- The clinic room was very small and contained no handwashing facilities.

However, we also found the following areas of good practice:

- The service demonstrated that it had appropriately refused some detox referrals on medical grounds, where the individual's medical history or current dose of prescribed opiate substitution treatment presented too great a risk for the service.
- The staff team had no vacancies and a low level of turnover and sickness. The service did not use agency staff, so clients benefitted from being cared for by workers familiar with them and the service.
- Staff had improved the pre-admission assessment process, following a serious incident in 2015, by introducing a list of medical exclusion criteria for admission to the detox service.

Are services effective?

We do not currently rate standalone substance misuse services.

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

- The GP assessment for new detox clients was brief, primarily consisting of the GP asking the client to confirm the accuracy of the information they had received for the client's own GP. The GP did not conduct a test to check for the presence of an opiate The prescription written for methadone only cited the total

amount of methadone needed for the forthcoming week, rather than stipulating how much methadone was to be administered each day. No record of the information from the client's own GP or the assessment from the detox GP were forwarded to Ravenscourt.

- None of the six care records we examined contained a care plan that had been signed by the client and none contained details of a medical assessment.
- There were no formal arrangements in place for nursing staff to receive regular and structured clinical supervision.
- Staff did not receive an appraisal. Instead, they merely completed a self-assessment questionnaire. Personal development plans were not completed and there was no evidence of a discussion between the members of staff and their line manager, resulting from the questionnaire.
- The minutes of monthly staff meetings were not recorded.
- Audits were infrequent, with some aspects of the service not audited within the last 12 months.
- The service did not have a policy in relation to the Mental Capacity Act 2005 (MCA) and staff had not received training in the MCA. Staff we spoke with were unable to demonstrate an appropriate level of understanding of the basic principles and application of the MCA. Although there was a specific policy and training in place on the Deprivation of Liberty Safeguards (DoLS), the policy was generic in nature, having been transplanted from a website. An additional paragraph, outlining the context of DoLS for Ravenscourt failed to provide clear guidance or demonstrate a solid understanding of the subject.

However, we also found the following areas of good practice:

- Three members of staff received specialist advice and support for the counselling and group therapy aspects of their work from an external professional.
- A daily handover meeting took place each morning to discuss the events of the preceding night. All staff on duty attended the meeting. Notes from each shift were written in the daily records book.
- Staff had received training in equality and diversity in September 2015.
- The service had strong links with two local GPs, local charities and a local community mental health team.

- Client care records were stored in a lockable cabinet in the staff office.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- We observed staff treating clients in an appropriate, respectful and supportive manner.
- Clients told us they felt involved in the care planning process, although there was a shortage of evidence of their involvement in client records.
- Prospective clients were encouraged to visit the service prior to admission, to meet staff and existing clients.
- Clients valued the support provided by staff to repair damaged relationships with their partner and/or family.

However, we also found the following issues that the service provider needs to improve:

- Some clients perceived that the regime imposed by the service was inflexible and lacked a common-sense approach. As a result, they felt that their dignity had sometimes been infringed.
- There were no clear systems in place for explicitly inviting feedback from clients, or for providing information on how the service had been adapted as a result of comments and suggestions received.

Are services responsive?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- The service operated with below capacity occupancy, so local people were able to access the service.
- The facilities contained a range of rooms and spaces that could be flexibly used to meet the needs of clients, including large areas for group sessions, and smaller rooms for individual meetings. A recently secured capital grant had provided funds for a summer house to be erected shortly before our visit. The summer house had two separate meeting rooms. Clients had unrestricted access to the kitchen and garden.

However, we also found the following issues that the service provider needs to improve:

Summary of this inspection

- Clients did not have a key to their bedroom door. None of the bedrooms contained a lockable space, including the four twin bedrooms in use.
- Some clients felt that the daily programme was very repetitive, and said there was a shortage of physical activities on offer. The financial contribution expected from clients to attend a weekly swimming session discouraged some clients from attending.

Are services well-led?

We do not currently rate standalone substance misuse services.

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

- There was no clear evidence of the service's values within the documentation we examined.
- The service did not use a risk register.
- Audits were infrequent, with some aspects of the service not audited within the last 12 months.
- Staff did not receive an appraisal and there were no formal arrangements in place for nursing staff to receive clinical supervision.
- The service did not use key performance indicators (KPIs) to gauge the performance of the team.
- The service did not use improvement methodologies and there were no examples of innovative practice available.

However, we also found the following areas of good practice:

- Staff we spoke with did not raise any concerns relating to bullying or a fear of victimisation and there had not been any whistleblowing concerns raised during the period 17 January 2014 to 04 March 2016
- Staff sickness rates were reported to be low. There was a total of 40 days' sickness during 2015, 30 of which were attributable to one member of staff who no longer is employed by the service.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

- The service did not have a policy in relation to the Mental Capacity Act 2005 (MCA) and staff had not received training in the MCA. However, there was a policy in place on Deprivation of Liberty Safeguards (DoLS) and specific training had been provided to staff in that area.

Substance misuse/detoxification

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse/detoxification services safe?

Safe and clean environment

- The building used by the service was a residential dwelling that had been comprehensively extended. Client accommodation was split across three floor levels. There were a total of five bedrooms on the ground floor (three single rooms and two twin rooms); five bedrooms on the first floor (four single rooms and one twin room); and three bedrooms on the second floor (two single rooms and one twin room).
- Two of the single rooms on the ground floor had been allocated for clients who were in the first week of a detox programme, to enable an increased degree of staff observation. They were the only two bedrooms that contained an en suite toilet and wash basin. Those two rooms were in separate corridor from other ground floor bedrooms. They were allocated exclusive use of a neighbouring shower room.
- At the time of our visit, the remaining three bed spaces on the ground floor (in one single room and one twin room) had been allocated for female clients (although the gender allocations of bedrooms were switched according to the numbers of males and females within the client cohort at any one time). However, there was limited gender separation within the building, as a male with relatively poor mobility would need to use the ground floor bathroom. Furthermore, if one male and one female were occupying the two single rooms allocated detox admissions, they would be allocated the shared use of the neighbouring shower room. There was no dedicated female lounge within the premises.
- Clients were expected to undertake tasks as part of a cleaning rota each morning. The premises were clean and tidy at the time of our visit.
- The condition of the décor and the furnishings within most areas of the building were old and required updating. This was particularly evident in the communal dining room, where the carpet was dirty and threadbare, and the furniture was damaged due to wear and tear. The provider had recently commenced a programme of updating the décor in some sections of the building and was planning to use a portion of a recently procured capital grant to update further parts of the building.
- An environmental risk assessment had been conducted on 13 April 2016. A variety of issues had been highlighted, mainly centring on the need to replace or maintain furnishings and equipment.
- The clinic room was very small and it contained no handwashing facilities. There was a blood pressure monitor and weighing scales. Medicines were appropriately stored in a locked cabinet. Controlled medicines were kept in a second locked cabinet and they were appropriately monitored in a controlled drugs book.
- There was no resuscitation equipment or Naloxone kept at the service. Naloxone is a medicine used to resuscitate someone if they had taken an overdose of opiates.

Safe staffing

- The service had one director who worked full time in an office-based capacity. The staff team comprised: two qualified nurses, one of which was also the registered manager for the service; two full time 'counsellors' (keyworkers), who worked only day shifts; four care assistants, who worked a mixture of day and night shifts;

a housekeeper, whose primary role was to cook meals and assist clients in developing life skills, but who also worked some care shifts as required; and an administrative officer.

- At the time of our visit, there were no staff vacancies. The service did not currently use bank or agency staff. In the past, they had employed a care assistant who worked on an ad hoc relief basis. There were no volunteers employed by the service at the time of our visit.
- Staff sickness rates were reported to be low. There was a total of 40 days' sickness during 2015, 30 of which were attributable to one member of staff who is no longer employed by the service. No percentage rate for staff sickness was available.
- Staff turnover during the 12 months to March 2016 was 8%. This represented one member of staff who left the service.
- Night shifts were staffed by one worker (either a qualified nurse or an unqualified care assistant), who had access to a staff bedroom, in which they were permitted to sleep. There were no protocols in place for when the night worker could sleep. According to the director, this was as/when they deemed it appropriate to do so.
- New clients entering the service for detox treatment were always admitted on a Tuesday morning, to fit in with dedicated appointment times that had been pre-booked with the detox GP, to complete assessments. The provider had stipulated that a maximum of two detox admissions were accepted each week. The staffing arrangements catered for one nurse to be on site during the first 72 hours of detox treatment. The registered manager was the nominated nurse on duty each Tuesday, Wednesday, Thursday and Friday, during office hours. The second nurse worked each Tuesday, Wednesday and Thursday night. The two nurses had an agreement that they would avoid booking annual leave at the same time. However, there were no measures in place to provide qualified nursing cover when one of the nurses was on annual leave or sick. In either scenario, unqualified care assistants filled the vacant shifts.
- The daily programme for clients allowed for adequate opportunity for regular meetings between keyworkers and their allocated clients.
- Staff had received mandatory training. Percentage attendance rates were not available. Training in the majority of subject areas was delivered during monthly staff meetings, by members of the staff team. Training in medicines management (and safeguarding) had been delivered internally, in the week prior to our visit. We were shown the course material on medicines management handed out to each attendee, which was of a basic level. According to the staff rota for the day on which medicines management training was delivered, only four of the nine members of staff with responsibility for administering medicines to clients were on duty that day.

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

- We examined the care records of six clients. All records we examined contained a risk assessment completed on admission. However, the information on the risk assessment forms was of poor quality, lacking appropriate details as to the nature of any identified risk. Furthermore, none of the records contained a plan to manage/mitigate the identified risks. None of the records examined contained a copy of any medical assessment conducted either prior to, or following admission.
- We examined the medicine records for five clients. Each medicine had its own recording sheet, for each individual client, which meant that some clients had several 'live' medicine charts. There was no differentiation between charts for regularly administered medicines and those for 'as needed' (PRN) medicines. We saw medicine charts for two clients on which errors had been revised using correcting fluid.
- Staff told us that they occasionally used physical restraint, for example in order to separate clients who were arguing/fighting. Figures were not available for the number of instances of restraint or the type of restraint used. According to the staff training matrix, internal training had been delivered in 'handling challenging

behaviour' in February 2016. However, this training did not include how to properly restrain clients. Instead, it focussed upon verbal de-escalation and diversion techniques.

- Safeguarding training had been delivered to staff and there was a safeguarding policy in place. However, the policy only applied to safeguarding adults. There was no policy in relation to safeguarding children.
- Clients had agreed not to leave the building without staff consent. Ultimately, clients had the freedom to leave the premises, with the knowledge that in doing so, they might forfeit their place in the service.
- There were a number of blanket restrictions in place, most of which were not explicitly referred to in the client contract. The blanket restrictions were justified by staff as forming part of the therapeutic process. Clients gave their implicit consent by remaining at the service. Examples were: clients were not allowed to have their mobile telephone; they were only allowed to use the service payphone at certain designated times; and, they were expected to wake, go to bed and eat their meals at stipulated times.

Track record on safety

- There had been one serious incident requiring investigation (SIRI) in the 12 months prior to inspection, which related to the unexpected death of a client.The service had conducted an internal investigation into the incident, but it was not adequately evidenced in the form of a robust report. Senior personnel within the service were able to communicate their findings and subsequent actions verbally, but these were not clearly evidenced in written form.
- As a result of the above incident, the service had made improvements to its pre-admission assessment process, including the introduction of medical exclusion criteria for admission to the detox service. However, it was difficult for the service to ensure that this was adhered to, given that it did not possess a copy of relevant medical details for clients.

Reporting incidents and learning from when things go wrong

- Incidents were documented in a daily records book, along with details of a range of other day-to-day happenings within the service. There was no dedicated system for the recording of incidents in isolation. We saw accounts of incidents within the book, and they did not follow a clear format. They were excessively brief, and had no summary of the event or subsequent investigations. There was no system in place for the auditing of incidents by type or number.
- There was a lack of clear documentary evidence that incidents had been discussed openly with staff or clients, and so there was no way of demonstrating that information had been appropriately shared or that learning had taken place.
- The manager informed us that records of more serious incidents were placed into a dedicated folder in the office. However, when we were shown the folder, it only contained two handwritten notes on separate sheets of paper. The first was apparently completed by a client, in which they made an allegation. The record was not dated and there were no details of any subsequent investigation, actions or outcomes. The second sheet of paper appeared to have been misfiled, as it related to a request from a client to go on a day trip. The note was dated 2012.

Duty of candour

- There was no policy in relation to duty of candour. There was a lack of clear, ongoing documentary evidence that the service was transparent with stakeholders. However, following the serious incident referred to above, we saw evidence that the service had shared relevant information with statutory bodies.

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

Assessment of needs and planning of care (including assessment of physical and mental health needs and existence of referral pathways)

- All medicines were prescribed by two local GPs. One was used exclusively for clients who entered the service for detox treatment, and the second was used for clients who entered the service for a rehab programme alone. The GP who prescribed for detox clients, took overall medical responsibility for overseeing the detox treatment process.

Substance misuse/detoxification

- Prior to admission for detox treatment, the service sent a letter to the prospective client's GP. The letter requested that the client's GP fax a "doctor's summary" and "recent blood test results" to the GP who was contracted to oversee the detox treatment. Upon receipt of the requested details, the detox GP assessed the suitability of the individual for admission to the service. The provider showed us a list of 12 individuals who had been denied admission for detox treatment between July 2015 and May 2016. The cited reasons for refusal included excessively high methadone prescription (100ml), insulin dependent diabetes and a history of seizures. Upon admission, detox clients were taken to see the GP on their first day (the service had an arrangement with the detox GP, where they paid a fixed fee for three pre-allocated appointment slots each Tuesday lunchtime). The GP conducted a face-to-face assessment and prescribed detox medicines for the forthcoming week.
- We observed the initial GP assessment for one client entering the service for detox treatment. The assessment was brief, primarily consisting of the GP asking the client to confirm the accuracy of the information they had received from the client's own GP. The GP did not conduct a test to check for the presence of an opiate. The prescription written for methadone only cited the total amount of methadone needed for the forthcoming week. It did not stipulate instructions as to how much methadone was to be dispensed each day. No record of the information from the client's own GP or the assessment from the detox GP were forwarded to Ravenscourt (according to staff we spoke with, it is standard practice for the service not to receive medical information about their clients).
- The admission process for clients considering entry to the rehab programme was overseen by the staff team, who sought medical advice as necessary.
- We examined the care records for six clients. All records contained a client care plan; however they were not signed by the client. None of the records contained details of a medical assessment. Progress notes were generally of good quality and included information on work that had been carried out, such as encouraging family involvement. The progress notes were written from the worker's perspective, rather than the client's. Progress notes mainly centred on psychological wellbeing, with little or no mention of physical health. Four of the six records contained self-completed assessments on alcohol/drug use; psychological health; spirituality; and, social issues.
- Client care records were stored in a lockable cabinet in the staff office. The records for most clients (current and former alike) were stored in named, A4 sized envelopes. The records of the remaining clients were kept in folders, in the same cabinet.

Best practice in treatment and care

- Both keyworkers employed by the service possessed a recognised qualification in counselling. They facilitated the range of therapeutic group sessions throughout each week, such as relapse prevention. We observed three group sessions during our visit. During the two staff facilitated sessions, the staff member leading the group was encouraging and non-judgemental. They facilitated the discussion in order to ensure that the objectives were met. The facilitator of the relapse prevention group we observed left the session (during time when clients were completing guided tasks) to join the weekly case review meeting that was taking place at the same time. A 'graduate' of the service's rehab programme, who returned to give support to current clients, led the third session.
- The provider submitted details of three audits that had been undertaken. A controlled medicines audit had taken place in February 2016; an audit of client files had taken place in August 2015; and an audit of care plans had taken place in April 2015. The audit reports submitted by the provider were very brief. According to the information submitted, many aspects of the service had not been audited within the last 12 months.

Skilled staff to deliver care

- A member of qualified nursing staff was normally on site throughout the first 72-hours of detox treatment. However, there were no arrangements in place to cover periods of absence from either of the nurses. Emergency medical assistance was accessed by requesting a response from paramedics.
- Medicines were administered by all members of staff who had caring responsibilities. Unqualified staff had only received recent training in the administration of medicines during the course of a staff meeting.

Substance misuse/detoxification

- Staff attended a monthly team meeting, which incorporated sessions of in-house training. The minutes of the monthly staff meetings were not recorded.
- Care assistants employed by the service had completed a relevant level two national vocational qualification.
- Three members of staff, including the two keyworkers received monthly supervision from an external professional, who provided specialist advice and support for the counselling and group therapy aspects of their work.
- The two nurses received informal support from the detox GP, but there were no formal arrangements in place for them to receive regular and structured clinical supervision.
- Staff did not receive an appraisal. However, every six months, workers were requested to complete a self-assessment questionnaire, which the provider referred to as an appraisal. We examined these records for eight members of staff. In every case, the individual's personal development plan was not completed. There was no evidence of a discussion between the member of staff and their line manager, following completion of the questionnaire. Only two contained any action points at the end of the questionnaire.
- Staff received a range of training sessions on subjects relevant to their work, such as care planning, blood borne viruses and legal highs. However, most sessions were delivered during monthly staff meetings, by members of the staff team.

Multidisciplinary and inter-agency team work

- Ongoing medical healthcare was provided by two local GPs, neither of which were contracted to the service.
- A daily handover meeting took place each morning to discuss the events of the preceding night. All staff on duty attended the meeting. Notes from each shift were written in the daily records book.
- A weekly case review meeting took place each Tuesday morning. The team held a discussion about each client, and their progress to any date, plus details of any issues that had been encountered. The team discussed ideas for solutions, such as referring clients to voluntary work organisations, or for family therapy. The discussions at the meetings were not appropriately evidenced by way of written minutes. The meetings were effective for the sharing of information, but they were unstructured and failed to adequately plan actions for progressing each client's situation.
- The service had strong links with two local GPs, local charities and had forged a connection with a community mental health team based in the same road. Clients maintained contact with their care manager, whilst at Ravenscourt.
- Informal processes existed for referring clients to external support agencies, such as advocacy or housing advice. The necessity for referrals was identified by individual keyworkers or at the weekly case review meeting.

Good practice in applying the Mental Capacity Act

- The service did not have a policy in relation to the Mental Capacity Act 2005 (MCA) and staff had not received training in the MCA. However, there was a policy in place on the related subject of Deprivation of Liberty Safeguards (DoLS).
- However, the DoLS policy was generic in nature, having been transplanted from a well-known website. An additional paragraph, outlining the context of DoLS for Ravenscourt failed to provide clear guidance or demonstrate a solid understanding of the subject.
- Staff we spoke with were unable to demonstrate an appropriate level of understanding of the basic principles and application of the MCA.

Equality and human rights

- The service had an equal opportunity policy in place. It was dated September 2012. The policy (or its content) was not referred to in the client contract, agreed and signed by all new clients.
- Staff had received training in equality and diversity in September 2015.
- Clients agreed with a therapeutic contract in advance of treatment. The contract did not refer to the imposed rule that clients were not permitted access to their mobile telephone during their stay; had time-limited access to the in-house payphone; or, were not allowed to leave the premises without staff consent.

Substance misuse/detoxification

Management of transition arrangements, referral and discharge

- When a client left the service in a planned discharge, staff compiled a discharge report, which was shared with the client and their referring agency. In the event of an unplanned exit from the service (e.g. where a client chose to discharge themselves), clients were given a single sheet of paper, entitled a "personal discharge care plan". The sheet had five boxes, in which clients were expected to self-assess their needs following discharge; their personal triggers and relapse risk factors; and, identify their available support network. However, we did not see evidence of any completed personal discharge plans.
- Staff used a "discharge checklist" to prompt them to ensure that relevant actions had been completed prior to discharge, such as: had they informed the client's next of kin and care manager; had the client been given all their personal belongings and medication for three days following discharge; and, had the client completed their personal discharge care plan.
- Two clients we spoke with told us of their feelings of anxiety surrounding their impending discharge. They said that there not been any community work incorporated into their recovery programme.

Are substance misuse/detoxification services caring?

Kindness, dignity, respect and support

- We observed a variety of interactions between staff and clients. Staff consistently treated clients in an appropriate, respectful and supportive manner.
- Staff demonstrated a positive attitude towards clients when interacting directly with them, and when talking about them with colleagues.
- Most clients we spoke with told us that staff were caring, compassionate, helpful, non-judgemental, supportive, understanding and responsive to their individual needs. However, one client we spoke with said that staff could be judgemental at times.
- We collected a total of 5 comments cards from the service. Clients wrote unanimously positive comments about staff.
- Some clients we spoke with voiced a concern that the regime within the service could be controlling, where rules were inflexible and lacked a common-sense approach. They were able to cite examples where they felt their dignity had been infringed.
- Clients we spoke with did not raise any concerns about staff maintaining their confidentiality.

The involvement of people in the care they receive

- We examined the care records of 6 clients. The majority did not display evidence of client involvement in the care planning process. However, clients we spoke with told us they had given input when their care plan had been formulated. Carers were not normally involved in the care planning process.
- Prior to admission, prospective clients were invited to visit the service, in order to meet the staff, look around the premises and gain an insight into the philosophy of the service. They were also encouraged to talk with existing clients, to forge initial links and to learn about the service provided, from the client's perspective.
- Clients had access to local advocacy services.
- Clients we spoke with told us that staff had supported them to build/repair their previously damaged relationships with their partner or family. Clients told us they greatly valued the input of staff in that regard.
- There were no displays around the premises, where the provider invited feedback from clients (for instance, via notices on client information boards). Similarly, there were no "You said, we did" boards to highlight how the service had been adapted as a result of comments and suggestions received. However, clients did have the ability to voice concerns in weekly community meetings. Also, the provider informed us that they employ anonymous questionnaires to seek feedback.

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

Access and discharge

- The service operated with below capacity occupancy, so local people were able to access the service.

Substance misuse/detoxification

- Clients accepted admissions from the local Sussex area, as well as placements from Hampshire and London. There were no concerns raised regarding the ability of local people to access the service.
- Clients routinely had periods of home leave during the latter stages of their rehab programme. Their beds were always kept open for them.
- New clients were admitted to the service during office hours. Clients being admitted for detox treatment were routinely admitted on Tuesday mornings.
- There were no instances where the rehabilitation programme was extended within the last six months.

The facilities promote recovery, comfort, dignity and confidentiality

- The facilities contained a range of rooms and spaces to meet the needs of clients, including large areas for group sessions, and smaller rooms for individual meetings. A recently obtained capital grant had provided funding for the erection of a summerhouse shortly before our visit. The summerhouse contained two separate meeting rooms.
- Clients had unrestricted access to the rear garden.
- Clients had access to a kitchen, where they were able to make drinks and snacks as desired.
- No concerns were raised about the quality of food provided. Clients participated in menu planning and the cooking of some meals.
- There were 13 bedrooms within the building, including four twin rooms. Clients did not have a key to their room, and none of the rooms contained lockable spaces. Clients were able to store personal possessions in a large safe or lockable storage cabinet, both of which were situated within the director's office.
- There was a therapeutic programme in operation seven days a week. The daily timetable for clients was comprehensively structured from 7am each morning, until 10.30pm each evening. Times for waking up; undertaking household chores; participating in group sessions; taking part in recreational activities; and going to bed were stipulated by the service, and clients were expected to comply with them.
- Some clients we spoke with told us that the daily programme was very repetitive, and they said there was a shortage of physical activities on offer. Clients were offered the opportunity to make a weekly visit to a local swimming pool. Other than the weekly swimming trip, the only other exercise-related activity on offer was walks along the nearby seafront. On six mornings each week, there was a 30-minute time slot dedicated to performing "therapeutic duties", which entailed clients carrying out household cleaning chores.
- Clients were required to hand in their mobile telephone upon admission. They were allowed to make personal calls on an on-site payphone each evening (so that such calls did not clash with the daily therapy programme).

Meeting the needs of all people who use the service

- The premises had some adjustments for people requiring disabled access, including a ramp to the front door of the property.
- According to staff, the client intake for the service was relatively similar in respect of their needs. However, we were told that the service responded to meet the individual needs of prospective clients (in terms of specific dietary, cultural, religious, language or physical requirements) as necessary.

Listening to and learning from concerns and complaints

- According to the provider, the service received one formal complaint in the last 12 months, which was not upheld.
- A copy of the complaints policy is routinely attached to the contract signed by each client at the time of their admission.

Are substance misuse/detoxification services well-led?

Vision and values

- According to the provider's website, the vision for the service was, "to provide the best possible residential rehab care to people suffering from addiction to alcohol and/or drugs".

Substance misuse/detoxification

- A clear statement on the service's values was not cited, nor was there evidence of a coherent ethos within the documentation within the service. However, it was evident that staff were committed to their work and to providing a high quality service to their clients.
- Given the small size of the organisation, staff had daily contact with both the registered manager and director for the service.

Good governance

- The majority of mandatory training was delivered during monthly staff meetings, by members of the staff team. We were concerned that the quality of the training provided was unsatisfactory due to insufficient skill on the part of the in-house facilitators (who were not professional trainers) and an insufficient amount of time to properly cover the subject area.
- Staff were involved in clinical audits. However, the audits were very infrequent, with many areas of the service not audited within the last 12 months.
- There were no formal arrangements in place for regular and structured clinical supervision of the two nurses employed by the service.
- Staff appraisals were simply a self-assessment questionnaire, completed by the member of staff. Personal development plans were not completed and there was no evidence of a discussion between the members of staff and their line manager, resulting from the questionnaire.
- The service did not use a risk register.
- The service did not use key performance indicators (KPIs) to gauge the performance of the team.
- The service did not have a policy in relation to the Mental Capacity Act 2005 (MCA) and staff had not received training in the MCA. Staff we spoke with were unable to demonstrate an appropriate level of understanding of the basic principles and application of the MCA. Although there was a specific policy and training in place on the Deprivation of Liberty Safeguards (DoLS), the policy was generic in nature, having been transplanted from a well-known website. An additional paragraph, outlining the context of DoLS for Ravenscourt failed to provide clear guidance or demonstrate a solid understanding of the subject.
- Safeguarding training had been delivered to staff and there was a safeguarding policy in place. However, the policy only applied to safeguarding adults. There was no policy in relation to safeguarding children, as it had not been deemed necessary by the director and/or manager.
- There was no dedicated system for the recording or investigation of incidents. Notes present in the daily records book were excessively brief. There was no system in place for the auditing of incidents by type or number. There was a lack of clear documentary evidence that incidents had been discussed openly with staff or clients, and so there was no way of evidencing that information had been appropriately shared or that learning had taken place.

Leadership, morale and staff engagement

- The service had a stable staff team, who were highly motivated and mutually supportive.
- Staff we spoke with did not raise any concerns relating to bullying or a fear of victimisation.
- There had not been any whistleblowing concerns raised during the period 17 January 2014 to 04 March 2016
- Staff sickness rates were reported to be low. There was a total of 40 days' sickness during 2015, 30 of which were attributable to one member of staff who no is no longeremployed by the service.

Commitment to quality improvement and innovation

- The service did not use improvement methodologies and there were no examples of innovative practice available.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must adequately safeguard the privacy and dignity of clients.
- The provider must ensure that the physical health of clients is adequately monitored during their detox treatment programme.
- The provider must ensure that staff receive all relevant mandatory and specific training and that the quality of training delivered is appropriate.
- The provider must ensure that a comprehensive risk assessment is conducted for every client and that a plan is formulated for the management and mitigation of identified risks.
- The provider must install a robust system for recording and investigating incidents.
- The provider must ensure that the physical health of clients is properly assessed on admission to the service and that they hold a copy of relevant medical information.
- The provider must ensure that medicine management systems provide a clear, accurate record of medicines administered.
- The provider must ensure that they have appropriate systems for monitoring the safety and performance of the service, including seeking feedback from clients and other stakeholders.
- The provider must ensure that all staff receive appropriate regular supervision and appraisal.

Action the provider SHOULD take to improve

- The provider should update the décor and furnishings within the premises.
- The provider should ensure that all relevant policies are in place.
- The provider should maintain records of staff meetings so that these can be referred to when needed.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect • Female patients did not have their privacy and dignity adequately safeguarded due to a lack of appropriate gender segregation. There were no day lounges for use by women only. There was sharing of bathroom facilities for both sexes. This is a breach of Regulation 10(1) and (2)(a)

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • Risk assessments were too brief and were of poor quality. They lacked necessary details about identified risks. • There were no management plans in place to mitigate the risks identified in client care risk assessments. • There was insufficient information held on the premises, regarding client medical histories and medical assessments conducted both pre- and post-admission. • Medicine records were confusing and some entries on medicine charts had been amended using correction fluid. • The physical health of clients was not adequately monitored during their detox treatment programme. This is a breach of Regulation 12(1), (2)(a), (2)(b) and (2)(g)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 17 HSCA (RA) Regulations 2014 Good governance • There was no robust system for appropriately recording or investigating incidents. • There was a lack of appropriate systems for assessing, monitoring and improving the quality and safety of the services provided. **This is a breach of Regulation 17(1), (2)(a) and (2)(b)**
Accommodation for persons who require treatment for substance misuse	Regulation 18 HSCA (RA) Regulations 2014 Staffing • Staff did not receive regular mandatory and specific training of an appropriate quality. • Nursing staff did not receive appropriate regular supervision. • Staff did not receive an appraisal. **This is a breach of Regulation 18(2)(a)**

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for service users by assessing the risks to the health and safety of service users of receiving the care or treatment; and, doing all that is reasonably practicable to mitigate any such risks. Regulation 12(1), (2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for service users by the proper and safe management of medicines. Regulation 12(1), (2)(g)

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must be established and operated effectively to enable the registered person, in particular, to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);

This section is primarily information for the provider

Enforcement actions

and, assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

Regulation 17(1), (2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 18 HSCA (RA) Regulations 2014 Staffing Persons employed by the service provider in the provision of a regulated activity must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18(2)(a)