AdAstra

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.

As a result of an inspection in March 2016 CQC proposed to cancel the provider's registration, which means that the provider would no longer be able to operate the service. The focus of this inspection was to check the progress the provider had made in addressing the breaches identified at the previous inspection in March 2016 and to provide updated information to the First Tier Tribunal hearing the providers appeal against the cancellation of their registration.

We found:

The majority of clients were prescribed medicines in excess of the dose recommended by best practice guidance (Drug misuse and dependence: UK guidelines on clinical management [orange book], Department of Health [DH], 2007), were prescribed medicines to be injected or were prescribed medicines not licensed for the treatment of substance misuse. Best practice guidance (DH, 2007) indicates that doses prescribed in excess of guidelines may not be effective and their prescription would be exceptional. Guidance (DH, 2007) also indicates that clients receiving injectable medicines should be closely supervised. Where prescribed medicines are not licensed for the treatment of substance misuse best practice indicates that systems and governance processes should be in place to ensure that treatment is effective and safe. The provider did not have appropriate systems in place to ensure that medicines prescribed in high doses, in injectable forms or off license were safe or effective.

The provider's contact with GPs was not consistent or systematic. Seventy five percent of the 16 client treatment records we looked at in full showed that required physical health checks had not been completed by the provider, or obtained from the clients' GPs. This included electrocardiograms (ECGs) which may be required to detect potentially fatal heart abnormalities. This meant that some client's health and safety remained at significant risk.

The provider did not have appropriate arrangements in place to ensure that missing assessment information for existing clients had been obtained. Sixty five percent of the clients whose records we reviewed had not had the risks associated with their treatment comprehensively assessed and management plans put in place. Risk assessments had not been systematically reviewed since the previous inspection and were not updated regularly. This meant that treatment decisions were based on incomplete client information which posed a risk to their health and safety.

The provider did not have arrangements in place to ensure that clients were seen every three months by the prescribing doctor, in line with best practice guidance (DH, 2007). Eighteen clients had not been seen face to

Summary of findings

face by the doctor who was prescribing medicines for them. The provider's system for producing and checking prescriptions was not safe as there was a risk that clients could receive an incorrect prescription that could present a risk to their health and safety. The provider had not put appropriate arrangements in place to ensure that existing clients who may benefit from being supervised whilst taking their prescribed medicines were able to access this.

The majority of staff did not receive regular supervision or appraisal. Limited progress had been made in identifying what training staff needed to complete or regularly update to provide safe care and treatment to clients. There was a risk that staff would not develop their skills and knowledge and be able to meet the needs of clients. There was also a risk that staff would not be aware of recent changes in best practice.

The provider's governance systems and controls to assess, monitor and improve the safety and effectiveness of treatment remained poor or absent. The provider had not been able to effectively and systematically, respond to and address, the concerns identified at the previous inspection in March 2016.

We also found:

The provider had made some progress in addressing some concerns raised at the previous inspection in March 2016. However, further improvements were identified as being required in many of these areas and the provider could not be sure that the changes made were embedded into practice and would be maintained. The improvements that had been achieved had not significantly improved the safety or effectiveness of the service provided.

Summary of findings

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Summary of this inspection

Background to AdAstra

Adastra is registered to provide care and treatment for people with a drug addiction. The service operates during the day and evening and does not provide accommodation for clients. The service provides substitute medicines and counselling to patients.

Adastra is registered to provide: Diagnostic and screening procedures and treatment of disease, disorder or injury.

A registered manager was in post at the service.

The service provides care and treatment to 148 private clients from inside and outside of London. All the clients paid for their treatment privately. No NHS or local authority commissioned services from Adastra.

We have inspected Adastra five times since 2010. At the last inspection in March 2016, we proposed to cancel the provider's registration. This means the provider would no longer be able to operate the service. Following the inspection in March 2016 the provider submitted an action plan to CQC, with updates on progress on 11 May and 10 June 2016. The action plan and update outlined how the provider intended to address the concerns identified. The providers action plan and update did not address all of the concerns identified during our inspection and did not include clear timescales by which improvements would be implemented.

Our inspection team

The team that inspected the service comprised a CQC inspection manager, two inspectors, a CQC national medicines manager and a specialist advisor, who was a consultant psychiatrist in addictions.

Why we carried out this inspection

This was an unannounced, focussed inspection. The focus of the inspection was to check the progress the provider had made in addressing the breaches identified at a previous inspection in March 2016 and to provide updated information to the First Tier Tribunal hearing the providers appeal against the cancellation of their registration.

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?

As this was a focussed inspection, we only looked at some areas of the service being safe, effective and well-led. Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- visited the location and looked at the quality of the physical environment
- spoke with the registered manager
- spoke with the prescribing doctor

Summary of this inspection

- spoke with the drugs worker
- looked in full at the care and treatment records, including medicines records, for 16 clients and looked in part at the records for two additional clients.
- observed the preparation of prescriptions and the disposal of returned ampoules
- looked at policies, procedures and other documents relating to the running of 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?

We do not currently rate independent standalone substance misuse services.

We found:

The provider did not employ staff in sufficient numbers to provide a safe service. The prescribing doctor had not been able to see all clients for whom they were prescribing medicines and was not meeting with clients every three months to review their treatment.

The provider had not addressed the concerns identified at the previous inspection in regard to assessing and managing individual client risk. Sixty five percent of the 16 client records we reviewed in full, had not had the risks associated with their treatment comprehensively assessed and management plans put in place. Risk assessments had not been systematically reviewed since the previous inspection and were not updated regularly.

The provider had not protected clients against the risks of receiving unsafe care and treatment as clients alcohol use had not been appropriately assessed.

The provider's system for producing and checking prescriptions was not safe. There was a risk that clients could receive a prescription for the wrong medicines or an incorrect dose. This presented a risk to their health and safety.

The provider had made limited progress in identifying what training staff needed to complete or regularly update to provide safe care and treatment to clients.

We also found:

The provider had made some progress in dealing with the concerns raised at the previous inspection regarding premises, equipment and infection control. Equipment was calibrated and testing kits were in date. The premises appeared visibly clean. The provider had carried out some remedial checks on staff to ensure they were of good character and had the skills and experience required for their role. However, one significant infection control risk was identified, relating to the handling and disposal of empty ampoules returned by clients. Some gaps in staff personnel records remained.

Summary of this inspection

The provider had not accepted new clients into the service whilst making improvements. The service was no longer providing treatment to overseas clients. The provider had ensured that there were always staff on site with up to date training in basic life support.

Are services effective?

We do not currently rate independent standalone substance misuse services.

We found:

Seventy five percent of the client treatment records we looked at showed that required physical health checks had not been completed by the provider, or obtained from the clients GP. This included electrocardiograms (ECGs). This meant that client's health and safety remained at significant risk. The provider had made contact with some clients GPs, however, this was not systematic. This meant that there was a risk that medicines prescribed by the GP and those prescribed by the service would interact. Some medicine interactions can cause serious health problems.

Fifty eight clients received prescribed medicines in excess of the dose recommended by best practice guidance (DH, 2007), 51 were prescribed medicines to be injected and 37 were prescribed medicines not licensed for the treatment of substance misuse. The provider had not ensured that clients were prescribed medicines in line with best practice guidance (DH, 2007) and that treatment was effective and met clients' needs. This was because the provider did not have prescribing protocols in place. No audit or review of prescribing practices had been completed since the last inspection. No other governance systems were in place to ensure that clients received the most effective treatment in the safest way. The provider had not put appropriate arrangements in place to ensure that existing clients, who may benefit from being supervised whilst taking their prescribed medicines, could access this.

The provider did not have appropriate arrangements in place to ensure staff obtained missing assessment information for existing clients. This meant staff made treatment decisions based on incomplete client information. This posed a risk to the clients' health and safety. The provider was developing new plans for assessing and commencing treatment for new clients, but we found these were not sufficiently robust to ensure that treatment was safe and met client needs.

Summary of this inspection

The provider did not have arrangements in place to ensure the prescribing doctor saw clients every three months, in line with best practice guidance (DH, 2007). Eighteen clients had not been seen face-to-face by the doctor who was prescribing medicines for them.

The provider could not be sure that staff could access all information required to provide safe treatment when needed or that staff stored records securely. Some client records were kept in a loose leaf format separately from the clients file. Some hand written entries in client's treatment records were illegible. Client records, including prescriptions waiting client collection, were not always securely stored and that there was a risk of inappropriate access to signed prescriptions.

The majority of staff did not receive regular supervision or appraisal. This meant staff may not develop their skills and knowledge and be able to meet the needs of clients. They would also not necessarily be aware of recent changes in best practice.

We also found:

The provider had improved their systems to ensure that clients undertook regular urine screening tests. The majority of clients whose treatment records we looked at had completed two screening tests in the last 12 months. Staff who were not qualified to do so, were no longer reading ECGs.

Are services well-led?

We do not currently rate independent standalone substance misuse services.

We found:

The provider did not have effective governance systems in place to underpin the delivery of safe, effective and high quality care. We found that systems and controls to assess, monitor and improve the quality of care remained poor or absent. The provider had not been able to effectively and systematically respond to and address the concerns identified at the previous inspection in March 2016.

Substance misuse services

Safe	
Effective	
Well-led	

Are substance misuse services safe?

Safe clean environment

At the previous inspection in March 2016, we found that the environment was not clean and safe and that there was no cleaning schedule in place. Potential infection control risks had not been appropriately managed and some single use medical equipment had not been replaced following use. Staff did not complete infection control audits and the service's infection control policy and procedure had not been updated. Medical equipment had not been calibrated, which meant that readings may be inaccurate. Some testing strips used in medical equipment had passed their expiry date which could also mean that the readings obtained from them were inaccurate. Personal protective equipment that was being used by the service, such as disposable gloves, had also passed their expiry date. Consultation rooms were being used for storage.

During our inspection of the provider in February 2017, we found that the provider had made some progress in dealing with the concerns raised at the previous inspection regarding premises, equipment and infection control. We toured the premises and looked at equipment. The machines in use by the provider in February 2017 had been calibrated. Testing strips were within their expiry dates. The premises appeared visibly clean and a cleaning contractor had been appointed in January 2017. However, there was no cleaning schedule available to show what had been cleaned. Since the previous inspection, the premises had been decorated and the flooring in some consultation rooms replaced.

During our February 2017 inspection, we also found that disposable gloves were available and these were within their expiry date. However, staff did not store other personal protective equipment, such as aprons, appropriately. There were a range of other minor infection control issues that we raised with the provider during the course of the February 2017 inspection: Staff had not signed and dated the sharps bin when its use commenced; there were no hand drying facilities available next to the sink in the doctor's consultation room; and staff had to carry urine samples along a carpeted corridor to the doctor's consultation room for testing. Any samples spilled on the carpet during transportation could not be properly cleaned. The provider had reviewed a range of its policies and procedures relating to infection control since the last inspection, however we saw that these were not being followed.

During the February 2017 inspection, we identified that the receptionist did not use appropriate personal protective equipment when handling used ampoules and was not following the provider's policy and procedure with regard to the disposal of used ampoules. This presented a serious infection control risk. The receptionist counted the empty ampoules returned by clients prescribed injectable medicines using a metal triangle, tweezers and thick, non-disposable gloves. They stored the thick gloves on an open surface in the reception area in between use. Whilst completing this task they should wear personal protective equipment, such as aprons, but they did not. When the ampoules had been counted they were placed in a plastic bag, tied and then placed in a locked clinical waste bin outside of the premises. The provider's policy and procedure "Guidelines for the Safe Use and Disposal of Sharps" states "The term "Sharps" is used to describe any item that may cause penetrative injury or may puncture clinical waste bags. For example needles, syringes, blades, ampoules" it goes on to state that "All sharps must be disposed of in a designated sharps bin". This meant there was an infection control risk, particularly in relation to blood borne viruses. We viewed the provider's waste collection contract, from the limited information available in the contract it was not clear that the waste contractor was aware that they were collecting and processing clinical waste that included sharps."

Safe staffing

During the previous inspection in March 2016, we found that staffing was not safe. The service did not have appropriate levels of medical cover in place. The service had not identified what training staff needed to complete or regularly update to provide safe care and treatment to

clients. No training needs analysis had been undertaken by the service. This meant that the service had not clearly identified the training staff required to be able to meet client's needs. Basic life support training had not been completed by any staff. This meant that the service could not be sure staff had appropriate knowledge, skills and experience to respond appropriately to medical emergencies.

Following the inspection in March 2016 the provider submitted an action plan to CQC, with updates on progress on 11 May and 10 June 2016. The action plan and update outlined how the provider intended to address the concerns identified. In their action plan, the provider stated that a full appraisal of staff competencies, including "long term goal setting" in terms of further training, would be undertaken. No date for completion was identified in the original action plan or updates. The action plan also stated that each staff member should submit a request for at least one training course, in addition to safeguarding, within six months. The update on the 16 June 2016 advised that this would be followed up in staff supervision. The provider's action plan also stated that staff employed at the service would be seeking professional registration with the Federation of Drug and Alcohol Professionals. In their action plan and update the provider notified us of changes in staffing at the service. One drug worker and the doctor had left the service and a new doctor had been appointed.

Since the last inspection in March 2016 there had been a decrease of approximately 20% in client numbers from 185 at the previous inspection to 148 at this inspection. During the February 2017 inspection, we found that despite the decrease in clients, the provider did not employ staff in sufficient numbers to provide a safe service, as there remained insufficient medical cover in place. In the 11 months since the last inspection the prescribing doctor had not been able to see all clients for whom they were prescribing medicines and were not meeting with clients every three months to review their treatment in line with best practice guidance (DH, 2007). In addition the number of drug workers at the service had decreased by two part time workers since the last inspection, with arrangements not in place for the cover of these posts at the time of the inspection.

There had been changes in staffing at the service since the March 2016 inspection. The previous doctor had left the service shortly after the inspection. After their departure, a locum doctor had provided cover until the current doctor took up post in July 2016. The current prescribing doctor was employed as a locum and worked each Wednesday and Friday and alternate Saturdays. We were told that if they took annual leave or were absent due to illness an alternative locum would be provided through an agency. The drugs worker with a nursing background, in post at the time of the March 2016 inspection, had also left the service. A second drugs worker was on long term sick leave. The registered manager told us they were planning to recruit to this post to cover the sickness absence. A drugs worker with a psychology background continued to work at the service for one day each week, on a Friday. The only full time members of staff were the receptionist and the registered manager. In addition to their role as registered manager, they also worked as a drugs worker and saw the majority of clients.

At the February 2017 inspection, we found that little progress had been made in identifying what training staff needed to complete or regularly update to provide safe care and treatment to clients.

The registered manager told us that a training needs analysis, or appraisal of staff competencies, had not been completed since the last inspection. The registered manager told us they had tried to source relevant affordable training options for staff, but had not identified a core or mandatory training programme. Since the last inspection the registered manager had completed a care certificate, which included: awareness of mental health, dementia and learning disability, safeguarding adults, safeguarding children, basic life support, health and safety and infection prevention and control. The registered manager had also registered as a member of the Federation of Drug and Alcohol Professionals in August 2016.

No other staff within the service had completed any training since the March 2016 inspection. However, the drugs worker from a psychology background and the prescribing doctor had made available copies of training certificates for courses they had completed prior to the March 2016 inspection. These demonstrated that the drugs worker from a psychology background had completed training in safeguarding adults and children to lead level and had completed courses in motivational interviewing, solution focussed therapy and CBT. The prescribing doctor had completed a course in basic life support for adults.

Substance misuse services

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

At the previous inspection in March 2016, we found that potential risks to clients had not been appropriately assessed and that there were not appropriate plans in place to manage or mitigate potential risks. This included the risk of overdose, dangerous injecting practice and client's mental health history. Furthermore, where client records indicated that a potential risk area may have changed, the current risk was not reviewed and an appropriate management plan was not put in place. Some clients were employed within other substance misuse services and the potential risks associated with this, for example access to and potential misappropriation of prescription pads, had not been assessed.

Following the inspection in March 2016 the provider submitted an action plan to CQC, with updates on progress on 11 May and 10 June 2016. In their original action plan the provider stated that client risk assessments would be reviewed to include information relating to clients employment and access to children. The provider stated that this should take no more than 28 days. In their update on the 11 May 2016, the provider stated that a new risk assessment form was being configured and would be introduced and completed after annual reviews for clients for 2016 were completed. No date for completion was provided.

During the inspection in February 2017, we reviewed all available treatment records for 16 clients. We reviewed parts of the treatment records available for a further two clients. We found that the provider had not addressed the concerns identified at the previous inspection. Over 65% of the clients whose records we reviewed had not had the risks associated with their treatment comprehensively assessed and management plans put in place. Risk assessments had not been systematically reviewed since the previous inspection and were not updated regularly. Five client files did not include any risk assessment or management plan. A further seven clients had partially completed risk assessments available on file. Some clients self-administered their medicines by injection. Staff had not appropriately assessed these risks nor developed risk management plans in response to them. They had also not completed risk assessments or management plans addressing the potential risk of overdose for clients prescribed high doses of medicines. In several clients treatment records we found reference in their progress notes and in correspondence to their GPs to their being "low risk". However, we did not see evidence of how this formulation had been arrived at, particularly where no risk assessment had been completed or the risk assessment had been partially completed.

At the February 2017 inspection, the registered manager provided us with a copy of their draft policy for healthcare workers in treatment. We noted that whilst this stated that the provider reserved the right to breach confidentiality, it did not identify the circumstances in which this might occur or outline the risk assessment and risk management processes the worker should follow when considering whether client confidentiality should be breached.

During the March 2016 inspection we found that 17 clients were travelling from overseas to receive treatment, including prescribed medicines. The service did not carry out its own assessment of risk for these clients, and where information was received from services within the client's home country, the provider did not update their own care and treatment records to reflect any changes in risk. At the February 2017 inspection, the registered manager and all staff we spoke with confirmed that all overseas clients had been discharged from the service.

At the March 2016 inspection we found the provider was not following best practice guidance (Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence, National Institute of Health and Clinical Excellence [NICE], 2011) with regard to alcohol use. When clients disclosed alcohol use during their initial assessment, this was not assessed using a recognised tool. This meant that some clients may be at risk of receiving unsafe treatment because their alcohol use had not been assessed. We also found that the provider was not fulfilling its responsibilities to consider whether clients receiving treatment would need to be referred to the Driver and Vehicle Licensing Agency (DVLA). During the March 2016 inspection, we saw that one emergency medicine had passed its expiry date. There were not appropriate arrangements in place when prescriptions were transported to the doctor at their home for signature.

Following the inspection in March 2016 the provider submitted an action plan to CQC on the 11 May 2016, with an update on progress on 10 June 2016. The action plan and update outlined how the provider intended to address the concerns identified. The provider's action plan did not specify how concerns regarding assessment of clients

alcohol use, consideration of referral to the DVLA or transportation of prescriptions would be addressed. The initial action plan did state that a review of policies and procedures should be complete within 28 days. On the 10 June 2016 the provider stated that this review was underway. The provider also stated that they were seeking advice from external professionals with regards to clinical governance, but no date for completion was stated. The provider's action plan also stated that all medical consumables would be subject to an inventory list, with expiry dates. No date for completion was given.

At the inspection in February 2017 we found that the provider had not protected clients against the risks of receiving unsafe care and treatment, as clients alcohol use had not been appropriately assessed. We reviewed the available treatment records for 16 clients. We found that one client was identified in their records as having potential alcohol misuse issues. They had disclosed alcohol use of six to eight units per day. A recognised alcohol assessment tool such as AUDIT had not been used to assess their alcohol use. We found that clients' alcohol consumption was not consistently explored during treatment. There are significant risks associated with alcohol and opioid use, particularly with the prescribed medicine methadone. This meant that the provider did not consistently assess the risks to the health and safety of clients of receiving treatment.

During the February 2017 inspection, we found that the provider was not fulfilling its responsibilities to consider whether clients receiving treatment would need to be referred to the DVLA. We spoke with the prescribing doctor, they told us that they had not considered this to date, but would do so moving forward. We asked the registered manager how they had addressed this issue with staff since the previous inspection. We were told that this had been discussed at a staff meeting, but no records of this meeting were available for us to look at to demonstrate the discussion had taken place. Whilst reviewing client care and treatment records we noted that there were potentially two clients who appeared to be driving, where a potential referral to DVLA may need to be considered.

During the inspection in February 2017, we looked at the emergency medicines available on site. We found that the provider had emergency medicines on site, suitable to meet the needs of clients who were established in their treatment regime. Narcan (naloxone) an emergency medicine for the treatment of overdose was in the process of being obtained. However, the provider did not have robust systems to monitor the expiry dates of emergency medicines and dressings. There was a risk that clients could be treated with emergency medicines or dressings that were past their expiry, which could affect their efficacy. We saw that a first aid box was present with an expiry date of 28/02/2017. An AED was present which was calibrated until August 2017. A urine and vomit spillage kit was also available. Other emergency medicines available on site included glucagen, an adrenaline epi pen, atropine sulfate and bactigras dressings. The bactigras dressing had expired in May 2005. The glucagen pen was marked with a manufacturer's expiry date of March 2019. The manufacturer's notes indicated that if the product was not stored in a refrigerator the expiry should be reduced by 18 months. The glucagen pen was not stored in a refrigerator, but the provider had not revised the expiry date to September 2017. We bought this to the attention of the provider along with the expired bactigras dressing.

During the February 2017 inspection, we noted that Narcan (naloxone), a medicine that could be used in cases of overdose was not available. We were told by the prescribing doctor and registered manager that this had been ordered. We asked to see an order confirmation or invoice but none was made available for us to see. No oxygen supply was included in the provider's emergency medicines on site. The provider's policy "Protocols and Policies for treatment at AdAstra" had been reviewed in December 2016. This stated that "Before any dose optimisation, make sure that Oxygen and Narcan is available and within easy access of the doctor". We noted that the provider was not accepting new clients to the service and dose optimisation was not currently being provided.

During the inspection in February 2017, we looked at the arrangements for producing client prescriptions. We found that the provider's system for producing and checking prescriptions was not safe as there was a risk that clients could receive an incorrect prescription that could present a risk to their health and safety. The receptionist showed us the system for producing prescriptions. The provider maintained a log of all prescriptions and the client they had been issued to. The receptionist generated the prescription on their computer, based on information already on the system and updates left by the prescribing doctor, which could be a verbal update or a note left in the diary. The

prescriptions were generated as a batch and then given to the prescribing doctor to sign. We were told that there was no distinction made during the production and signature of the prescriptions between those that had been revised and those that remained the same. We saw that the prescribing doctor did not cross check the prescriptions they were signing with any other record to ensure that they correct. We saw that for one patient, whose prescription we saw being produced and signed by the doctor, the prescription issued did not correspond with the doctor's entries in their treatment record. The doctor's entry in the client's notes stated that their prescribed medicines should be reducing. However, this was not reflected in the prescription printed and subsequently authorised by the doctor. This discrepancy was not picked up by the doctor when they signed the prescription. We bought this to the doctor's attention and observed that they asked the receptionist to update the information regarding the client's prescription.

During the February 2017 inspection, we found that prescriptions were no longer being transported off site for signature by the prescribing doctor.

At the March 2016 inspection, we found that the majority of staff had not completed safeguarding training recently and that staff did not systematically gather and record information relating to any children that clients may be living with, or have regular access to. This meant there was a risk that staff were able to identify potential child safeguarding concerns. We also found that the service was not comprehensively assessing potential abuse of adults. The provider could not be sure that policies and procedures relating to safeguarding included the most up to date guidance. Some staff could not describe their responsibilities with regards to safeguarding in line with their role. This meant the provider was not ensuring that clients, their families and carers were protected from abuse.

Following the inspection in March 2016 the provider submitted an action plan to CQC, with updates on progress on 11 May and 10 June 2016. The action plan stated that all staff should undergo certificated safeguarding training with 60 days. The provider also stated that risk assessments would be reviewed within 28 days to ensure they contained information relating to children the client may live with or have regular contact. The update on the 10 June 2016 stated that new risk assessment form was in the process of being developed, but did not provide a date for its completion.

During the February 2017 inspection, we found that the provider had made some progress in addressing the concerns identified in this area at the previous inspection. We saw that the majority of staff had up-to-date safeguarding adults and children training. Staff could explain to us their responsibilities should they have a safeguarding concern. Since the previous inspection in March 2016 the provider had reviewed and updated its safeguarding adults and children policies and procedures. These had been shared with staff, who had signed to confirm they had received and read them. However, in the 16 client treatment records we reviewed, we found four client records indicated that the client may, or did, have children living with them or had regular contact with children. Insufficient information was recorded in these client's records to demonstrate that staff had undertaken an appropriate level of inquiry in this area. The lack of records concerning client's children was not appropriate. Staff had not recorded that they had explored potential risks for abuse. This meant the provider did not have an effective system in operation to adequately assess, monitor and mitigate the risks relating to the health, safety and welfare of clients and others who may be at risk which arise from the carrying on of the regulated activity.

A review of staff employment records during the March 2016 inspection showed that the provider had not carried out appropriate checks on staff before they started their employment. This meant the provider could not be sure that the staff they employed were of good character and had the appropriate skills and experience for the role they were employed.

Following the inspection in March 2016 the provider submitted an action plan to CQC, with updates on progress on 11 May and 10 June 2016. In their update on 10 June 2016 the provider stated that criminal records bureau checks had been requested for all staff, with all but one received. The provider's action plan also stated that staff personnel files would be updated and completed for all staff. The update on 10 June 2016 outlined that this was ongoing, but no date for completion was given.

During the February 2017 inspection, we reviewed staff personnel files and found that the provider had made

some progress in this area. We saw that for each member of staff a copy of their criminal record check had been obtained from the disclosure and barring service (DBS). However, we noted that for two drug workers and the receptionist some checks had not been requested from the disclosure and barring service. This meant that not all information available from DBS had been obtained and the provider could not be sure that they had access to all information relevant to deciding whether a staff member was of good character and suitable for the role for which there were employed. In addition, we found that some gaps in the personnel records required by regulation remained. For example, for the drugs worker on long term sick leave no employment history and no references had been obtained. For the drugs worker from a psychology background a second reference was not available. For the prescribing doctor, who was employed a locum through an agency, no references were available.

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

Assessment of needs and planning of care

At the March 2016 inspection we found that client initial assessments were not always fully completed and were not signed or dated, which meant that the provider could not demonstrate that initial assessments were always carried out by an appropriately qualified member of staff. In line with best practice guidance (DH, 2007), the provider's policy and procedure required clients to be medically assessed by the doctor prior to treatment commencing. However, we found that some clients had not been medically assessed by the doctor prior to their treatment commencing. This meant that the provider could not be sure that the treatment provided was safe and met the needs of clients.

Following the inspection in March 2016, the provider submitted an action plan to CQC on the 11 May 2016, with an update on progress on 10 June 2016. In their action plan the provider stated that annual reviews of clients were underway, but did not provide a date for the completion of annual reviews. In their action plan the provider also confirmed that no new clients had been accepted by the service since the inspection in March 2016.

During the February 2017 inspection, we were given a copy of the provider's assessment protocol. This outlined the procedures for taking new referrals, their initial assessment and commencement on medicines prescribed by the service doctor. This had been annotated by hand to read "Draft 2/2/17". We spoke with the registered manager regarding this protocol. They told us that the assessment protocol had been revised in consultation with the prescribing doctor. They also told us that they anticipated that the assessment protocol would be finalised within four weeks of the inspection.

At the February 2017 inspection, the registered manager and all staff confirmed that no new clients had commenced treatment with the provider since the previous inspection. During this inspection we reviewed the arrangements to reassess existing clients and the planned arrangements to initially assess new clients. We found that the provider did not have appropriate arrangements in place to ensure that the treatment provided to existing clients was safe and met their needs. We also found that the providers planned arrangements for assessing new clients were not sufficiently robust to ensure that treatment was safe and met client needs.

The registered manager told us that since the March 2016 inspection a new comprehensive client review tool had been developed. They told us this tool would be used to assess all new clients in the future and to review existing clients. The comprehensive client review combined initial assessment, review and risk assessment documents. At the time of this inspection, the registered manager told us that approximately 5% of existing clients had been reviewed using the new comprehensive client review. This 5% of clients had been reassessed by the registered manager. They told us that they anticipated that 100% of existing clients would have been reviewed using the comprehensive client review within seven to ten weeks of the February 2017 inspection.

During the February 2017 inspection, we reviewed all of the available treatment records for 16 clients. One of these clients had been reassessed using the provider's comprehensive client review tool. We found that some information in the client comprehensive review contradicted other information contained within the client record, for example, whether they were experiencing depression or not. The provider could not therefore be sure that its new comprehensive client review tool, where implemented, contained accurate information upon which safe treatment decisions could be made.

Substance misuse services

For the remaining 15 clients whose entire treatment records we looked during the February 2017 inspection, we found that information that had been omitted during previous assessments and reviews had not systematically been revisited and the missing information obtained. This meant that for the 95% of clients who were yet to be reviewed using the provider's new comprehensive client review tool, treatment decisions were being based on incomplete information. This meant that the provider did not do all that was reasonably practicable to assess and mitigate the risks to the health and safety of clients of receiving the care or treatment.

During the March 2016 inspection, we also found that client treatment records were not securely stored. In one instance a client file could not be readily located when requested and two client files did not contain a complete and contemporaneous record of the treatment provided. This meant that the provider could not be sure that all the information required to provide safe treatment was available when needed.

Following the inspection in March 2016 the provider submitted an action plan to CQC, with updates on progress on 11 May and 10 June 2016. The action plan and update outlined how the provider intended to address the concerns identified. The provider stated that a new electronic records system was in development for use in the clinic which would improve record keeping.

During the February 2017 inspection, we found that the provider had not addressed the concerns identified at the previous inspection. The provider could not be sure that all information required to provide safe treatment was available when needed and securely stored at other times. We noted the provider had not moved to the electronic records system it had outlined in their action plan and updates.

For two of the 16 client treatment records we looked at during the February 2017 inspection, some of their records were given to us in a loose leaf format and were not filed in the client record. There was a risk that these loose papers may be mislaid, or that some members of the team were not aware that additional loose papers were available for some clients. We saw that the doctor completed hand written records when they met with clients. A template had been developed for the doctor to record their meetings with clients. However, we found that on some occasions this template was not used, in these circumstances the doctors notes were difficult to follow. We also found that some of the doctor's handwritten notes were difficult to read or understand. This meant that a complete, contemporaneous record of client contacts was not readily available in client files that all staff could access. This placed clients at risk of receiving treatment that was not safe and did not meet their needs.

During the February 2017 inspection, we saw that when not in use, client files were stored in filing cabinets in the doctor's consultation room. Outside of office hours the filing cabinets were locked. However, the keys were kept nearby and easily accessible. Some confidential client information was recorded on prescription cards stored in the reception area. Prescriptions waiting to be collected by clients were also stored in this area. During the inspection we observed that the door to the reception area was not locked and that on some occasions the reception area was left unattended. This meant that client records were not always securely stored and that there was a risk of inappropriate access to signed prescriptions.

Best practice in treatment and care

At the previous inspection in March 2016, we found that the provider did not have suitable arrangements in place to ensure that clients were safely started on their prescribed medicines and that the risk of overdose during this period was appropriately mitigated. Supervised consumption for clients commencing treatment is attributed by best practice guidance (DH, 2007) to reducing the number of deaths of clients commencing treatment. Clients were not seen frequently whilst starting their prescribed medicines and a recognised withdrawal tool was not used as part of the system to establish the optimal dose of prescribed medicines. Some clients were prescribed initial doses of prescribed medicines that exceeded best practice guidance (DH, 2007).

In addition, we found at the March 2016 inspection that clients who were established in their treatment regime, but may be failing to benefit from that treatment, could not access supervised consumption when taking their medicines. This is one of the treatment options recommended for consideration by best practice guidance (DH, 2007).

Following the inspection in March 2016 the provider submitted an action plan to CQC, with updates on progress on 11 May and 10 June 2016. In their action plan the provider confirmed that they had not accepted new clients

since the March 2016 inspection. The plan and updates did not outline the arrangements the service was considering to provide supervised consumption to new or existing clients.

At the February 2017 inspection, staff employed at the service confirmed that no new clients had been accepted by the service since the previous inspection in March 2016. We found the provider had not revised its initial assessment protocols sufficiently to be able to safely accept and commence treatment for new clients. We were given a copy of the provider's assessment protocol. This outlined the procedures for taking new referrals, their initial assessment and commencement on medicines prescribed by the service doctor. This had been annotated by hand to read "Draft 2/2/17". We spoke with the registered manager regarding this protocol. We noted that the draft protocol did not make reference to best practice guidance (DH, 2007) regarding initial dosages for clients commencing treatment. The protocol did not state that a recognised withdrawal tool should be used during the initial stages of treatment when the dose of medicine prescribed was being optimised. The protocol did not outline the arrangements for supervised consumption, for a period of up to three months. The registered manager could not describe to us the arrangements that would be put in place to supervise consumption should the service start to accept new referrals.

We found that, since the last inspection in March 2016, the provider had not put arrangements in place for existing clients to systematically access supervised consumption, if required. Neither the registered manager nor prescribing doctor could tell us what arrangements had been put in place to provide supervised consumption to existing clients who were failing to benefit from their treatment. The registered manager told us that since the last inspection one client, who had since been discharged, had been provided with daily prescriptions during a two week period of crisis. We noted that providing a client with a daily script does mean that their consumption of the prescribed medicine will be supervised. We saw, from our review of client records, that one client had reported using on top of their prescribed medicines since the March 2016 inspection, which could constitute failure to benefit. There was no evidence that supervised consumption had been considered or offered to this client.

At the inspection in March 2016, we also found that clients were not regularly tested or screened to establish which substances were present in their systems, in line with best practice guidance (DH, 2007). Regular screening can help establish whether the treatment prescribed is effective and meeting the client's needs. In addition, clients were not regularly reviewed by the prescribing doctor; best practice guidance (DH, 2007) indicates a review every three months. For some clients, a review had not taken place for over 12 months. This meant that the provider could not be sure that client's treatment met their current needs and was safe.

Following the inspection in March 2016 the provider submitted an action plan to CQC, with updates on progress on 11 May and 10 June. In their action plan and updates the provider identified that their planned electronic records system would flag when screening and review was due. The provider's action plan also stated that physical examinations would be conducted as quickly as possible with the new doctor, but did not give a timescale when this would be achieved.

During the February 2017 inspection, we found that the provider had made progress in ensuring that clients were regularly screened by way of a urine test. We saw that a new, manual system to flag when clients were due for urine drug screening tests had been put in place. The client records we reviewed showed that the majority of clients were being screened at least twice yearly. The registered manager told us that by July 2017 all clients would have been screened at least twice annually and that at the time of our inspection 80% of clients had been screened at least twice in the previous 12 months.

During the February 2017 inspection, we saw that the prescribing doctor had not reviewed or regularly seen all clients. We found that the provider did not do all that was reasonably practicable to assess and mitigate the risks to the health and safety of clients of receiving treatment. The registered manager advised us that since the last inspection the service had focussed on each client being seen by the doctor. Whilst some clients had been seen by the doctor on more than one occasion, others had yet to meet with the doctor. The registered manager further told us that once all clients had been seen at least once by the prescribing doctor they envisaged that they would then be systematically reviewed comprehensively by the doctor every six months, with a shorter review with the prescribing

doctor in between this every three months, or more frequently if required. We were told that all clients would have been seen at least by the prescribing doctor by April 2017. This meant that at the time of our inspection clients were not being seen at least every three months by the prescribing doctor in line with best practice guidance (DH, 2007).

At the February 2017 inspection, we were told by the registered manager that 18 clients had not been reviewed by the doctor since they came into post in July 2016. One client's treatment record did not show that they had been seen by a doctor at any point during their treatment with the provider. We found that the provider did not do all that was reasonably practicable to assess and mitigate the risks to the health and safety of clients of receiving the care or treatment. This was because the doctor was prescribing medicines for clients they had not met face to face. Best practice guidance (DH, 2007) states that 'Before prescribing substitute drugs the clinician should conduct a full or comprehensive assessment'. Guidance by the General Medical Council (Good practice in prescribing and managing medicines and devices, 2013) states 'You should prescribe medicines only if you have adequate knowledge of the patient's health and you are satisfied that they serve the patient's needs'.

During the March 2016 inspection, we found that some clients were prescribed methadone at almost double the recommended dose, in some cases up to 220mg each day. The prescribing doctor did not did not have the required specialism to prescribe some medicines clients were prescribed. In addition, some clients were being prescribed medicines that best practice guidance (DH, 2007) did not find effective and recommended against their prescription. Clients from overseas were prescribed medicine that was not licensed for medical use in the UK. This meant that the provider could not be sure that clients were prescribed medicines that were effective, met their needs and were safe.

At the inspection in March 2016, we also found that the provider had not carried out a recent audit of client treatment records or prescribing practices. The audit that was available identified that some clients had not had their medicines appropriately authorised by the doctor and that for these same clients their treatment records were not up-to-date. No other clinical audits were completed by the provider.

Following the inspection in March 2016 the provider submitted an action plan to CQC, with updates on progress on 11 May and 10 June 2016. The provider stated that the doctor in post at the time of the March 2016 inspection left the service on the 12 May 2016 and that a replacement locum doctor, with the required specialism would be providing services. The provider's action plan also stated that clinical audits would be conducted once the new electronic records system was in place and a review of governance procedures had been completed. No timescale for completion was provided.

During the inspection of the service in February 2017, we found that a locum doctor with the required specialism had been in post since July 2016. However, we also found that the provider could not be sure that clients were prescribed medicines in line with best practice guidance (DH, 2007), that met their needs and were effective. This was because the provider did not have prescribing protocols in place. No audit or review of prescribing practices had been completed since the last inspection. No other governance systems were in place to ensure that clients received the most effective treatment in the safest way.

At the time of the February 2017 inspection, the provider was treating 148 clients. Fifty eight clients were prescribed high doses of methadone (in excess of 120mg each day) and from this group 16 clients were prescribed extremely high doses of methadone at or above 200mg each day. Best practice guidance (DH, 2007) indicates that up to 120mg of methadone each day produces most benefit and indicates that higher doses would be exceptional.

We found at the February 2017 inspection, 51 clients received their medicines in an injectable form. Best practice guidance (DH, 2007) states injectable treatments "may be suitable for a small minority of patients who have failed in optimised oral treatment" it also states that injectable treatments "require(s) greater commitment of time and resources from the patient, the clinician and the service".

At the time of the February 2017 inspection, 37 clients were prescribed medicines for the treatment of substance misuse that were not licensed for this purpose in the UK. This included methadone tablets and dexamphetamine. A further 28 clients were prescribed morphine, which is also not licensed for the treatment of opiate dependence and which best practice guidance (DH, 2007) indicates should

not normally be used in community settings. Best practice guidance (DH, 2007) states "prescribers, dispensers and those administering medicines must take precautions to ensure that the use of 'off label' or 'unlicensed' medications is managed properly. There should be local safety standards and arrangements in place to monitor the use of unlicensed and off label medicines." The provider did not have systems or arrangements in place to monitor the use of unlicensed medicines.

We asked the registered manager what measures had been put in place to ensure that client treatment records were up to date. The registered manager told us that since the March 2016 inspection a monthly file audit had been carried out. They told us that their audit indicated that approximately 80% of client records were up to date. They told us that they expected all client files to be up to date by the end of April 2017. We asked to see records of the file audit completed, but none were available. Our review of available treatment records for 16 clients indicated that files were not up to date and that gaps in information existed in the majority of client files that we looked at. The registered manager told us that no clinical audits had been completed at the service since 2014.

During the inspection in March 2016, we found that specific post-traumatic stress disorder (PTSD) interventions offered by the provider should not routinely be offered to clients undertaking treatment for substance misuse, in accordance with best practice guidance (Post-traumatic stress disorder: The management of PTSD in adults and children in primary and secondary care, NICE, 2005). Following the inspection in March 2016 the provider submitted an action plan to CQC, with updates on progress on 11 May and 10 June 2016. The provider's action plan and update did not provide any information with regards to this concern.

At the inspection in February 2017, we found the service no longer provided PTSD interventions. The service did not provide formal psychosocial interventions as recommended by best practice guidance (DH, 2007). The drugs worker with a psychology background, who had suitable training to provide formal psycho social interventions, told us they saw only a small number of clients and identified three specific clients they were currently working with. The registered manager and prescribing doctor did not provide formal psycho social interventions. Best practice guidance (DH, 2007) states that "Treatment for drug misuse should always involve a psychosocial component. " The registered manager, who saw the majority of clients receiving a service, told us they used their meetings with clients to form a therapeutic alliance.

During the March 2016 inspection, we found that clients did not have routine physical health checks. For clients prescribed in excess of 100mg each day the provider's policy and procedure required an electrocardiogram (ECG) be taken each year. This was to check for a potentially fatal heart abnormality. Treatment records indicated that some clients were not receiving ECGs each year which meant that their health and safety were potentially at risk.

Following the inspection in March 2016 the provider submitted an action plan to CQC, with updates on progress on 11 May and 10 June 2016. On the 10 June 2016, the provider updated CQC that some physical health testing equipment had been withdrawn from use and that in future a limited range of physical health tests would be provided on site. Where additional physical health tests were required, the client would be referred back to their GP for these. The provider further stated that physical examinations would be conducted as quickly as possible with the new doctor, but did not give a timescale when this would be achieved.

During the inspection in February 2017, we found that the systems currently in place did not ensure clients health, safety and wellbeing. We saw that clients were no longer being offered ECGs by the provider, and were being referred back to their GP for an ECG and a range of other physical health checks and tests. We examined the available treatment records for 16 clients. We found that for 12 of the clients (75% of our sample) whose records we looked at appropriate physical health checks had not been completed by the provider, or obtained from the clients GP. This included ECGs. This meant that client's health and safety remained at significant risk.

At the February 2017 inspection, we also found that for two clients potentially serious health concerns had been identified by the prescribing doctor and a range of physical health tests were indicated, including ECGs. The prescribing doctor intended to refer both these clients back to their GP for tests but both clients had declined. For one client this discussion with the prescribing doctor had occurred in August 2016, for the other client in November 2016. There was no record that these concerns had been

discussed or followed up with clients during subsequent visits to the service. They continued to be prescribed medicines without the required physical health tests being undertaken or the results obtained. We raised this as an immediate concern with the provider during our inspection.

During the February 2017 inspection, we saw that for a further three clients, the prescribing doctor had written to their GP requesting physical health checks. However, no response to this request had been received. One of these clients required an ECG but this had not been received from the GP. The client's records indicated that the previous ECG had been obtained in 2015. The doctor continued to prescribe medicines to these clients. The provider did not have a system in place to flag when physical health tests had been requested from GPs and not received and to then chase a response.

Skilled staff to deliver care

At the inspection in March 2016, we found that some members of staff performed tasks for which they did not have the appropriate skills or training. This included reading and interpreting ECG results and checking for interactions between medicines prescribed by the service doctor and the client's GP. We also found that the prescribing doctor at the service did not have the specialist knowledge and training required for the complex prescribing they were undertaking.

During the February 2017 inspection, we found that staff no longer read or interpreted ECG results. When ECG results were received from GPs, these were passed to the doctor for review. The service had a suitably qualified locum doctor in post since July 2016. Our discussions with the doctor indicated that they were undertaking continuous professional development relating to their substantive post within an acute mental health setting. They did not undertake any continuous professional development related to their substance misuse employment.

During the inspection in March 2016, we found that staff did not receive regular supervision or an annual appraisal. Following the inspection in March 2016 the provider submitted an action plan to CQC, with updates on progress on 11 May and 10 June 2016. The provider stated on the 11 May 2016 that staff supervision had commenced. The provider did not include information on the arrangements for appraising staff in its action plans or updates.

During the inspection in February 2017, we found that staff did not receive regular supervision or appraisal. This meant staff did not have a formal meeting to discuss their work. It also meant that any gaps in staff members' skills or knowledge were not identified. There was a risk that staff would not develop their skills and knowledge and be able to meet the needs of clients. There was also a risk that staff would not be aware of recent changes in best practice.

At the February 2017 inspection, the registered manager advised that the provider's supervision policy and procedure had been reviewed and updated. We were also advised that the doctor would be supervising the drugs worker with a psychology background, and that this drugs worker would provide supervision to the registered manager and other drug workers. Whilst the provider stated in their June 2016 action plan update that supervision was in place, we were told by the registered manager and the drugs worker with a psychology background that supervision was not being provided. It was not clear why this had not been implemented. Neither the registered manager nor the drugs worker with a psychology background, were able to tell us when supervision would commence.

During the February 2017 inspection, we were told by the registered manager that they were providing supervision to the receptionist. The doctor was receiving appropriate external supervision that included their work with the provider. The doctor also had external appraisal arrangements in place which included their work with the provider. No other staff had received an appraisal and the registered manager was unable to advise when staff appraisals would be introduced.

Multidisciplinary and inter-agency team work

At the inspection in March 2016, we found that the provider did not systematically liaise with clients GPs – where the client's consent had been obtained – prior to treatment starting, when treatment commenced or when there was a change to their prescribed medicines.

Following the inspection in March 2016 the provider submitted an action plan to CQC, with updates on progress on 11 May and 10 June 2016. On the 10 June 2016 in their update, the provider stated that they were completing a series of GP update letters, which would be audited on completion.

Substance misuse services

During the inspection in February 2017, we found that whilst the provider had made some improvements in their contact with clients GPs, this was not systematic. This meant that there was a risk that medicines prescribed by the GP and those prescribed by the service would interact, which can cause serious health problems. There was also a risk that clients may have developed physical health problems, which could affect the treatment a client received, but because the service did not have regular contact with a client's GP they did not know about them or adjust the client's treatment in response. There was also a risk that clients could receive the same medicines from the service and their GP which could affect the efficacy of the treatment provided or lead to prescribed controlled drugs being diverted to the illegal drugs market.

At the February 2017 inspection, the registered manager told us that 80% of clients GPs had received a letter since the previous inspection advising them of the provider's treatment of the client. We were also told that where the prescribing doctor had met with a client and the client had given their permission, a letter had been sent to their GP by the prescribing doctor. We asked the prescribing doctor how frequently they planned to contact client GPs with update letters. We were told that there was no policy or procedure in place stating the frequency with which GPs should be contacted. We were told that the prescribing doctor would contact GPs if there was a major change in their presentation or treatment, but the provider was unclear what would constitute a major change. We queried whether client GPs would be notified each time their prescribed medicines changed but did not receive a definitive response. This meant that clients remained at risk of receiving unsafe treatment as the provider was not systematically liaising with client GPs regarding the treatment they were providing.

During the February 2017 inspection, we reviewed the available treatment records for 16 clients, some of whom were yet to be reviewed by the prescribing doctor. For seven clients there had been no contact with their GP since 2012 or earlier. For two of these clients, there was no evidence that the provider had ever made contact with their GP.

At the previous inspection in March 2016, we saw that some clients had signed a GP waiver, which meant they did not give their consent to the service liaising with their GP. During the February 2017 inspection, we found that the health and safety of two clients had been compromised because the provider had not shared significant health concerns with their GP because the client had not consented.

During the February 2017 inspection, we were told that the service did not maintain a list of clients who had a GP waiver in place. The registered manager also told us that the number of clients with a GP waiver in place had decreased since the last inspection. They were not able to give us precise figures but said that this had decreased from approximately eight clients to four. We asked the registered manager to identify from their client list who had a current GP waiver in place. We noted that all clients with a waiver in place were not immediate identifiable. The prescribing doctor advised that they would develop a system to clearly identify which clients had a current GP waiver in place. We were also advised by the prescribing doctor that they would overrule any GP waiver in place, should the health and safety of the client indicate this. We noted that this had not been the case for two clients whose records we looked at with potentially serious health concerns who had refused permission for the prescribing doctor to contact their GP. During the discussion, the registered manager advised that the service would further review its GP waiver with a view to withdrawing this. We advised that staff and clients would all need to be formally advised with regards to this change in policy and procedure.

Are substance misuse services well-led?

Good governance

During the inspection in March 2016, we found that the provider did not have effective governance systems in place to underpin the delivery of safe, effective and high quality care. Following the inspection in March 2016 the provider submitted an action plan to CQC, with updates on progress on 11 May and 10 June 2016. In their action plan, the provider stated that they were seeking advice from external professionals with regards to clinical governance, but no date for completion was given.

During the February 2017 inspection, we found that whilst the provider had implemented some changes and made some improvements, these were not systematic and were not sufficient to ensure that the treatment provided was safe or effective. We saw that systems and controls to

assess, monitor and improve the quality of care remained poor or absent. We found that the provider had not been able to effectively respond to the concerns identified at the previous inspection.

At the inspection in February 2017, we asked to see the service risk assessment, or risk register. None was provided. This meant potential risks associated with delivering the regulated activity had not been assessed and there were plans in place to manage or mitigate these. No clinical audit programme was in place. Staff meetings did not happen regularly and were not recorded, which meant that the provider could not be sure that staff were aware of and implemented the services policies and procedures. The service was not providing all staff with regular supervision and appraisal. A core or mandatory training programme had not been identified and staff had completed limited training since the previous inspection in March 2016.

We found at the February 2017 inspection that the provider did not do all that was reasonably practicable to assess and mitigate the risks to the health and safety of clients of receiving treatment because they had not ensured that an accurate, complete and contemporaneous record was maintained for each client. Risk was not being effectively and systematically assessed with appropriate management plans put in place. Not all clients had been seen or were being seen regularly by the doctor who was prescribing their medicines. Safe, effective systems to monitor client's physical health and to obtain any required physical health tests were not in place. Effective systems to ensure regular contact with all GPs were not in place. The provider did not have systems in place to provide supervised consumption and robust systems to ensure the safe prescribing of medicines.

At the February 2017 inspection, we found some areas where governance systems had improved. We saw that the provider was monitoring the number of ampoules prescribed and subsequently returned by clients. Urine screening tests were happening more regularly. The environment had been redecorated and some infection control procedures had improved. Some policies and procedures had been reviewed and updated. Staff had been issued with job descriptions and had a clear understanding about their roles. Further information to establish the good character and suitability of staff for their role had been obtained. Overseas clients had been discharged from the service. However, further improvements were identified as being required in many of these areas and the provider could not be sure that the changes made were embedded into practice and would be maintained.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment CQC took enforcement action to cancel the providers registration from 21 April 2017.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance CQC took enforcement action to cancel the providers registration from 21 April 2017.