Birmingham Inpatient Drug Treatment Service

Quality Report

Park House
15 Park Road South
Hockley
Birmingham B18 5QL
Tel: 0121 5235940
Website: www.changegrowlive.org

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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

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Overall summary

We do not currently rate independent standalone substance misuse services.

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

- Staffing levels were low at times and there were some vacancies as a result high levels of agency staff were used.
- Risks identified by staff during the assessment of new clients were not accurately reflected in risk assessment plans.
- The service did not operate systems where Male and female only corridors could be facilitated. Due to the nature of the service there were no locks on the toilet doors, and there were no signs on the doors to indicate male or female use.
- Clients reported that the food on offer at the service was below an acceptable standard.

However, we found the following areas of good practice:

Summary of findings

- Staff completed e learning safeguarding training, 91% of staff had completed both adults and children safeguarding training.
- New admissions to the service received good assessment of needs and care plans, there was good on going physical health care checks. Clients were fully involved with the development of the care plan.
- The service worked alongside other specialists and professionals that clients accessed such as midwives. There was good multidisciplinary working with staff both within and external to the service.
- There were good electronic systems in place, which ensured information could be viewed and updated by all staff at CGL. There were systems in place to monitor safety the service had CCTV throughout the building and an intercom system.
- Staff provided a good induction for clients that incorporated their rights, confidentiality the rules and restrictions of the service.
- The service had a range of rooms to support clients' recovery and comfort whilst using the service.
- Staff ensured there were discharge plans and contingency plans for clients leaving the service and returning to the community.
- Leaflets were available in different languages and there was access to interpreters and signers.
- The service had a commitment to completing audits and addressed any issues raised using action plans.
- The service had good governance structures and systems to monitor all aspects of care and oversee areas for improvement.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Substance misuse/ detoxification		

Summary of findings

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Birmingham inpatient drug treatment service

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Summary of this inspection

Background to Birmingham Inpatient Drug Treatment Service

The service registered with the Care Quality Commission in 2015 and this was their first inspection.

Change Grow Live is a social care and health charity in England and Wales. They provided a residential detoxification and stabilisation service for substance misuse clients over the age of 18 years in Birmingham. The residential unit was known as Park House, a purpose-built 18 bedded unit. Birmingham City Council commissioned nine of the beds for residents of Birmingham and the remaining nine beds were for out of area placements.

Park House was staffed 24 hours a day, 7 days a week and supported by clinical and operational on-call systems. A client's average length of stay at Park House was two weeks but that can vary depending on clients' individual needs.

Park House was not suitable for clients who had a primary mental or physical health issue that requires hospitalisation.

Our inspection team

The team that inspected the service comprised CQC Sonia Isaac, inspection lead, two other CQC inspectors, a nurse specialist advisor and expert by experience. An expert by experience is a person who has personal experience of using, or supporting someone using, substance misuse services.

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, asked other organisations for information, and gathered feedback from staff members in response to an email we asked the provider to send to them.

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 nine clients
- spoke with the registered manager and the clinical service manager

Summary of this inspection

- spoke with eight other staff members employed by the service provider, including nurses and support workers
- spoke with three staff members who worked in the service but were employed by a different service provider, including a clinical psychologist
- received feedback about the service from two commissioners
- spoke with three peer support volunteers
- attended and observed a ward review /multi-disciplinary team meeting, and a daily meeting for clients
- collected feedback using comment cards from 12 clients
- looked at 12 care and treatment records, including medicines records, for clients
- observed medicines administration
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

- All clients, except two, said that staff were approachable, friendly and caring.
- Two clients' feedback comment cards said they felt some staff were not empathic and that they were disrespectful.
- One client left feedback to say they felt it was a safe and pleasant environment.
- We received negative feedback about the food at Park House. Clients overwhelmingly said the range of choices available were poor. One client said they had a special diet to help them tolerate their medication and staff refused to give them the food they needed. Another client said that they sometimes did not get the food they requested.
- One client said they would like to keep their 'as needed' medication in their possession rather than having it removed and having to ask staff every time they needed their medication.
- One client said it would be good to have a daily newspaper to keep up to date with what is going on in the world.

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:

- No distinction was made in separating male and female corridors where client bedrooms were situated. Although the layout of the building meant it was possible. There were no facilities to accommodate separate male and female lounges. Toilets did not identify whether they were for male or female use and due to the nature of the service did not have locks. This could have an impact on the clients' privacy and dignity.
- The disabled room was located on the first floor and required a lift to access it. That meant in an emergency it might be difficult to manage an emergency evacuation.
- Park House only had one ligature cutter, which was held by a nurse on duty. There were no other ligature cutters available within the unit. This meant that in an emergency, staff would need to find the nurse in charge, which might cause delays.
- Staffing levels were not always adequate. There were a number of vacancies at Park House and there were high levels of agency staff used.
- Not all staff had completed mandatory training programmes. For example, equality, diversity and inclusion in practice had an 18% completion rate, this fell far below 75% which was the national target. Not all staff had health and safety management training. This might mean that staff were not knowledgeable enough to manage health and safety well on the unit.
- All clients had up to date risk assessments and risk management plans. However, the risk management plans did not always accurately reflect all the risks identified at assessment. This meant staff did not have accurate risk information and may not respond appropriately.
- There were a number of blanket restrictions at Park House. For example, clients were not permitted to have mobile phones or to buy sugary snacks. Managers told us clients agreed to these restrictions as a condition of admission to the service.

We found the following areas of good practice

Summary of this inspection

- Park House had systems in place to monitor safety, for example, regularly reviewed environmental risk assessments and close circuit television systems. Where risks were identified, staff used individual risk assessments and observations to mitigate against these risks.
- There were well equipped clinic rooms and equipment was monitored and maintained at regular intervals to maintain effectiveness and ensure they were safe to use.
- There were good medication management systems in place with regular local pharmacy audits.
- Staff attended weekly meetings to discuss health and safety matters and staff completed a health and safety review every six months. Staff had pinpoint personal alarms and there were suitable control measures in place to ensure there were enough staff on shift.
- There was always a qualified member of staff present on the unit. There was a full time permanent doctor working on the unit from Monday to Friday. There was additional prescribing support and an on call rota for the consultant. Staff also worked with clients' community GP's and emergency services for other physical health needs.
- Staff carried out audits, for example, daily checks of room temperature. Audit outcomes were shared with the team through business meetings or urgent issues were resolved with staff as soon as possible.
- The service had not reported any serious incidents to the care Quality Commission. Information received from the service states there had been no serious incidents requiring investigation in the last 12 months.
- Staff knew how to report incidents and followed the service incident reporting policy. There was a process to investigate clinical and operational incidents and an integrated governance team to look for themes to present to teams for learning purposes.
- Staff completed e learning safeguarding training, 91% of staff had completed both adults and children safeguarding training.

Are services effective?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- There were good assessment of needs and planning of care for new admissions to Park House. There was ongoing physical health care monitoring by staff, which was documented. We were provided with examples of when further physical health check investigations were needed.

Summary of this inspection

- CGL staff could access all client information on the electronic recording system. This meant they could access the most updated information to help support clients in their treatment.
- Clients could access recovery groups and alcoholics and/or narcotics anonymous. Staff worked alongside specialist organisations and professionals for example, specialist midwives.
- Staff carried out audits to monitor standards and help identify areas needed for development.
- Staff came from a range of professional and non-professional backgrounds. There was a consultant psychiatrist, doctors, qualified nurses, pharmacists, and support workers to support the needs of the residents at Park House.
- Staff from all professions attended regular weekly multi-disciplinary team (MDT) meetings. The pharmacist attended twice weekly. Staff worked closely with care co-ordinators in community teams and those who referred in to the service to ensure a smooth client transition and experience.
- Some staff were trained in Mental Capacity Act (MCA). Staff knew where to access help and advice if needed. There was a policy on the MCA including DoLS, which staff could access if needed.

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

- CGL's mandatory training submission indicated low levels of compliance. This meant Park House were not reaching their targets of completing their mandatory training and staff might not be sufficiently skilled to work with the complexities of the client group.
- CGL had an equality, diversity and inclusion policy and training was mandatory at induction however, not all staff had received this training.
- The quality of client's recovery plans were variable and required a more consistent approach to quality.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Clients told us that they felt staff were caring, compassionate, and respectful.
- Clients were inducted in to the service and provided with information on admission about rights, complaints, confidentiality and rules and restrictions of the service.

Summary of this inspection

- Clients were given information on admission about treatments and medication choices were taken in to consideration.
- Clients were fully involved in the development and review of their individual care plan and had their needs and recovery orientated goals incorporated into this plan.
- Clients' involvement was actively encouraged. CGL worked with clients in creating opportunities for people who used services. This encouraged a sense of ownership and contributed to successful outcomes.

Are services responsive?

We do not currently rate standalone substance misuse services.

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

- Many of the clients were smokers and the cigarette smoke flowed in to bedrooms one and two on the ground floor. This area is where new clients spent their first few days. It was also loud and there was very little privacy, which could impact negatively on new clients comfort, dignity and confidentiality.
- Clients rated the quality of food on offer as below an acceptable standard. They reported that the food was unpleasant and they did not always get what they requested. There was a new chef in post and they were planning improvements to meet the needs of clients.
- Access to the disabled room was via a lift on the first floor. The lift was broken at the time of inspection, however there were no disabled clients. Disabled clients would be risk assessed and a plan put in place to support their needs including mobility issues.
- Clients were limited in their discussion with families and friends over the telephone. Calls were limited to ten-minute durations.

We found the following areas of good practice:

- Clients were admitted and monitored on to an assessment bedroom with ensuite. This meant clinical staff could work closely with them to monitor their wellbeing.
- Clients had discharge plans and contingency strategies in place for their planned or unplanned transition back to the community. Clients who were discharged were followed up within seven days. All discharges were communicated to key stakeholders with discharge planning information.

Summary of this inspection

- There were a range of rooms and equipment to encourage recovery and comfort, for example, an activity room and a tv lounge with games. There were private spaces and places to meet with visitors and have one to one's with staff to promote dignity and to ensure confidentiality.
- Clients had a safe in their bedrooms where they could safely store their belongings.
- There were hot and cold drinks and snacks available at any time and clients could help themselves.
- There were leaflets in different languages and access to interpreters and signers if needed.
- Clients knew how to make formal complaints. They used daily meetings to resolve issues when possible in the first instance. There were processes in place to ensure complaints were dealt with and shared with staff and clients.

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:

- Staffing levels were low and there were high levels of agency staff used.
- CGL's mandatory training submission indicated low levels of compliance. This meant Park House were not reaching their targets of completing their mandatory training and staff might not be sufficiently skilled to work with the complexities of the client group.
- CGL had an equality, diversity and inclusion policy and training was mandatory at induction however, not all staff had received this training.
- There were no facilities to accommodate separate male and female areas. This could have an impact on the clients' privacy and dignity.

We found the following areas of good practice:

- Managers attended a recent event to discuss and agree the organisations values, which was then shared with staff through supervision and team meetings.
- There was a governance lead to oversee governance systems for monitoring and quality improvement.
- There was a commitment to carrying out audits and using action plans to address any issues highlighted as a result of audits and changes made based on the outcome of audits.
- Staff received regular supervision and annual appraisals.

Summary of this inspection

- There was a leadership team with clearly defined roles. There were no known issues relating to bullying or harassment and staff knew the whistleblowing policy.
- The overall sickness rate was 1.1%.

Detailed findings from this inspection

Mental Health Act responsibilities

- Park House did not admit patients detained under the Mental Health Act.

Mental Capacity Act and Deprivation of Liberty Safeguards

- All clients using Park House were able to make decisions independently. No clients were subject to deprivation of liberty safeguards in the 12 months prior to inspection.
- Mental Capacity Act training was part of the core basic training package completed on induction. Information gathered by us before the inspection indicated that training was an eLearning package and Change Grow Live (CGL) were not meeting their target of 100% compliance. Information from service stated that Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS) guidance is in place and training for all staff was planned.
- The manager told us that most of the staff on the team should have completed the training but did not provide us with the number of staff whose training was outstanding. All staff except one new health care worker that we spoke with at inspection had completed the eLearning Mental Capacity Act training.
- On admission, clients and staff talked through rules, expectations, emergency contacts and who they might share information with during their stay.
- Clients signed care plans and risk assessments to evidence agreement and consent to the detail.
- Staff knew and understood there was a protocol in place if clients appeared to lack capacity due to intoxication or deterioration of physical health.

Substance misuse/detoxification

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse/detoxification services safe?

Safe and clean environment

- Staff, clients, and visitors could access Park House via an intercom system operated by staff on reception. All visitors were required to sign in and out when attending or leaving the unit.
- Staff could view close circuit television (CCTV) in the unit. It had a multiscreen layout and each camera recorded up to two weeks of activity. One of the cameras in the stairwell was broken. The manager provided information stating a request had been made to have it fixed by housekeeping. The manager could not give us a timescale for completion of the work.
- The manager pointed out two blind spots (an area where a person's view was obstructed) at the top and bottom of the stairwells. There was also a blind spot at the fire exit. There was a camera at the top of the stairs, but it did not capture the view of the bottom of the stairs. Staff used individual risk assessments and hourly observations to mitigate against the risks.
- Staff carried out audits that highlighted risks in various places at Park House. For example, blind spots in the stairwells, ligature risks in the laundry room and window hinges. Staff mitigated against the risks by individual client risk assessment, CCTV monitoring and hourly observations.
- One fire exit that led to the side of the building was easy to open and was not alarmed. None of the doors or windows had alarms. This meant that people could move in and out of the building without anyone being alerted. This could present as a risk, for example, in the event of an emergency evacuation staff might not know who was in or out of the building.
- The clinical service manager carried out a ligature audit on 23 May 2016. A ligature point is anything, which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Sometimes this resulted in asphyxiation and death. The audit gave an overview of the current position of the service. It stated all bedrooms were compliant with anti-ligature showers, curtain tracking and wardrobe shelving. A tour of the bedrooms at Park House confirmed this was the case.
- There were ligature risks that had not been identified outside of the bedrooms. For example, handrails at the side of a Jacuzzi bath and windows. However, the Jacuzzi bathroom was kept locked. There was a sign on the wall explaining clients would be risk assessed before being allowed to access the Jacuzzi bathroom. There were risk assessments in files relating to use of the Jacuzzi bathroom, which meant risks were managed.
- The nurse in charge had ligature cutters on their possession. There were no other ligature cutters available within the unit. This meant that in an emergency, staff would need to find the nurse in charge, which might cause delays. The manager said they would review this matter with a view to all staff carrying ligature cutters.
- Client bedrooms were situated over two levels, ground floor and first floor; all were ensuite. Each floor was a mix of male and female clients. No distinction was made in separating corridors, therefore there were no female or male only areas. The service was considering having male and female only corridors, and there was scope to facilitate this.
- It was identified that there were vulnerable female clients admitted to Park House. There were no separate

female spaces. There was no formal way of reviewing whether female clients admitted to Park House wanted a female only space. This meant vulnerable female clients might not feel safeguarded during their stay.

- Communal toilets did not identify whether they were for male or female use and due to the nature of the service did not have locks. This could have an impact on the client's privacy and dignity.
- The clinic room was spacious and clean. It had an adjoining room for examinations and observations. It was equipped with a couch, scales, blood pressure, temperature and Electro Cardiogram (ECG) machine. The equipment had been checked and calibrated to ensure safety and accurate readings.
- Staff monitored the clinic room and fridge temperatures daily and recorded them in a file. We checked medicines requiring cold storage and found fridge temperatures had been recorded in accordance with national guidance. A report was made of any missed recordings. The fridge was locked and only contained medication. It was not over stocked and was clean and defrosted.
- The emergency bag was situated in the clinic room. Night staff checked and recorded the contents of the bag daily. There had been two occasions where the bag had not been checked 3 August and 4 August 2016. We reported this to the nurse in charge to follow up.
- The environment and facilities appeared clean, tidy, and reasonably well maintained. Equipment was portable appliance tested (PAT) up to June 2017. This meant that electrical appliances and equipment were tested to ensure they were safe to use.
- Cleaners were contracted to work on site between two and four hours each day. There were no formal cleaning procedures in place when the cleaners were not on site. Cleaners used a pre-printed cleaning schedule to determine the areas that required cleaning either on a weekly or daily basis.
- Cleaners had access to a control of substances hazardous to health (COSHH) cupboard. COSHH is the law that requires employers to control substances that are hazardous to health. The cleaners told us they were aware of COSHH and used and stored products accordingly. A health and safety review was completed on a six monthly basis to check compliance with COSHH.
- Staff had access to a kitchen that was clean. However, the fridge was small and full to bursting with food, which might mean cold air could not circulate to keep the food safe for consumption. There was a temperature checking system in the kitchen, which was not always completed.
- Staff had access to hand sanitizers throughout the unit and on entry to and from the unit. We looked at a health and safety audit, dated 29 July 2016. Not all staff had health and safety management training and not all staff had evidence of completing their health and safety induction, which was mandatory. The manager told us there was an eLearning module being introduced from September 2016 to improve access and compliance.
- Staff had a weekly meeting where health and safety matters were discussed. Staff completed a health and safety review every six months. The last one was on 24 March 2016. Staff completed a health and safety audit, which was due to be reviewed 29 September 2016.
- Each member of staff had a pinpoint personal alarm. We witnessed an alarm going off while we were on inspection. There was an immediate response to the emergency from the nurse in charge.
- There was an assessment of suitable control measures in place for lone working, it indicated that staff would not need to work alone, and there was always enough staff on shift.

Safe staffing

- The manager told us that staffing levels and skills mix were appropriate for the needs of the service. Staff told us that staffing levels were inadequate and that there were high levels of agency staff used and we saw this indicated in data reports provided to us by CGL.
- The manager told us that staffing levels were based on recommendations from the Nursing and Midwifery Council (NMC). The service had 21 staff including eight qualified whole time equivalent (WTE) and eight WTE Health Care Assistants.

Substance misuse/detoxification

- Information from the data pack showed there were three qualified nurse vacancies and four nursing assistant vacancies in the last three months, total vacancies 7%. Following the information received from the data pack the service recruited to the vacant positions.
- The manager confirmed they now had two nurse vacancies and had recruited to these posts. Staff were due to start in September 2016. There were also two health care assistant vacancies; interviews were due to take place in two weeks. The service had also recently recruited a chef and a housekeeper.
- The provider reported a total permanent staff sickness rate of 1.1% over all. The substantive staff turnover as of 24 June 2016 was 15%. There was 20 substantive staff, three substantive leavers, of the three leavers, two transferred to other services within CGL.
- The registered manager told us there was no specific staffing tool used. Managers discussed the staffing requirement for the service with the nursing team and looked at guidelines from the NMC.
- Staffing numbers were based on a non-complex mental health unit of two qualified staff Monday to Sunday. One qualified staff and two Health Care Assistants covered the night shift Monday to Sunday.
- We viewed the rotas from February 2016 up to and including August 2016. It demonstrated the staffing figures outlined by the registered manager.
- The manager and staff told us there was high use of agency staff. During the period of 1 January 2016 to 24 May 2016, there were 196 nurse shifts and 215 health care assistant shifts available. Therefore 99.5% of shifts were available, bank and agency staff covered these shifts. During this time, two health care assistant shifts were not covered.
- Agency workers attended the unit one hour before their start time. This was to familiarise themselves with the staff, the unit, pin point alarms, client group, policies and procedures and routines. One clinical lead told us permanent staff would support agency workers that were not familiar with the service.
- Substantive staff worked overtime to cover vacant shifts and sickness. The manager told us they had a pool of bank staff at CGL and they were in the process of developing a bank of qualified nursing staff to reduce the number of agency nurses used.
- Staff told us there was always a qualified member of staff present on the unit. They would not take breaks together and would not leave the unit during this time.
- Clients had one to one time with a member of staff. This consisted of completing the recovery plan with a named worker. This did not take place daily; however, clients could request ad hoc one to one support to address any matters.
- Clients were not detained under the Mental Health Act and could leave Park House unescorted when they wanted to.
- Park House had one full time permanent doctor working on the unit from Monday to Friday. There was a locum contracted consultant to support the doctor who attended the service twice a week. During the day, doctors could be accessed quickly. Managers used an agency to cover emergencies out of hours. CGL also had an on call rota for the consultant.
- Staff worked with clients' community GP for their physical health needs. In an emergency, if a GP could not attend, staff would call emergency services.
- Boundaries training was identified as mandatory training but no staff had completed this at the time of our visit.

Assessing and managing risk to clients and staff

- Staff did not use seclusion, segregation, or restraint at Park House.
- Staff gathered information prior to admission from the referrer about risk and contingency plans.
- Clients had a risk assessment on admission. Change Grow Live (CGL) had a specific risk assessment tool, used to develop a risk management plan tailored for the client. Of the eight care records we looked at the risk management plans were up to date.
- The risk management plans of five care records did not accurately reflect all the risks identified at assessment. This meant those risks might not be appropriately

managed. For example, one client had a risk of seizures documented in their assessment paperwork. In the risk management plan, staff documented the seizures as blackouts.

- Staff documented a client's risk of vulnerability, mental health and self-harm on their risk assessment. However the information was not reflected in the risk management plan. This meant staff did not have accurate risk information and may not respond appropriately.
- Staff discussed risks at ward rounds. We observed a ward round but not all individual risks were addressed. For example, staff discussed immediate observations of risks but there were no long-term management plans put in place to manage those risks.
- A staff consultation to review blanket restrictions had taken place on the 19 May 2016. Responses from staff were collated and reviewed with the clients who used the service at that time. There were a number of blanket restrictions at Park House.
- Clients were not permitted to have mobile phones. The rationale was mobile phones could be used to request drugs and calls could not be monitored. Staff monitored client calls by limiting contact with others to a public payphone in the reception area. This was also said to enable staff to assess risk. The review of the blanket restrictions stated removing mobile phones did not restrict clients' opportunities to contact others by phone.
- Clients were not permitted to use substances while in treatment; this was deemed an essential blanket restriction due to the nature of the service. Gambling was not allowed whilst using the service to avoid the development of other addictions.
- Clients were not permitted to buy sugary snacks. The manager told us that the consumption and reliance on sugary foods had been evidenced to create feelings similar to cravings for alcohol and drugs. He could not reference the evidence base. This restriction was highlighted on an undated blanket restriction review document.
- Clients were told not to have exclusive relationships and cliques. The rationale was that it increased the risk of clients disengaging from services and would distract their focus from the detoxification process. The service had also deemed this a valid blanket restriction.
- Clients were permitted to leave at any time. There were no detained patients at Park House. There were contingency plans in place for those who self-discharged. Plans were developed with the client and the community teams who were the care co-coordinators.
- Staff assessed patients to reduce risk and followed an observation protocol by observing and recording client observations hourly.
- Staff did not use restraint, rapid tranquilisation or seclusion.
- The safeguarding lead told us community teams, who were the client's care coordinators, identified, and managed safeguarding concerns. However, staff we spoke to understood how to make safeguarding alerts and understood their responsibilities.
- The service provided information on mandatory training. This showed 91% of staff had completed an eLearning programme in safeguarding adults and children, data protection, and information sharing.
- A doctor told us they also received online safeguarding training. The doctor identified abuse through assessment and observation. They looked for signs of physical, emotional and other types of abuse.
- The registered manager explained the service had separate children and adults safeguarding policies. They were developing and improving their adult safeguarding pathways. They had safeguarding leads and representatives and good links with the Multi Agency Safeguarding Hub (MASH), which is the single point of contact for all professionals to report safeguarding concerns.
- A qualified pharmacist carried out medication audits on a weekly basis to make sure staff managed medicines correctly as determined by the latest guidance. They provided weekly reports to the nurse in charge. The clinical lead managed any issues raised within the report.

Substance misuse/detoxification

- Staff identified allergies during the admission process, which was documented on the admission form. Staff removed all medication from clients and stored them in the cupboard in the clinic.
- The lead nurse audited the clinic room, for example, daily checks of room temperature, and stocking of controlled drugs. Any issues were fed back to team through business meetings or urgent issues were resolved with staff as soon as possible. We saw evidence of this in the minutes of the staff meeting 14 July 2016. The pharmacist had highlighted issues with the fridge temperature not being recorded correctly.
- The registered manager told us that all visits were care planned and the visitor policy was followed. This gave the service and client the chance to see who the visitors were and the possible impact. There was a designated room where visitors could meet with clients. Children and young people below the age of 16 could not visit on their own.

Track record on safety

- The service had not reported any serious incidents to the care Quality Commission. Information received from the service states there had been no serious incidents requiring investigation in the last 12 months.

Reporting incidents and learning from when things go wrong

- All staff we spoke with knew how to report incidents. Staff followed the services incident reporting policy. They gave some examples of incidents that were reported, for example, medication errors, verbal abuse, inappropriate behaviour and health deterioration.
- We looked at internal data, which showed no incidents, safeguarding concerns or alerts had been received at Care Quality Commission (CQC) in the last 12 months.
- Managers told us staff recorded incidents on an electronic incident recording system. Staff recorded detailed information about the incident and how it was managed.
- The clinical manager or lead nurse looked at clinical incidents. The service manager would investigate operational incidents. A response was required within 18 days, which included an action plan to take to the integrated governance team (IGTM). Incidents over a 3 month period were reviewed and themes selected for discussion.
- We viewed the minutes of two IGTM meetings, which showed discussions about incidents across CGL. The registered manager had broader discussions about incidents through the IGTM locally.
- The lead nurse gave an example of lessons learned following a local incident and investigation following a medication error. The outcome of the investigation was that additional prescribing support was needed. This resulted in the recruitment of a non-medical prescriber two full days a week to support the consultant with prescribing.

Duty of candour

- Staff we spoke with told us the importance of being open and honest with clients. The provider used complaints and investigations into incidents to highlight errors made and responded to clients. The provider and clients also worked closely with commissioners and met weekly to discuss any issues, incidents, complaints or concerns.

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

Assessment of needs and planning of care

- Staff told us that on admission to the service, clients received a physical health care assessment within 24 hours. We viewed eight care records of clients using the service. There was evidence of physical examinations carried out at each client admission. There was on going physical health care monitoring by staff, which was documented. We were provided with examples of when further investigations were needed.
- Staff at Park House were not care co-ordinators. Responsibility for care coordination was with the community team or referring team. Staff at Park House could access online shared client information relating to

their treatment with the CGL community team. The community team or referring team were responsible for managing care pathways to other supporting services, for example, housing, and education.

- Client information was stored securely either in locked drawers or on password protected electronic record systems. Staff across CGL services could access information on the electronic recording system, which meant they could access the most up to date information to help support clients in their treatment.

Best practice in treatment and care

- The consultant told us that they followed NICE guidance for medical, mental health and substance misuse and policies were updated to reflect changes in NICE guidance. However, a lead nurse told us that they had an incident relating to medication management which would indicate that Park House staff were not always following NICE guidance in relation to 'controlled drugs: safe use and management records of handling controlled drugs'. A monthly audit completed by the pharmacist on 15 March 2016 showed incomplete Controlled Drugs register. Also a lack of timely and correct destruction of controlled drugs.
- The pharmacist completed monthly audits and reported any issues to the lead nurse and in staff meetings. We saw issues had been raised in the staff meeting on the 14 July 2016. The pharmacist stated the service was always proactive with rectifying issues raised and medication management had improved.
- Patients had access to daily recovery group meetings and visits from Alcoholics and Narcotics anonymous.
- Staff worked alongside specialist organisations and professionals if needed, for example, specialist midwives to work with pregnant clients. Staff worked with GP's for general healthcare needs and local accident and emergency hospitals for urgent care.
- CGL provided us with a list of audits carried out by staff at Park House. For example, weekly clinical audits. Lloyds Pharmacy also carried out an independent clinical audit to identify improvements in medications management.

Skilled staff to deliver care

- Staff were from a range of professional and non-professional backgrounds. There was a consultant psychiatrist, doctors, qualified nurses, pharmacists, and support workers to support the needs of the residents at Park House.
- CGL's mandatory training submission indicated that two (18%) of staff had completed mandatory equality, diversity and inclusion in practice training. Only two (18%) staff had completed mandatory health and safety training and no (0%) staff had completed the mandatory boundaries training. This meant Park House were not reaching their targets of completing their mandatory training and staff might not be sufficiently skilled to work with the complexities of the client group.
- The new doctor told us there was no specialist training that he was aware of for medical staff. They told us they received professional supervision every two weeks and an appraisal once a year.

Multidisciplinary and inter-agency team work

- Staff from all professions attended regular weekly multi-disciplinary team (MDT) meetings. The information from the MDT was presented to staff at daily handovers. Important medical information was passed directly by doctors.
- The pharmacist told us they attended Park House twice weekly. They occasionally attended the MDT and offered clients the opportunity to discuss medication. We saw documentary evidence that pharmacy audited medication records and supported staff in achieving good standards of medication management.
- Staff told us they had effective working relationships and good links with for example, GP's and social services. The doctor told us that they could have better relationships with the local community mental health teams.
- Staff told us that they linked with care co-ordinators in community teams and with referrers to ensure a joint working approach to improve client transition and experience.

Adherence to the MHA (if relevant)

- The service was not registered to accept clients detained under the Mental Health Act. If a client's

mental health were to deteriorate, staff were aware of who to contact. Some of the nursing staff had been trained as registered mental health nurses, which meant that they were aware of signs and symptoms of mental health problems.

Good practice in applying the Mental Capacity Act

- The doctor told us that Mental Capacity Act (MCA) training was completed online. One worker told us that they had been trained but they did not understand what it meant in practice. They did know where to access help and advice if needed.
- There was a policy on the Mental Capacity Act including Deprivation of Liberty Safeguards, which staff could access if needed.
- The doctor told us that they assessed for capacity but did not record how capacity to consent was assessed.
- The doctor told us that clients were supported to make decisions. That they would explain how treatment was going to be beneficial. Clients signed a behaviour contract if they decided to stay at Park House.
- The service stated that consistency of training required improvement, and is outlined in their training action plan. In particular in areas such as Mental Capacity Act and Deprivation of Liberty Safeguards, boundaries and equality and diversity. This will be in place by June, 2016

Equality and human rights

- The provider had an equality, diversity and inclusion policy. Equality and diversity level two training was mandatory at induction for all staff. However, figures provided showed that staff were not up to date with a rate of 18% completion.

Are substance misuse/detoxification services caring?

Kindness, dignity, respect, and support

- Staff interacted positively with clients. Clients told us overwhelmingly in discussions that they felt staff were caring, compassionate, and respectful. For example, they were approachable and if clients needed to discuss matters, staff would talk to them quietly away from other clients.
- Staff discussed an issue of a vulnerable female at handover. We saw no further discussion to help to safeguard client's privacy and dignity when they are often at their most vulnerable. There were no separate female or male areas or rooms to accommodate those with identified vulnerabilities.
- Clients with children were allocated time slots to speak with them over the telephone. Families and friends were encouraged to visit clients at Park House and were allocated a space to see them.
- Clients were asked in the morning if they needed to make any calls in the day and they were allocated a time slot under supervision. When there was high demand to use the phone, calls could be limited to ten-minute duration.

The involvement of clients in the care they receive

- Clients received a service user guide to residential inpatient detox prior to attending the service. This included information on the clients rights, complaints, confidentiality and rules and restrictions of the service.
- The registered manager told us clients were able to express their choice of detox. Staff had discussions with clients and made recommendations on different detox that were available. Client choices were taken in to consideration.
- Clients were actively involved in care planning and risk assessments. We saw this indicated in the content of the care plans. Clients signed their care plans to agree the content and were offered a copy.
- Service user involvement and services led by people who used or still use services were actively encouraged. We saw this in partnership working, associated volunteer services.
- Park House actively encouraged service user involvement and peer support. Peer support is the process of giving and receiving non-professional, non-clinical assistance from individuals with similar conditions and experiences. They used services led by people who used similar services to provide support and advocacy. We saw this in partnership working, associated peer, and mutual support services. Clients were encouraged to get involved in training to be volunteers to support others in their recovery.

Substance misuse/detoxification

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

Access and discharge

- New clients were located in bedrooms on the ground floor during their initial detox period. They remained there until they were assessed to be sufficiently steady on their feet to reduce the risk of slips, trips and falls. Clients would then be transferred to the main area of the ward.
- When clients were discharged, this took place at an appropriate time. Clients had discharge plans in place to support them when they completed their treatment at the service.
- Staff told us that clients entered Park House with contingency plans developed with their community keyworker. Any changes made to plans during their stay at Park House were conveyed to the community keyworker to ensure a smooth transition back to the community.
- Staff told us they worked with the client to develop a recovery plan. We looked at eight care records, two did not have a recovery plan present, four of the recovery plans were less than adequate, for example, they were not strengths or goals based. Two of the care records had a good recovery plan in place.
- CGL provided us with information that 100% of clients discharged were followed up within seven days. For all discharges, a discharge letter and a full discharge letter from the GP was faxed and posted to the clients GP and the referrer on the day of discharge.
- Information provided from the service stated in the last 12 months up to 20 May 2016, 21 clients did not attend. When this occurred the service contacted the referrer to inform they had not attended detox and to inform them to continue treatment

The facilities promote recovery, comfort, dignity and confidentiality

- The windows in bedrooms one and two opened out to a communal smoking area where many of the clients congregated. The area smelled strongly of cigarette smoke, it was loud and there was very little privacy. This meant that new clients would not be afforded the comfort, dignity and confidentiality needed to help them with their recovery.
- Clients could not make phone calls in private, however clients agreed to this as one of the criteria of admission. There was a quiet, separate area in the conservatory where clients could meet with their visitors. However, it did not have privacy screens, which meant clients using the outside space, could see in.
- There were a range of rooms and equipment to support treatment and care, for example, clinic rooms to examine patients, activity and therapy rooms. There were bedrooms available on the ground floor for new admissions during the initial detox period.
- The sitting room for clients had a working TV, games and other activities. Partition dividers separated the sitting room, one to one room and dining room. The partition was used to make the space adaptable, and therefore the sitting room could be expanded to match the number of residents in the service. However, when all rooms were in use and separated by the partition, the sitting room was very small. This meant during this time there would be a limited number of clients who would be able to access it at any one time.
- There was an outside space. We observed that the outside area, was well used by clients who smoked.
- There were leaflets available to clients and these could be accessed in different languages if needed. Clients were offered leaflets about local services, how to complain and make comments and give compliments.
- Clients could have access to interpreters and signers if needed. Staff told us that they could access an interpreting service and would not depend on friends and family to interpret. This meant clients' could speak and express their views with independence.
- Clients had a safe in their bedrooms where they could safely store their belongings.
- Clients could have hot and cold drinks and snacks if they wanted them at any time. There were a range of teas, coffees and fruit juices in the common area where clients could help themselves.

- One client informally complained while we were on inspection they did not have access to the Jacuzzi bath for a week. We were told by the client and staff that the
- Jacuzzi bath was to help aid detox.

Meeting the needs of all clients

- The unit was over two floors and the disabled room was on the first floor. There was a lift, which was out of order on one of the days we visited. The service had an EVAC chair for use for disabled clients in the event of a fire, however the manager told us that staff were not trained to use it. The manager told us they would wait for either the fire service or manual handle clients in the event of an emergency. Staff would also individually assess clients with a disability to manage risks associated with their mobility issues.
- Seven clients said the food was unpleasant. One client said they had a special diet to help them tolerate their medication however, their requests were not always met. Two clients said they did not always get the food they requested. One client said they would only eat cereal and fruit and avoid food from the kitchen. There was a chef who produced a menu. The chef and manager told us that they catered to the needs of clients. All clients we spoke with overwhelmingly rated the food as unacceptable. The manager and chef told us they hoped that now there was a new chef in post, clients would see improvements in the service.
- One client said they felt safe and the environment was pleasant.

Listening to and learning from concerns and complaints

- All clients were informed of how to make a complaint at admission and were provided with a service user guide that explained the process. The complaints process was also displayed in the reception area.
- All service users spoken with told us that they knew and understood how to make a complaint. There were suggestion boxes and a Care Quality Commission comments box available to clients. There were complaints flow charts displayed throughout the building. Clients also discussed issues at their daily meetings where they attempted to resolve them.
- CGL provided us with data highlighting that Park House received seven complaints in 12 months. Four of the complaints were upheld. None of the complaints were referred to the Parliamentary Ombudsman. Park House also received three compliments.
- Clients had complained about the standard of food. This was taken on board and there was a new chef in post at the service. They told us they were keen to listen to clients views about food and provide a healthy, balanced diet to meet the needs of the clients.
- Staff had documented service improvements to develop specific spaces and programmes for single gender groups, which were to be in place by July 2016. They had not yet actioned this at the time of inspection.
- The quality lead looked at outcomes of audits, safeguarding reviews, incidents and complaints. The doctor, staff and quality lead told us that investigations from complaints were fed back to staff through the multi-disciplinary team meeting.

Are substance misuse/detoxification services well-led?

Vision and values

- The organisations vision and values were to help people change the direction of their lives, grow as a person and live life to its full potential. To respect the clients and support their rights to self-determination and independence. The service had incorporated their own visions and values with the organisations, which placed quality and safety as their top priority.
- The service had recently experienced a period of change following the transfer of the service and staff to Crime Reductions initiative (CRI) in 2015. Crime Reduction Initiatives rebranded to Change Live Grow (CGL) in 2016. Managers told us they attended a CGL event to discuss and agree the organisations values and that this was discussed with staff in supervision and team meetings.
- In the minutes of the staff meeting 21 April 2016, it was identified that staff morale was low. This was said to have impacted on the effectiveness of working practices. The manager asked staff to revisit the CGL values around passion, empowerment, focus and respect.

Substance misuse/detoxification

Good governance

- Although there was scope to have separate male and female facilities the service was not meeting the needs of clients regarding same sex accommodation. All sleeping corridors were of mixed gender. This was also evident with the toilets, as they did not specify whether they were for male or female use. There were no locks on the toilet doors due to the type of service.
- The service had a low completion of mandatory training. This included equality, diversity and inclusion training.
- The service had a high use of bank and agency staff. However, they were in the process of recruiting staff to the vacant posts.
- The service was not meeting the needs of clients' concerning the food provided. Clients' reported that the food was unpleasant and at times did not get the food they requested. A new chef had been recruited to the post, which the manager said would improve the quality.
- The provider had a clear governance structure and a governance lead who oversaw all governance issues. This included good systems for monitoring all aspects of care and from this being able to see areas for improvement.
- Staff completed audits that gave them the opportunity to analyse the safety and effectiveness of service. There were audits such as physical health audits, environmental audits and medication audits.
- There were examples of action plans addressing any issues found in these audits and examples of changes made.
- Managers and staff used an electronic system to see their compliance with mandatory training. Staff received regular supervision.
- Staff had annual appraisals, which were up to date and complete. CGL provided us with a data to confirm that as of June 2016 100% staff had received an appraisal. Policies were available in their most up to date form on the provider intranet system and this was where staff accessed them from to ensure they were using the most up to date version.
- Safeguarding training for both adults and children was 91% completion.

Leadership, morale and staff engagement

- Park House had a leadership team made up of a service manager, clinical manager, and clinical lead. The leadership team had clearly defined roles and expectations of service delivery.
- The overall sickness rate was 1.1%.
- The organisation had a whistleblowing policy and a telephone number that the staff could use to report any concerns confidentially. One staff member told us they were aware of the whistle blowing policy and could find it on the intranet.
- One staff member told us that they felt 'alright' about their job and when asked if it was a happy team, they responded 'I think so'. They also said that stress levels were high due to workload. One staff member told us that they loved their job and felt management were approachable. One volunteer told us it was a very supportive and caring team.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure the privacy of the clients from those using the communal areas during the assessment phase of the clients' admission.
- The provider must ensure that when assessing clients all risks identified must be correctly and accurately documented in risk management plans.
- The provider must ensure where possible that same sex accommodation guidance is followed at Park House. Toilets must be identified for male or female use.

Action the provider SHOULD take to improve

- The provider should ensure that the food provided is of an improved standard and takes into account all dietary needs.
- The provider should ensure that all care records have a recovery plan present that is holistic and includes the clients' strengths and goals.

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 The service provider did not operate female or male only areas or female only lounges therefore not fully protecting the clients against risks posed to their privacy. The service provider must ensure privacy and confidentiality during the assessment process from other clients using the service. Regulation 10 (2)(a)

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Risks identified from the assessments of the clients on admission were not accurately reflected in the risk management plans. Regulation 12 (2)(a)(b)

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.