Gladstones Clinic Lexham House

Quality Report

28 St Charles Square
London W10 6EE
Tel:011 7929 2102
Website:www.gladstonesclinic.com

Date of inspection visit: 22nd and 23rd November 2016
Date of publication: 13/03/2017

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.

The service had made improvements since our last inspection in March 2016, we found the following areas of good practice:

- The provider had reviewed their governance processes. Managers from the service now met with colleague managers and members of the senior management team to review incidents, trends, and issues relating to the service. The processes were not fully embedded at the time of this most recent inspection, though work had begun.
- The service now had regular medical input from a doctor during office hours and out of hours. These doctors had specialist knowledge and were experienced in working this client group.
- At the last inspection, we found that the service's assessment of client risk prior to admission was not robust. During this inspection, we found that the service obtained information prior to admission and now undertook a thorough and holistic assessment of risk prior to clients being admitted to the service. Staff reviewed risk on a regular basis and took action to manage client risk.

Summary of findings

- When the service was inspected in March 2016, we found that the provider had not ensured that all appropriate emergency medicines were in date and were available in the service. At this inspection, the inspectors found that the provider had made improvements and emergency medicines were in date and available.
- When this service was last inspected, we found that the staff had not undertaken safety checks of equipment. We found that these were now being undertaken.
- At the last inspection, the inspectors noted that the provider had employed staff without the appropriate pre-employment checks being undertaken. Two staff had not had criminal record checks undertaken. During this inspection, we found that the service now ensured that all staff had the appropriate employment checks. They also undertook a risk assessment of each member of staff prior to them commencing employment. Where risks were identified the managers implemented a risk management plan.

However, we found the following issues where the service provider needs to make further improvements:

- At the last inspection, we identified that there were no up to date training records for staff working in the service. At this inspection, we found that there were now training records. However, not all staff had completed their mandatory training and some aspects of mandatory training completion were below 75%.
- During this recent inspection, we found that there were no records of when the physical health monitoring equipment had been cleaned.
- During this inspection, we observed that the clinic room environment was also being used as an office. Clients had their physical examinations undertaken in a room that was cramped. The room lacked privacy and client's personal information was on display on the wall and also on desks.
- During this inspection, we found that clients were asked to sign a consent to treatment form when admitted. However, the information contained in the form was not in line with provider's current policies and procedures.
- The service had yellow clinical waste bins in their clinic room. However, during this inspection, inspectors found that the service was not managing their clinical waste in line with Department of Health (DOH) guidance 2013, which states that clinical waste bins should be collected at least every three months, regardless of filled capacity. The bin had not been collected for over three months.

Summary of findings

Contents

Gladstones Clinic

Services we looked at
Substance misuse/detoxification;

Summary of this inspection

Background to Gladstones Clinic Lexham House

Gladstones Clinic, Lexham House is registered to provide care and treatment for people undergoing alcohol or drug detoxification. The service provided care and treatment to both men and women, and could accommodate eight clients. At the time of the inspection, there were six clients in the service.

Gladstones Clinic, Lexham House is registered to provide:

Accommodation for persons who require treatment for substance misuse and treatment of disease, disorder or injury.

A registered manager was in post at the service.

The service received referrals from statutory agencies and private clients from inside and outside of London.

The service was last inspected on the 21 and 22 March 2016. The inspection was unannounced and focused on whether the service was safe and well-led. We found that there were concerns about the safety of the service and issued a Warning Notice to the provider. We also issued a number of requirement notices, which the provider must take action to address.

Our inspection team

The team that inspected the service comprised two CQC inspectors, a specialist advisor who had experience in working with substance users, a pharmacist inspector and an 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 undertook a comprehensive inspection as part national programme of inspections. During the comprehensive inspection we checked to see if Gladstone Clinic, Lexham House had made improvements that we required it to make following the focused inspection in March 2016.

The inspection in March 2016 focused on whether the service was safe and well-led. We issued one warning notice and six requirement notices. We told the provider it must take the following actions to improve the service:

- The provider must ensure that it obtains sufficient information to conduct a full risk assessment before clients are accepted for treatment.
- The provider must ensure that there is an appropriate level of regular medical input in the service.
- The provider must ensure that there is a robust system for ensuring the attendance of a doctor with substance misuse experience in the service, outside of normal working hours.
- The provider must ensure that all appropriate emergency medicines are available in the service. Emergency medicines must be checked regularly for their expiry dates.
- The provider must ensure that up to date training records are available for each staff member.
- The provider must ensure that all pre-employment checks are carried out before staff begin to work in the service.

These requirements related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

Regulation 12 HSCA (RA) Regulations 2014 Safe care and Treatment, Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed and Regulation 17 HSCA (RA) Regulations 2014 Good governance.

Summary of this inspection

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.

- visited the service and looked at the quality of the physical environment
- spoke with the interim manager and registered manager for the service
- spoke with five staff members employed by the service provider, including nurses and support workers
- spoke with five clients who were being treated at the service
- looked at six care and treatment records, including medicines records, for people who used the service
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with all the clients at the service. Their feedback was very positive about the service and the staff. They felt that the staff were supportive and had a good understanding of their individual needs. Clients felt that there was a good range of therapeutic input but did state that they would like more physical activities to be included as part of the programme.

Clients using the service knew how to complain, and were provided with this information upon admission.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We do not currently rate standalone substance misuse services.

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

- There were no cleaning records for the equipment. The provider could not be assured that the equipment did not present a risk of infection to clients.
- The service did not have call for assistance alarms in the building. If a client or member of staff needed to summon assistance they might have had difficulty in accessing this urgently.The service did not have panic or call for assistance alarms in the building. If a client needed to summon assistance out of hours, they had either go downstairs to find the member of staff or shout for help if they were unable to physically go downstairs. The service was over three floors and each landing had a fire door, which was kept shut. This meant that staff might not easily hear when a client needed assistance. The provider sought to mitigate some of the associated risks by undertaking observations on clients at night
- Some medicines were stored in a refrigerator that was not locked. Staff were not recording the maximum and minimum temperatures. There was no assurance that medicines had been stored at all times at the correct temperature.
- The service did not have sufficient stocks of Naloxone and adrenaline to administer the maximum doses detailed in the prescribing policy.
- The provider did not have a risk assessment that informed the choice of equipment and medicines.
- The provider did not have a standard operating procedure to support the safe and effective administration of as required medicines. The provider stated that they were in the process of introducing this.
- The service was not complying with Department Of Health guidance with regards to the disposal of their clinical waste.
- The service had not requested an enhanced criminal records check for one member of staff.
- The service had only one set of ligature cutters which were located on the ground floor of the building.

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

- The service ensured that they had appropriate pre-employment checks for staff.

Summary of this inspection

- The service had sufficient medical cover.
- The service undertook a comprehensive and thorough risk assessment of clients who were being admitted into the service. The staff updated the client's risk assessment on a regular basis.
- The building was clean and well maintained. There were regular fire drills and fire equipment had been safety checked.
- The staff monitored who was coming into the building. Visitors were asked to sign a visitors book.
- The staff understood the principles of the duty of candour.

..

Are services effective?

We found the following areas of good practice:

- Staff completed comprehensive assessment of clients need prior to admission. Staff liaised with the clients' GPs and requested relevant physical health checks prior to admission.
- The provider used recognised tools including opiate withdrawal scales and severity of alcohol dependence questionnaire (SADQ) to measure the severity of withdrawal from alcohol and opiates.
- Doctors working at the service prescribed medicines for detoxification in line with National Institute of Health and Care Excellence (NICE) guidelines and the provider's prescribing guidelines (dated August 2016).
- Clients had access to a range of therapies provided by the team in the service. Therapies were provided seven days a week.
- The service had provided support workers with a range of specialist training to meet the needs of the client group.
- Staff received clinical, management or peer supervision regularly and the service had a planner with future supervision dates for all staff up until the end of 2016.
- Staff had handover meetings at the start of each shift. During the handover meetings, staff discussed clients using the service and identified what support they required.
- Multi-disciplinary team meetings were held weekly. The meeting was attended by the Consultant Psychiatrist, Registered Mental Health Nurse, Manager and therapy team to discuss treatment and progress of each client.

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

Summary of this inspection

- The service's consent to treatment form was not aligned to the providers' policies. Clients were asked to consent to being restrained. However, the provider did not have a restraint policy to support how and when a restraint should take place. Staff were not trained in restraint techniques.

Are services caring?

We found the following areas of good practice:

- All people using the service were very positive about the service.
- Staff understood individual needs and were aware of their preferences.
- People using the service said they felt safe. They said they received all of the information they needed and understood what to expect from treatment.
- The service actively sought the feedback of clients

Are services responsive?

We do not currently rate standalone substance misuse services.

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

- The clinic room environment did not promote the comfort, dignity or confidentiality of the clients using the service.
- The service had very little information on display that acknowledged and recognised the diversity of the client group. There was no information for clients who wanted to explore other aspects of their identity.

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

- There was no waiting list for a place at Lexham House. The service planned all admissions.
- Information on how to complain was readily available to the clients and the service had improved some of their processes as a result of a client's complaint.

Are services well-led?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- The provider's vision was to support people using the service to make changes in their lives and to help them make a new start. The work undertaken by staff fully reflected the organisations' vision and values.

Summary of this inspection

- Following a previous inspection in March 2016, where requirements to improve the service were put in place. We found that the provider had made a number of improvements and it was clear that the service was improving its governance systems. The provider now had better oversight of key issues within the service.
- The provider had established a new clinical governance group which had begun to meet regularly. At the point of the inspection this group had met on two occasions and were in the process of establishing the agenda and meeting dates for future meetings.
- The managers from the various locations had the opportunity to sharing learning from the various services during their twice weekly teleconference call
- The service had a business continuity plan and if the building became unusable, they would move the clients to another location owned by the provider.
- Staff were open and transparent and explained to people using the service when things went wrong.

Detailed findings from this inspection

Mental Health Act responsibilities

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

Mental Capacity Act and Deprivation of Liberty Safeguards

Nurses, support workers and therapy staff had received training related to the Mental Capacity Act. We saw that there was reference to capacity to consent to admission and treatment in care records.

Clients signed consent forms prior to commencing treatment.

Substance misuse/detoxification

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse/detoxification services safe?

Safe and clean environment

- Staff controlled access into the building via an intercom system. This meant that staff monitored those who were either coming into or leaving the building. Although clients did not have keys to the building they were able to ask the staff to open the doors. There was an emergency exit button next to the front door. This meant that clients could leave the building in an emergency.
- The provider ensured that fire exits and evacuation notices were clearly displayed. The service had ensured that there were fire extinguishers, emergency lighting and fire doors throughout the property. The service had tested the fire extinguishers within the last 12 months, this meant that they were fit for purpose. There was a fire detection system panel by the front door, which meant that staff could identify where the fire was within the building. There was also a fire action plan next to panel, which outlined what individuals should do in the case of a fire. The service had regular fire drills and recorded the dates of this in their fire safety logbook.
- The service's infection control policy and procedures had been reviewed in October 2016, however it was unclear who had reviewed the policy. Infection control audits were undertaken regularly. The most recent audit was dated November 2016 and there were no actions required as a result of the audit.
- The service had not complied with Department Of Health guidance 2013, with regards to the disposal of clinical waste. The service disposed of its used sharps in a yellow clinical waste bin. The bin was dated as having been first used on the 01 August 2016 and therefore should be been collected no later than the 01 November 2016. The guidance states sharps receptacles should be collected when filled to the fill line and should never exceed the permissible marked mass. If the sharps receptacle is seldom used, it should be collected after a maximum of three months, regardless of the filled capacity.
- At the last inspection, we identified that there was no cleaning schedule in use in the service. This meant that there was no system for ensuring that staff cleaned all parts of the service regularly. This was a potential infection control risk. National guidance states that a cleaning schedule should be available providing details of the standards of cleaning. The provider stated they planned to introduce a cleaning schedule after our last inspection visit. During this inspection, we found that the service had introduced a comprehensive cleaning schedule, which identified what items needed to cleaned and the frequency that they should be cleaned. The provider ensured that when items were cleaned that it was recorded in a log and dated. We found that the service was clean, tidy and well maintained.
- The service had a control of substances hazardous to health policy (COSHH). The policy identified what substances the service could and could not use. An external company had undertaken the Control of substances hazardous to health (COSHH) assessments in November 2016.
- There were weekly safety checks undertaken in the service. The staff checked fixtures and fittings in the service. For example, the hot water temperature was checked as well as garden fixtures and smoke alarms. The service also undertook ligature risk assessments.
- A ligature point is anything, which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. The service assessed the environment to identify potential ligature anchor points. The assessment detailed the action required to mitigate and manage the risks. The service did have a set of ligature cutters, however, these were located in the

clinic room, which was on the lower ground floor. Clients' bedrooms were located on the second and third floor, this meant that staff who needed the ligatures cutters would have to go down several flights of stairs to get them and there would be a delay in responding to the client who had tied a ligature. This was brought to the attention of the provider who stated that they would ensure that ligature cutters were located on the other floors of the building.

- The service had the necessary equipment to carry out basic physical health checks on clients. Staff had access to weighing scales, blood pressure monitoring equipment and monitors to measure how much alcohol the clients had drunk.
- The prescribing guidelines described how to manage medical emergencies. The clinic had Naloxone, adrenaline and Diazepam in stock to manage medical emergencies, however there were not sufficient quantities of Naloxone and adrenaline to administer the maximum doses detailed in the prescribing policy. The provider checked the Naloxone, adrenaline and Diazepam weekly. The provider had some equipment to treat medical emergencies (including a defibrillator and one oxygen cylinder). However, there was no risk assessment/guidance for staff that informed the choice of equipment and medicines to be used in an emergency.
- The service admitted and treated both men and women. Each client had his or her own bedroom. Where possible the service said that they tried to accommodate male and female clients on separate floors. The bathrooms were shared but could be locked.
- The service did not have panic or call for assistance alarms in the building. If a client needed to summon assistance out of hours, they had either go downstairs to find the member of staff or shout for help if they were unable to physically go downstairs. The service was over three floors and each landing had a fire door, which was kept shut. This meant that staff might not easily hear when a client needed assistance. The provider sought to manage this through undertaking observations on clients at night. However, the building was quite large.
- Medicines were well organised and stored securely in locked cupboards. Some medicines were stored in a refrigerator that was not locked. Staff recorded the actual fridge temperature daily but were not recording the maximum and minimum temperatures. There was no assurance that medicines had been continuously stored within the correct temperature range.
- Controlled drugs were stored and recorded in line with legislation.

Safe staffing

- The service operated 24 hours a day. There was a nurse and therapists on duty during the day as well as managers and other staff, for example administrative staff and catering staff. At night and at weekends the service had support workers on duty. The managers could increase the nursing staff at night and at weekends if they admitted clients who might need additional nursing care. If the service needed additional nurses, they used agency nurses who had substance misuse nursing experience and who were familiar with the service.
- The service had not had any unfilled shifts since February 2016.
- At the last inspection, we found that the service did not undertake regular medical reviews of clients. A doctor had not been to the service for four days at the time of our last inspection. Since the last inspection, the provider had reviewed their medical input. Two doctors now provided input into the service. The medical doctor now visited the service on a weekly basis and was available on an on call basis Monday to Thursday. When the service admitted clients, they were seen by the consultant psychiatrist who then undertook a review of the client within 48 hours of admission. The provider's medical director was also available via email if there were queries regarding a client's care and treatment.
- The service had a doctor and nurse on call out of hours during the week and at weekends.
- The provider ensured that newly appointed staff had a corporate and local induction. The local induction for all staff included a tour of the building. The management of the service provided new staff with the relevant policies and undertook an analysis of their training needs. The staff induction pack was comprehensive.
- At the last inspection, we found that the provider's pre-employment checks were not robust. The service had not obtained criminal records checks on two members of staff prior to them starting work at the service. The provider had not explored gaps in the employment history of four members of staff and

another member did not have a record of their employment history in their file. The provider had improved their systems since the last inspection. In the files we reviewed, all staff had a criminal records check as well as a risk assessment, which was undertaken by the provider prior the member of staff starting. All the criminal records checks reviewed except for the receptionist, whose duties did not include lone working, was an enhanced check. The enhanced check meant that the provider had requested information to assure themselves that the member of staff was not on the "barred list" and were suitable to work with vulnerable adults. The provider's DBS/Disclosure policy and procedures stated that it was best practice for all staff to have an enhanced level check for all staff in all instances due to the practical difficulties of ensuring that a person subject to a standard check never has unsupervised access to service users"

- The provider had a list of mandatory training that all staff were expected to complete. The training completion rates were below 75% in a number of areas. The completion rate for safeguarding was 61%, some of the staff who had not been trained, were not staff who undertook therapeutic work with clients but nonetheless did have day-to-day contact with clients and might observe something that might constitute a safeguarding risk. Without adequate knowledge these staff might not recognise a safeguarding concern and might not raise an alert. The training completion rate for drug and alcohol awareness was 57%. Low mandatory training rates can put clients at risk if the staff are not able to manage or protect clients from avoidable harm.

Assessing and managing risk to clients and staff

- At the last inspection, we issued the provider with a requirement notice because they did not appropriately assess the risks to the health and safety of clients of receiving the care or treatment. Since the last inspection, the provider had reviewed their risk assessment and admission processes. The provider now had a pre-admission assessment. Staff now undertook a pre-admission assessment over the phone prior to admission. The staff sent the information gathered through this assessment to the medical director and admitting doctor prior to the person arriving. The service had clear exclusion criteria, for example the service would not admit clients who had a history of seizures or a history of violence to others. The service also liaised with the client's GP, requested blood tests, and other relevant tests, GP notes and list current medications prescribed. If a client refused consent to contact their GP, the service reviewed the case and made a decision, regarding admission based on the information provided by the client and a thorough assessment of risk.
- The service did not admit during late afternoon, at night or at weekends due to risk factors and the lengthy admission process. The service was able to take emergency admissions and had facilities to organise for prospective clients to have a face-to-face pre-admission assessment and to have blood tests on that same day. The service did not admit until they had the client's test results returned and reviewed by a member of the medical team.
- The nurse and doctor completed a comprehensive risk assessment of all clients. The risk assessments considered the risk of suicide, self-harm, aggression, alcohol withdrawal, physical health needs and mental health.
- Staff undertook hourly observations of clients, which was documented.
- Although the overall training completion rate for safeguarding training was below 75%, the staff we spoke to had a good understanding of safeguarding. Ninety-four per cent of the staff who undertook lone working with clients had been trained in safeguarding. Staff said they would report safeguarding concerns to the safeguarding lead within the service. There was information on display for clients who might have concerns regarding safeguarding.
- People using the service were subject to some blanket restrictions. These were rules, which applied to all individuals. People using the service were required to store items of value in the safe and alcohol based items, for example aftershave was not allowed in the service. Clients were not allowed to leave the premises unescorted. These restrictions were appropriate to ensure alcohol or illicit substances did not come into the service and were part of a therapeutic contract. Staff agreed these restrictions with people using the service as part of the admission process, and the client had given consent to these restrictions being in place
- The provider did not have medicines management standard operating procedures. Standard operating

procedures are documented processes to guide staff to work consistently and safely. The management said that standard operating procedures were being written at the time of the inspection.

- Staff prescribed clients with PRN medication for specific situations. When PRN medicines are prescribed for 'as required' administration, it is good practice to have protocols written by the prescriber to support staff to administer the medicines effectively and safely. Although there were some medicine protocols in use they were not available for all medicines prescribed as required. For example, we found for one client undergoing alcohol detoxification did not have a protocol for a medicine to be given as required for withdrawal symptoms. This was a potential risk in the safety of the administration of medicines.
- Registered nurses and support workers were responsible for managing the medicines in the clinic. The support workers had received medicine training and we saw evidence of competency assessments for the safe administration of medicines. Staff were also trained in the administration of emergency medications.
- Staff completed the medicine administration records (MARs) accurately and the prescriber checked and signed each MAR. A local pharmacy supplied the medicines; all medicines were available for people that used the service. The pharmacy disposed of medicines no longer needed. Staff maintained clear records of what was returned to the pharmacy.

Track record on safety

- Since the last inspection in March 2016, there had been two incidents. The incidents were dissimilar. The service had thoroughly reviewed the circumstances relating to both incidents and had taken appropriate action. The service had changed its procedures because of one of the incidents in an effort to improve client safety.

Reporting incidents and learning from when things go wrong

- Staff were aware of the procedures for reporting all incidents. There was evidence that there was learning from incidents and the managers shared this learning with the staff group. For example, the managers of the service had amended their policy regarding how to deal with clients who presented to the service under the influence of drugs or alcohol or who had relapsed and had begun to use substances.
- Staff audited the quantities of stock medicines weekly and identified errors. We saw that staff recorded medicine incidents and the error reports were analysed on a monthly basis. The service had implemented changes to minimise the chance of repeating errors. For example, managers sent memos to staff to remind them about safe working practices. The provider had issued instructions that only doctors and nurses could write the medicine administration records (MARs) to try to minimise transcription errors.

Duty of candour

- At the last inspection, we found that the management did not have an understanding of the duty of candour. The duty of candour describes what must happen when a clients' treatment has, or could have, caused them serious harm. This involves informing the client and apologising. It also involves keeping the client up to date with any investigation and the outcome. The duty of candour aims to ensure that services learn from mistakes and for clients to be fully involved. At this inspection, we found that the manager had a good understanding of the duty and the importance of ensuring that staff offered clients apologies promptly when things went wrong. None of staff in the service had received specific training relating to the duty of candour, however, the importance of being open and transparent when working with clients was emphasised in the staff induction pack.

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

.

Assessment of needs and planning of care

- Prospective clients had a comprehensive pre-admission assessment completed over the phone. The records we checked showed that the assessments were thoroughly completed and contained relevant information. For example, the assessment asked questions regarding the client's physical health, mental health and social circumstances.
- Staff re-assessed clients when they were admitted. We reviewed five care and treatment plans of clients. We found that assessment information was comprehensive

and there was information on file from the client's GP and other relevant health professionals, for example dentists. Information regarding the risks associated with relapse were discussed during group work and individual therapy sessions. Clients were given assignments on relapse prevention which helped them to identify triggers and ways to manage them. It is important that staff discuss these risks with a client who has recently detoxed as their risk of overdose increases post detoxification.

- All clients had physical health checks on admission including drug and alcohol screening as necessary and physical health was monitored regularly throughout their treatment. We saw records, which showed that these were carried out.
- Clients had been screened for blood borne viruses and this screening was routinely offered on admission.
- Information was stored in paper based records which were kept securely locked in a filing cabinet.
- The provider used recognised assessment tools including opiate withdrawal scales and severity of alcohol dependence questionnaire (SADQ) to measure the severity of withdrawal from alcohol and opiates. There was timely identification of people who were becoming acutely unwell as a result.

Best practice in treatment and care

- Staff were using assessment tools and taking physical observations to assess withdrawal severity. We saw prescribing for detoxification in line with National Institute of Health and Care Excellence (NICE) guidelines and in line with the provider's prescribing protocols.
- Clients had access to a range of therapies provided by the team in the service. Therapies were provided seven days a week. The therapeutic programme included cognitive behavioural therapy, gestalt therapy, yoga, as well as sound bowls therapy, which helped reduced client's stress and anxiety.
- Staff had received training in the use of clinical institute withdrawal assessment for alcohol (CIWA) scales to determine the needs of clients using the service and staff also used the clinical opiate withdrawal scale (COWS) for clients when necessary. Clients had access to 12 step groups (including alcoholics anonymous and narcotics anonymous).

Skilled staff to deliver care

- The service supported clients with a variety of needs and as a consequence needed a skilled workforce. The service employed therapists, support workers and nurses and there were appropriately skilled staff to deliver care.
- The support workers had undertaken the care certificate training. The provider had offered this training to other disciplines, for example administrative staff and therapists. The care certificate provides a set of standards that social care and health workers use whilst at work. It is the new minimum standards that should be covered as part of induction training of new care workers
- The manager of the service had completed a leadership course and received a qualification.
- All the doctors attached to the service had been revalidated. This meant that they had demonstrated their fitness and ability to provide a good level of care. One of the doctors had undertaken Royal College of General Practitioners training parts 1 & 2 in the management of drug use. The other doctor was a consultant psychiatrist, specialising in treatment for addictions.
- The service had provided support workers with a range of specialist training to meet the needs of the client group. The specialist training included medication administration and Introduction to supporting clients through medication assisted recovery (MAR)
- Staff received clinical, management or peer supervision regularly, and the service had a planner with future supervision dates for all staff up until the end of 2016. This provided them with the opportunity to discuss practice issues. The service had been open less than 12 months, which meant that not all staff received an annual appraisal.

Multidisciplinary and inter-agency team work

- Staff had handover meetings at the start of each shift. All of the staff team, including the doctors could contribute to the handover. During the handover meetings, staff discussed people using the service and identified what support they required.
- Multi-disciplinary team meetings were held weekly. The meeting was attended by the Consultant Psychiatrist, Registered Mental Health Nurse, Manager and therapy team to discuss the treatment and progress of each client. These meetings were minuted which ensured that there was a record of the discussion.

Substance misuse/detoxification

- If clients had additional needs, staff in the service liaised with secondary health care services as necessary. For example, when clients needed to attend appointments at local acute hospitals. The staff shared information with these services with the consent of the client.
- We saw that where there were concerns about people on discharge, staff had made referrals to relevant statutory services, for example, the local community mental health team.

Good practice in applying the MCA

- The service asked all clients to sign a consent form prior to them commencing treatment. The consent form included asking the client to agree to staff restraining them should they become violent or be at risk of self-harming. The consent document stated " I agree that if I am in an emergency situation where there is a risk of harm Gladstones Clinic may need to use restraint to prevent harm to myself or others". The service did not have a restraint policy nor had any of the staff been trained in safe restraint techniques. Staff should discuss the consent form with clients prior to it being signed; however, none of the staff had noted that they were asking clients to consent to something that was not in line with the provider's policy. This was brought to the managers of the service who stated that they would address this.
- On admission, the psychiatrist undertook a mental state examination.
- All staff had completed training in the mental capacity act. Staff presumed that clients had capacity. If there were concerns that this was no longer the case, a member of the nursing staff undertook an assessment of the client's capacity.

Adherence to the MHA

- 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. All 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.

Equality and human rights

- The provider offered training in equality and diversity and emphasised the importance of accepting all individuals.
- The service was open to men and women had a mixed gender and mixed ethnicity staff group.
- Blanket restrictions were in place at the clinic and all clients had consented to these. These restrictions were in place to ensure the safety of clients and were outlined the consent to treatment document, which was signed by clients. These restrictions included attending therapeutic groups, consenting to give samples for drug and alcohol tests and consenting to not leaving the building alone. Clients were informed that they would be discharged should they not comply with these restrictions.

Are substance misuse/detoxification services caring?

Kindness, dignity, respect and support

- All people using the service were very positive about the service. People using the service described staff as 'caring', 'responsive' and 'knowledgeable'. They always had time to listen to individual's concerns.
- Staff understood individual needs and were aware of their preferences.
- People using the service said they felt safe. They said they received all of the information they needed and understood what to expect from treatment.

The involvement of clients in the care they receive

- The service had made links with an advocacy service, which could support people using the service. The noticeboard in the service had advocacy information displayed on it.
- Clients had the opportunity raise issues in the weekly community meeting. These meetings were minuted so staff could follow up on the actions identified during the meeting. The clients were also asked to give feedback on the staff group. The managers reviewed client feedback and if there were issues or compliments identified, this was shared with the relevant staff member in a timely manner.

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

Access and discharge

Substance misuse/detoxification

- Individuals or their family members privately funded all admissions. There was no waiting list for a place at Lexham House. All admissions were planned. The service endeavoured to respond to clients who wanted to be admitted urgently. The service was able to take emergency admissions. If a prospective client required an emergency admission, the service conducted a face to face assessment with the client and the client had their blood tests on the same day. The service did not admit clients at night or at weekends due to risk factors and the lengthy pre-admission process.
- Since the opening of the clinic in February 2016, the service had admitted 54 clients. Six clients were receiving treatment at the time of the inspection. Forty-four clients had successfully completed treatment. Four clients had exited treatment early. The service did not have targets regarding occupancy and considered each potential new admission on a case by case basis. Staff gave clients who had completed the initial detoxification the option to either extend their stay, move onto secondary treatment or attend the service's aftercare programme.
- The service began planning with the clients for discharge approximately a week before they were due to leave. The staff and clients formulated the exit plan together. The service did not retain copies of the clients exit plans. This meant that they had no records they could refer back to should problems arise.
- The service was not routinely formulating early unplanned exit plans with clients but stated that they were introducing this. We reviewed one care plan of a client who had exited the treatment early. Although there had not been any pre-planning, we found that staff responded appropriately to client who exited early and ensured that they left the service with information regarding the risk of overdose, sufficient medication and clear instructions to contact their GP.

The facilities promote recovery, comfort, dignity and confidentiality

- The clinic room environment did not promote the comfort, dignity or confidentiality of the clients using the service. The service used the clinic room as an office for the nurses and therapists. The room was cramped, there was no space for an examination couch, and clients had to sit on a chair to have their physical examinations. The manager stated that the provider was planning to build a dedicated clinic room. There was personal patient information on a white board in the office and on the desks, which could easily be seen by clients.
- The provider had made efforts to ensure that other parts of the building promoted the privacy of the clients who were at the service. The windows of the building had a privacy film at the bottom of the windows. This meant that members of the public could not see into the building.
- The service had a range of therapy rooms, where staff could see clients in private. There was also a main lounge and a smaller quiet room for clients to use. None of the bathrooms were ensuite but there were sufficient bathrooms and toilets on each floor.
- The service was non-smoking. If clients wished to smoke, they had to do this in the garden. Staff did not offer smoking cessation sessions but supported clients who wished to stop smoking by signposting them to appropriate services.
- The support staff were available to accompany clients if they had appointments or wished to go for a walk or shopping. The clients also had access to range of activities. There were limited facilities for physical activities on site other than yoga classes. The service was in the process of exploring whether they could get access to a local gym for the clients at the service.
- Clients' belongings could be stored securely. Items of value could be stored in the service safe. Staff kept an inventory of the items that were stored.
- Facilities were available so that people using the service could make a drink when they wanted to.

Meeting the needs of all clients

- The location of the service was not wheelchair user friendly. The service could not admit clients who used wheelchairs or had significant mobility issues due to the bedrooms and bathrooms being upstairs. There was no scope to adapt the rooms on the ground floor to enable the service to admit clients with mobility issues. The service made prospective new admissions aware of this. Staff were able to sign post prospective clients to alternative providers if necessary.
- The service employed a full time catering team and provided clients with cooked meals. Clients could be

provided with meals that met their specific needs. For example, the catering team provided clients with a gluten free, halal, kosher, vegetarian or dairy free meal if required.

- The service supported clients who were religious to attend places of worship. The only exception to this was if the client was in the initial stages of detoxification, where it was deemed too risky to the client's health to allow the client to leave the service. If necessary, the staff were able to arrange for a suitable religious leader to come to the service to meet with the client.
- All the service literature for both clients and their families was in English. The service did not have any literature in braille or in any other languages. Staff delivered group work and therapy sessions in English. However, the service was able to support individuals in therapy whose first language was not English. Staff said they would use interpreters if required to deliver one to one therapy sessions.
- There was a patient noticeboard in the service, which displayed information about the service, activity timetable and information intended to inspire the clients. The service had very little information on display that acknowledged and recognised the diversity of the client group. There was no information in the service for clients who wanted to explore other aspects of their identity or wanted information that was relevant to them. For example, there was no information for clients who maybe lesbian, gay, bisexual or transgendered, or who had experienced domestic violence or sexual assault.

Listening to and learning from concerns and complaints

- Information on how to complain was readily available to the clients. Information regarding the complaints procedure was on display in the location and in the client's handbook. The service had an informal and formal procedure to deal with complaints and the service encouraged clients to voice their concerns. The staff tried to resolve complaints as soon as possible. Clients were encouraged to use the formal complaints process if there were concerns that there had been a breach of procedure. If the formal process was used the service responded to the complaint within 28 days. Regardless of whether the complaint was informal or formal if the client was dissatisfied with the response there was an appeal process. The appeal process stipulated that a member of the senior management team reviewed and –re-investigated the complaint. If the complainant remained unsatisfied the provider signposted them to the CQC, the citizens' advice bureau or an advocacy service.
- The service had received one formal complaint in the nine months prior to inspection. The service had thoroughly investigated the complaint the manager investigating the complaint had partially upheld the complaint. The provider had improved some of their processes as a result of the complaints. Improvements included developing procedures to manage client behaviour should they appear to be disinhibited through drugs or alcohol.

Are substance misuse/detoxification services well-led?

Vision and values

- The provider's vision was to support people using the service to make changes in their lives and to help them make a new start. The work undertaken by staff fully reflected the organisations' vision and values.
- Staff knew who the senior managers in the organisation were and these managers had visited the service.

Good governance

- Following a previous inspection in March 2016, where requirements were put in place for the service, a number of improvements had been made to systems and it was clear that the service was improving governance systems. The service had improved the governance processes since the last inspection, though further work was needed to ensure these improvements were fully embedded. The service now had a training matrix which had details of the training required by each member of staff and information as to whether this training was outstanding. However, at the time of inspection, the provider had not set a mandatory training compliance target. Emergency medicines were now available. The service now ensured that they liaised with prospective client's GP's prior to admission to ensure that they had relevant information regarding the client's needs. The provider stated that were planning to implement a system to assist them in ensuring that staff member's DBS were updated regularly. The service had also updated a number of their policies, for example,

the service had amended their supervision policy. The service had also begun to conduct audits regarding the incidents that took place at the service and were analysing the emerging trends. The managers at the service planned to discuss this as part of their senior level clinical governance group.

- The provider had established a new clinical governance meeting since our last inspection. Senior managers who worked at other locations attended the new meeting. The clinical governance meetings were scheduled every three months. At the time of this most recent inspection, there had been two clinical governance meetings and the provider was still finalising the agenda of these meetings. Proposed agenda items included auditing staffing and patient feedback to ensure the service could improve. The provider ensured that these meetings were minuted.
- The managers from the various locations also discussed what was happening at the different locations during their twice-weekly conference calls. The provider did not keep records of these teleconference calls.
- The service had a business continuity plan and if the building became unusable, they would move the clients to another location owned by the provider.

Leadership, morale and staff engagement

- There was strong leadership at the service, which had led to improvements. The provider had recently recruited a full time permanent manager who was in the process of being inducted by the interim manager. The interim manager was also looking at how to improve the service by employing additional staff.
- Staff were open and transparent and explained to people using the service when things went wrong.
- The provider had a whistle-blowing procedure, which directed the staff member to a contact the manager of the service or a member of the senior management team.
- There were no ongoing bullying or harassment cases and no staff on long term sickness leave.
- The provider did not conduct a staff survey, nor did the service have regular formal team meetings. However, all staff we spoke to stated that they could raise issues with the management team and felt that they would be listened to. The team were enthusiastic about the work they undertook and were complimentary about their colleagues. The manager of the service recognised that staff would benefit from a regular team meeting during which staff could discuss issues that related to them.

Commitment to quality improvement and innovation

- The service had contracted an external professional to conduct mock inspections before the visit.
- The provider did not participate in any national accreditation schemes

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that they undertake regular cleaning of physical health monitoring equipment.
- The provider must complete a risk assessment on the management of medical emergencies. The risk assessment should be used to inform the choice of emergency equipment and medicines.
- The provider must ensure that all emergency equipment and medicines are checked regularly and the checks are documented.
- The provider must ensure that staff complete their mandatory training to ensure that staff are supported to carry out their roles safely and effectively.
- The provider must ensure that clients who are receiving treatment at the service understand what they are consenting to. The consent to treatment form, which clients sign, should be aligned to their current policies and procedures.
- The provider must ensure that the clinic room environment is suitable and that the client's dignity, comfort and privacy is maintained whilst they are having physical examinations.
- The provider must ensure that they keep personal client information secure and confidential.

Action the provider SHOULD take to improve

- The provider should ensure that there are sufficient ligature cutters in the service to respond in an emergency situation.
- The provider should ensure that they comply with their DBS/Disclosure Policy and Procedure best practice guidance and obtain an enhanced check from the Disclosure and Barring Service for all staff.
- The provider should ensure that clients have means to summon assistance from staff at night if they require it.
- The provider should ensure that the medicine fridge is locked and maximum and minimum fridge temperatures recorded.
- The provider should make sure that there is a standard operating procedure to support the safe and effective administration of as required medicines.
- The provider should ensure that they have sufficient quantities of Naloxone and adrenaline to administer the maximum doses detailed in the prescribing policy.
- The provider should have a protocol for staff to use to support administering as required medicines to relieve symptoms of alcohol withdrawal. The service should have medicine management standard operating procedures documented to make sure staff follow safe processes.
- The provider should ensure it has clear oversight of arrangements to dispose of clinical waste in line with national guidance and operates procedures in accordance with nationally recognised good practice.
- The service should consider retaining copies of clients exit plans so they can be referred to should problems arise.
- The provider should ensure that the information available to clients within the service take more account of the nine protected characteristics contained in the Equality Act 2010 – age, disability, gender reassignment, marriage and civil partnership, race, religion or belief, sex, sexual orientation, and pregnancy and maternity.
- The provider should continue embedding the newly implemented governance processes.

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 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control The provider was not providing care and treatment in a safe way for service users. The provider was not ensuring that equipment and/or medical devices that are necessary to meet people's needs were cleaned There were no cleaning records of the medical equipment that was being used in the service. The provider had not undertaken a risk assessment on the management of medical emergencies. Staff had not been provided with guidance to assist them in identifying the correct emergency equipment and medicines. This was breach of Regulation 12 (1) (e)

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The provider was not ensuring that service users were being treated with dignity and respect. The clinic room was a shared office space. The environment was cramped. Client's personal information could clearly be seen by others and was displayed on desks and on a whiteboard. This was a breach of Regulation 10 (1)(2) (a)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 17 HSCA (RA) Regulations 2014 Good governance Clients were asked to consent to being restrained should they become agitated or aggressive. The provider did not have a restraint policy nor were any staff trained in restraint techniques. The provider was not aware that the consent to treatment form contained this clause. This was a breach of Regulation 17 (1) (2) (a) (b)
Accommodation for persons who require treatment for substance misuse	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider was not ensuring that persons employed by the service were receiving appropriate training as is necessary to enable them to carry out the duties they are employed to perform. The completion rates of mandatory training was low. This was breach of regulation 18 (2) (a)