Ocean Recovery and Wellness Centre

Quality Report

The Gables
94 Queens Promenade
Blackpool
Lancashire
FY2 9NS
Tel: 01253 530553
Website: www.oceanrecoverycentre.com

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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:

- The service did not have suitable arrangements in place for the administration and management of medicines. Staff had not been trained in the necessary skills to treat a patient in the event of an emergency. Records of controlled drugs were not always completed in accordance with the National Institute for Health and Care Excellence guidance. Fridge temperatures were not monitored. Medicines and Healthcare products Regulatory Agency guidelines were not observed. Physical observations had not been completed as directed by the doctor for some clients. Observations out of the normal range were not being escalated to the registered manager. The service did not assess client's withdrawal symptoms during the detoxification

Summary of findings

regime which was not in accordance with national guidance. Prescription charts were not being used in accordance with legislation. We issued a Warning Notice under section 12 of the Health and Social Care Act 2008.

- Policy management was poor. Of all the policies we looked at only two had been signed to say they had been reviewed. There were three different versions of the complaints policy available. The equal opportunities policy and diversity in care policy did not mention the most recent legislation of the Equality Act 2010.Two versions of the service user handbook had incorrect information regarding CQC involvement in complaints. We issued a Warning Notice under section 17 of the Health and Social Care Act 2008.
- There were not sufficient qualified staff to provide care. The registered manager was the only qualified permanent member of staff which meant that the registered manager was always on call as there were no other staff with sufficient skills to cover for the manager. Lack of qualified staff meant that client care was compromised. Clients did not always have access to a psychiatrist as there were no cover arrangements for the consultant psychiatrist if they were off sick or on annual leave. We issued a Warning notice under section 18 of the Health and Social Care Act 2008
- Staff performance and continuing professional development was not being regularly reviewed. The registered manager for the service had not received an appraisal and three of the eight permanent staff had not received appraisal as per the policy. There was no documented supervision completed for the registered manager. They did not receive clinical supervision from a suitably qualified person. We did not receive information to confirm that the doctor had received supervision from a specialist substance misuse doctor. The service did not support staff to access specialist training. We issued a Warning notice under section 18 of the Health and Social Care Act 2008
- Mandatory training was not being provided in line with the training policy for the service. The majority of staff had not completed any training in the policy. Safeguarding training was not part of mandatory training but the safeguarding policy stated that all staff should be trained in this.
- Care records were poorly completed. They did not document recovery aspects and goals of treatment. The medicine administration record did not have space for the persons address or date of birth or allergies. It was unclear who was making changes on these records. There were no contemporaneous notes for medicines. There was no documented observations of a person's physical health using a recognised tool. Initial assessments from the all of the referring agencies except one gave limited information on the presenting problems of the client and there was no standardised way of capturing this information.
- Systems were not in place to identify shortfalls in standards of care and making the necessary improvements. No internal audits had been carried out since August 2015. There were no identified quality improvement measures in place and no system to ensure the service was following best practice guidelines.
- The safeguarding policy did not state that CQC were to be informed of safeguarding alerts or concerns which meant that staff were not aware of the need to notify CQC.
- Environmental risks were not being effectively managed and mitigated. Ligature assessments did not identify ways to reduce or manage these risks.
- Not all staff had the relevant checks such as photographic identification, disclosure and barring service which is a regulatory requirement.
- The exit door from the third floor fire escape had no signage to say the exit was to be used a fire escape only.The exit led to a flat roof and then down the external metal fire escape. The flat roof had a railing fence around it. The fence was waist height and was not a solid structure. It was therefore possible for someone to slip under the barriers and fall

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

Summary of findings

- All areas of the building including the bedrooms and bathrooms were clean and well maintained. Fire evacuation procedures and checks were regularly completed
- Clients had access to a range of therapies and interventions to promote their recovery. Group sessions were interactive and informative. Staff established therapeutic relationships with clients and involved them in their care.
- Staff treated clients with respect and kindness and supported them throughout their stay. All clients had full involvement with their treatment throughout their stay. They made decisions about their treatment during sessions with their keyworker. Staff supported clients to engage with support groups in their locality following their discharge.
- There was an aftercare group provided by the service which clients could access for up to a year after leaving the service.
- Sickness and absence rates were low. There were no bullying and harassment cases ongoing. Staff felt confident to raise concerns to either the registered manager or more senior managers.

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Background to Ocean Recovery and Wellness Centre

Ocean Recovery and Wellness Centre provided 24 hour care for clients who were undergoing detoxification from alcohol or substance misuse. The service was based in the north of Blackpool on the promenade. It had 18 beds over three floors but there are only ever a maximum of 12 clients admitted to the service at any one time. There were nine clients admitted to the service at the time of our inspection The service accepted nationwide referrals from males and females aged 18 years or older. The service accepted referrals for clients who were privately funded.

As well as detoxification, the service provided individual and group work sessions which included family work, neuro-linguistic programming and recovery. Sessional staff attended the service to deliver activities and treatments including acupuncture, reiki, yoga and meditation.

The service was registered with CQC to provide accommodation for persons who require treatment for substance misuse and treatment of disease disorder or injury. The service had two registered managers, one of whom hadn't worked at the service for several months. The provider said they would be looking to cancel the registered manager status for this person.

The service was registered with CQC in December 2014. We have inspected the service twice before. We carried out a focussed inspection on 3 June 2015 following whistleblowing concerns and issued warning notices relating to regulation breaches regarding premises and equipment and good governance. A follow up inspection was carried out on the 25 September 2015 and we found that the provider had taken sufficient action to address the issues we raised in the two warning notices. However we issued a requirement notice on this occasion asking the provider to improve their arrangements for safe care and treatment. On this occasion we found that a client admitted with already identified pressure sores was not receiving appropriate treatment or care to reduce the risk of the pressure sores worsening. The records relating to personal evacuation plans were not individualised to direct what staff assistance and support would be required in the event of a fire evacuation when service users required assistance such as those with limited mobility..

Our inspection team

The team that inspected the service comprised three CQC inspectors and one pharmacist specialist.

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.

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 and asked other organisations for information.

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 three current clients and one ex- client
- spoke with the registered manager
- spoke with threeother staff members employed by the service provider, including addiction workers and support workers
- spoke withone consultant psychiatrist
- attended and observed two group sessions for clients
- looked at five care records for clients
- looked at eight medicines records for clients
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

Clients we spoke to all spoke highly of the service provided. They told us that they felt the staff genuinely cared about their recovery and that staff quickly got to know them well in the short time they were there. Clients said they felt highly motivated to continue their recovery once discharged and this was because of the treatment that had been provided at the service.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We do not currently rate standalone substance misuse services.

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

- The service did not have suitable arrangements in place for the administration and management of medicines. Staff had not been trained in the necessary skills to treat a patient in the event of an emergency. Records of controlled drugs were not always completed in accordance with the National Institute for Health and Care Excellence guidance (NG46). Fridge temperatures were not monitored. There was only one adrenaline pen despite recommended guidance from the Medicines and Healthcare products Regulatory Agency which stated there should be two. Physical observations had not been completed as directed by the doctor for some clients. The service did not assess client's withdrawal symptoms during the detoxification regime which was not in accordance with national guidance. Prescription charts were not being used in accordance with legislation as they were not being signed by the doctor. Patients were not afforded privacy when receiving their medication. We issued a Warning Notice under section 12 of the Health and Social Care Act 2008
- Mandatory training was not being provided in line with the training policy for the service. The majority of staff had not completed any training in the policy. Safeguarding training was not part of mandatory training but the safeguarding policy stated that all staff should be trained in this. There were not sufficient qualified staff to provide care. The registered manager was the only qualified permanent member of staff which meant that the registered manager was always on call as there were no other staff with sufficient skills to cover for the manager. There were no cover arrangements for the consultant psychiatrist if they were off sick or on annual leave. We issued a Warning notice under section 18 of the Health and Social Care Act 2008
- There was no ligature risk action plan in the ligature risk assessment
- The exit door from the third floor fire escape had no signage to say the exit was to be used a fire escape only.The exit led to a

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flat roof and then down the external metal fire escape. The flat roof had a railing fence around it. The fence was waist height and was not a solid structure. It was therefore possible for someone to slip under the barriers and fall
- There was no risk management plan in place for the client who was deemed to be a medium risk of harm to themselves or others.
- The Duty of Candour policy could not be located at the time of the inspection.

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

- All areas of the building including the bedrooms and bathrooms were clean and well maintained.
- Fire evacuation procedures and checks were regularly completed.

Are services effective?

We do not currently rate standalone substance misuse services.

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

- The registered manager for the service had not received an appraisal and three of the eight permanent staff had not received appraisal as per the policy. There was no documented supervision completed for the registered manager. The registered manager had verbal supervision from a person who was not a registered nurse or allied health professional. We did not receive information to confirm that the doctor had received supervision from a specialist substance misuse doctor. The service did not provide access to specialist training, staff paid for this themselves. We issued a Warning notice under section 18 of the Health and Social Care Act 2008.
- All staff did not have the relevant checks such as photographic identification, disclosure and barring service which is a regulatory requirement.
- Staff were not aware of the National Institute for Health and Care Excellence guidelines that had been produced in relation to alcohol or substance misuse.
- The service did not use a recognised tool to monitor a person's wellbeing throughout their detoxification.
- Care records were poorly completed. Initial assessments were incomplete and care records did not document recovery aspects and goals of treatment.
- There were limited outcome measures for the service.
- Limited audits had been completed.

Summary of this inspection

- Staff were not trained in the Mental Capacity Act and there was no Mental Capacity Act policy for the service.

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

- Clients had access to a range of therapies and interventions to promote their recovery.
- Group sessions were interactive and informative.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Staff established therapeutic relationships with clients and involved them in their care.
- Staff treated clients with respect and kindness and supported them throughout their stay.
- All clients had full involvement with their treatment throughout their stay. They made decisions about their treatment during sessions with their keyworker.
- Staff supported clients to engage with support groups in their locality following their discharge.

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

- There was no advocacy support.
- Staff did not act on clients' suggestions for improvements.

Are services responsive?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- There was a structured programme of care, therapy and activities.
- Discharge planning included support to engage with local support groups. There was an aftercare group that ex-clients could attend on a weekly basis
- The provider tried to meet the diverse cultural, spiritual and dietary needs of all clients who used the service. For example staff could arrange for specific religious or physical health dietary requirements. Staff would support individuals to attend local places of worship.

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

- There was no opportunity for staff to carry out pre-admission assessments before clients arrived at the service.

Summary of this inspection

- The environment was not fully accessible and the provider had not made adjustments according to need, for example, for clients with reduced mobility.
- There was no written care plan for clients who exited the service unexpectedly.

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:

- The service was not following guidance in the Medicines and Health Products Regulatory Agency. Records for controlled drugs were not completed properly. There were no contemporaneous notes for medicines. Physical observations were not being recorded in line with the consultant psychiatrists' instructions and observations out of the normal range were not being escalated to the registered manager as per the administration of medicines policy.
- Systems were not in place to identify shortfalls in standards of care and making the necessary improvements. No internal audits had been carried out since August 2015. There were no identified quality improvement measures in place and no system to ensure the service was following best practice guidelines.
- The safeguarding policy did not state that CQC were to be informed of safeguarding alerts or concerns which meant that staff were not aware of the need to notify CQC. Environmental risks were not being effectively managed and mitigated. Ligature assessments did not identify ways to reduce or manage these risks.
- Policy management was poor. Of all the policies we looked at only two had been signed to say they had been reviewed. There were three different versions of the complaints policy available. The equal opportunities policy and diversity in care policy did not mention the most recent legislation of the Equality Act 2010. Two versions of the service user handbook had incorrect information regarding CQC involvement in complaints. We issued a Warning Notice under section 17 of the Health and Social Care Act 2008.
- Staff appraisal rates were low and we did not see a record of supervision for the registered manager
- There was no local or provider level risk register for the service
- There were few opportunities for leadership development
- Staff were not aware of the values of the service

However, we also found areas of good practice, including that:

Summary of this inspection

- Sickness and absence rates were low.
- There were no bullying and harassment cases ongoing
- Staff felt confident to raise concerns to either the registered manager or more senior managers.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act training was not mandatory at the service and no staff had undertaken training in this area. There was no Mental Capacity Act policy.

Upon admission some clients may not have had the capacity to make significant decisions due to their level of intoxication however this was recognised by staff and the service. Consent to treatment was not sought until clients were deemed to have capacity to consent. Staff said that they acted in the clients best interests and supported them to make decisions where appropriate.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

We saw that all areas of the building were clean and well maintained. Furniture and furnishings were in good repair. Housekeepers were employed by the service and we saw cleaning rotas which demonstrated that all areas were cleaned on a regular basis.

Bedrooms were all clean, well maintained, and comfortable. The majority of bedrooms had ensuite facilities whilst those that didn't had sole use of bathrooms located near to them. Clients were able to personalise their bedrooms with personal items from home.

There was no clinic room for clients. Physical examinations were completed in the lounge area by the consultant psychiatrist upon admission, however others could not enter the lounge during an examination and the lounge door was shut. Medication was administered in the hallway of the building as this was where the medication cupboard was situated. This compromised client's privacy as other people could pass through and overhear conversations.

There was a clinical waste bin and sharps bin which was collected by a private company on a regular basis. There was an infection control policy which included the sharps policy. This had been reviewed in December 2015.

We looked at the health and safety risk assessment for the building which was up to date and contained all necessary information. We also saw in care records that health and safety for clients was assessed and each client was assessed for their ability to use the hot and boiling water.

There was a ligature risk assessment for the building but no ligature risk action plan. A ligature is a place to which patients intent on self-harm might tie something to self-harm. However the service stated it did not accept clients with acute mental problems. There had been no reported incidents of self-harm by ligature or others means.

There was a fire risk assessment in place that had been completed in August 2015. It was due for renewal after 12 months. There were no specific actions or recommendations made in the report.

There was a record of evacuation drills. Drills should take place every six months. There were two entries covering the 12 October 2015 and 09 March 2016. There was also a log of unplanned evacuations where a false alarm had been activated. These occurred on 25 May 2015, 30 June 2015 and 11September 2015.

There was a record of daily checks on fire escapes and exit routes going back to July 2015. There were a few occasions when the inspection had not taken place but an inspection had occurred the following day so there was never a gap of more than one day. On the day of the inspection we saw that all fire escapes routes were clearly marked and free from obstruction.

There was an evacuation procedure in place for the service and we saw records of regular maintenance of the fire alarm and detection system by an external contractor.

During a tour of the building we found that a fire exit on the third floor led to a flat roof space with a waist height fence round it that was not a solid structure. There was no signage on the door to say that the exit should only be used in an emergency and there was no system in place to alert staff if a client were to exit the door. This meant that it was possible that a client could exit the fire door without the staffs' knowledge and slip under the barrier and fall. However the manager of the service informed us that all

clients were informed that they were not to use the exit except in an emergency and there had been no incidents around this. Clients confirmed that they were given information on fire procedures and exits upon admission.

All clients had a personal evacuation plans in place in the event of a fire. We looked at the personal evacuation plan for one client with a physical disability and saw that the plan was individualised to ensure their safety.

There was a current gas safety certificate in place and this was held in a folder in the main office.

The registered manager had current first aid training. We saw in staff files that three other members of staff had completed an eLearning first aid awareness course in early August 2015, however this did not include any practical application of cardiopulmonary resuscitation techniques. This meant that staff were not equipped with the necessary skills to treat a patient in the event of an emergency. The majority of staff were aware that they should dial 999 in the event of an emergency, however one member of staff said that if they witnessed a client having a seizure they would provide them with oral medication which would pose a choking risk to the client.

Safe staffing

The service employed a full time manager, five addiction workers and three support workers. In addition there were seven sessional staff who were employed to come in to the service to deliver further therapies or care. These included a consultant psychiatrist who was contracted to provide an assessment and detoxification regime upon admission. There were two cooks and three cleaners contracted in by the service. There were no bank or agency workers and there were no vacancies. In the event of staff shortage such as sickness, regular staff would undertake extra shifts. All of the clients we spoke to said that staff were available at all times, day and night. They said that activities were never cancelled because of shortages of staff.

The service was staffed 24 hours a day. The majority of staff worked from 8am until 8pm on a rota basis. The manager worked on a ratio of one member of staff to six clients. Arrangements for night time differed with the number of clients admitted to the service. If the service had eight clients or less there was one member of staff on site and one on call. If the service had eight or more clients admitted there was one additional member of staff on a twilight shift from 7pm-11pm. We saw rotas from the previous four weeks and saw that any shifts not covered were highlighted in red and appropriate cover was found. Rotas were planned in advance.

However, there were not sufficient qualified staff to provide care. The registered manager was the only permanent qualified member of staff. Service users were prescribed medicines that were only to be given by qualified nurses. These included intravenous treatments. This meant that the registered manager had to be available at all times to assist. Where observations were outside the normal range, support staff were to contact the registered manager. This meant that the registered manager was always on call as there were no other staff with sufficient skills and knowledge to cover for the manager.

The on call rota was always covered by the manager except by prior arrangement which meant that the registered manager was not being properly supported to enable them to carry out the duties they were employed to perform.

We found that all staff did not have the relevant checks in place to ensure that staff were of good character. Of the eight permanent support workers or addiction workers, two members of staff did not have photographic identification and we could not find evidence of a disclosure and barring check for one member of staff. The manager confirmed this was the case. The manager was subsequently able to provide photographic identification for one of these members of staff on the day of inspection. We asked to see the relevant documents for the seven sessional and five housekeeping staff. Of these, only one had a disclosure and barring check in place. There was no photographic identification for any of these staff.

The service accessed consultant psychiatrist input when patients were admitted however there was no system in place for if the consultant psychiatrist was unable to attend the service. No arrangements in place to cover the consultant's absence such as sick leave or holidays. This meant that there was insufficient staff cover to enable the safe running of the service.

Mandatory training was listed in the quality management system folder as moving and handling, first aid, food hygiene, health and safety, prevention of violence and

aggression, administration of medication and National Vocational Qualification level II. However it was not specified what subject the national vocational qualification covered.

Recommended and useful training was listed in the same folder as seizure and use of rectal diazepam, behaviour as communication, addiction awareness, alternatives to restraint, dietician and healthy eating, medication awareness, basic counselling skills, supervisor's certificate and fire safety training.

However we were not provided with mandatory training rates for staff. Staff completed training via an online system but the training certificates in staff files only related to the following mandatory training:

Moving and handling- two staff completed

First aid awareness – three staff completed

Health and safety- two staff completed

Administration of medication-two staff completed

Staff told us that they did not feel that the online training was adequate. Staff were not enabled by the provider to obtain further qualifications where appropriate and said they paid for further training themselves. The manager told us that the online system of training provided was not adequate. They told us that he had requested improved training for the service.

The safeguarding policy stated that all staff were required to undertake safeguarding training to an appropriate level however we did not see evidence of this in staff files or records and it was not listed as a mandatory training course.

Assessing and managing risk to clients and staff

We looked at the care records of five clients in the service. All of the records we looked at had a basic risk assessment in place that took into account issues around risk to self or others. We were told that the risk assessment was updated if there was a change in a client's presentation. All clients whose records we looked at had been assessed as low risk apart from one who was deemed to be medium risk. For this client there was no risk management plan in place which included triggers and signs or symptoms that the risk was present. This meant that there was no clear plan for staff to ensure that risks were managed or minimised effectively. All risk assessments had been signed by both staff and clients. All records had a completed and signed confidentiality agreement within the files. Clients were asked upon admission if they had been checked for blood borne viruses but there was no routine testing.

There was no written plan for unexpected discharge from the service in any of the care records we looked at and the manager of the service confirmed that no written plans were provided to any client if they left the service unexpectedly. However verbal information was given on safety and relevant services when the client was leaving. Staff members would also try and contact services in the client's local area with the clients consent. There was a self discharge form that clients signed upon leaving the service unexpectedly.

The registered manager was the identified lead for safeguarding. There was a safeguarding policy for the service. There was no issue number or date on the policy although it stated that it should be reviewed two yearly or if there were any changes in legislation. The policy stated that safeguarding and the safeguarding policy would be discussed with staff during induction and at safeguarding training, however only one member of staff had completed eLearning safeguarding training within the last year.

We saw in individual staff files that there was a copy of the safeguarding policy and procedure which staff had signed to say they had read it. The policy did not make reference to the need to report safeguarding issues to the CQC but the CQC document to providers regarding 'Roles and responsibilities for safeguarding' was attached. The copy of the safeguarding policy in the staff office also had the Lancashire authority 'safeguarding vulnerable adults a shared responsibility' document attached.

We looked at the systems in place at the service for medicines management. We checked nine sets of records and spoke with the registered manager and support staff who were responsible for medicines. The medicines policy expired in November 2015 and did not include the management of controlled drugs, which are medicines that require extra checks and special storage arrangements because of their potential misuse. The registered manager told us the current policy was being reviewed.

Medicines were stored securely with access restricted to authorised staff. Controlled drugs were not managed appropriately. The balance of controlled drugs was incorrect as there were two extra in the controlled drugs

cupboard then what was in the controlled drugs register. It was unclear whether a dose had been signed out of the register but not administered. Records of controlled drugs were not always completed in accordance with National Institute for Health and Care Excellence guidance. For example, the time when a controlled drug had been administered to a person was not recorded and there was crossing out in the register.

We checked medicines requiring cold storage and found fridge temperatures had not been recorded as there was no thermometer to take the temperature with, which is not in accordance with national guidance. Taking minimum and maximum temperature readings each day gives assurance that medicines have been stored between two and eight degrees Celsius and are safe to use.

Clients were often referred by an external agency. Pre admission assessments were not in place prior to admission to the service. Clients would have the assessment when they arrived and would wait for the consultant psychiatrist to review them and to prescribe the medication needed to for the detoxification regime. We asked staff whether clients would be declined if a pre-assessment had not been done, but they said this did not happen, however the nominated individual for the service stated that one person had been declined in the last 12 months.

There was no formal process for medicines reconciliation. Clients would bring personal medicines for their stay but if they hadn't their registered GP would be contacted and a fax would be sent to the local pharmacy for this to be prescribed.

Two clients were at risk of developing Wernicke's encephalopathy (a disorder affecting the brain) and were prescribed an injection containing vitamin B1. They had not been given the injection, which increased the risk of them developing the disorder. When administering the injection there is a risk of a person developing a severe allergic reaction to it. The recommended guidance from the Medicines and Healthcare products Regulatory Agency was to have two adrenaline pens available in the event that a severe allergy occurred; yet the service only had one adrenaline pen on the day we inspected.

Prescription charts were not being used in accordance with legislation, as they were not always signed by the doctor. One person had a seven day detoxification plan and a 10 day detox plan in their records (one of which had not been signed by a doctor) and on one day both detoxification plans had been signed as being administered. A second person had a detoxification regime that carers had signed to say the medicine had been given but the prescription chart had not been signed by the doctor. It was unclear whether printed detoxification regime prescription charts had been printed by the doctor or another member of staff.

Two other clients had prescription charts that had been signed by the doctor but had no medications written on them, which is not in accordance with best practice. Blank prescriptions should not be signed by a doctor as medicines could be added onto them without the knowledge of the doctor.

One person who was prescribed a detoxification regime that reduced every 24 hours had their regime reduced after 12 hours on the first day, which increased the risk of them developing withdrawal symptoms and increasing the risk of a seizure developing.

The doctor only assessed clients before the detoxification programme started. The doctor requested staff to monitor the clients blood pressure and pulse for the first 24 hours, but records showed that this did not occur for every client. The service did not assess clients during the detoxification regime as per national guidance. The Clinical Institute Withdrawal Assessment for Alcohol was completed upon initial assessment but not subsequently which meant that staff were not using a recognised tool to monitor a person's wellbeing. One clients blood pressure had been recorded as high on three occasions but the support staff had not contacted the registered manager as per the procedure for advice.

Track record on safety

There had been no serious incidents reported to the CQC in the last 12 months. The manager explained that if there were a serious incident there would be a debrief for both clients and staff.

Reporting incidents and learning from when things go wrong

There had been no incidents reported to the CQC in the past year. The manager explained that if there was an

incident the outcome would be discussed with all relevant parties and the provider would be informed. The incident would then be documented on an incident form in the back of the clients file.

Duty of candour

Duty of Candour is a statutory requirement to ensure that providers of healthcare services must be open and honest with clients and other 'relevant persons' (people acting lawfully on behalf of clients) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology.

The service had a Duty of Candour policy which staff had been asked to read and sign to say they had completed this. The policy could not be located at the time of our inspection however we were provided with a copy shortly after our inspection.

Staff were able to demonstrate that they knew about Duty of Candour and described being open and honest with clients.

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

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

Clients were referred to the service via a number of external agencies by telephone which was then followed up by email. Referral information received by the service was limited to basic details for all but one referring agency. This meant that there was no way of knowing if a client arriving at the service had a complex presentation. One member of staff undertook pre admission checks on arrival to determine suitability to the service. These checks included an assessment of history of suicidal ideation or attempts, history of abuse, physical health needs and any additional needs. If at this point the client was deemed to be too complex to be treated by the service then admission would be refused. However this meant that if the client were to be refused admission they had to return back to their home address which could anywhere in the United Kingdom, delaying and potentially affecting their motivation to enter treatment.

We looked at five care records. Care records were poorly completed. Initial assessments were incomplete and care records did not document recovery aspects and goals of treatment. However; all had a support plan in place. The service had implemented the 'wheel of life' self assessment tool but these were not in care records.

Best practice in treatment and care

There was a range of therapies and activities offered at Ocean Recovery and Wellness Centre. Groups and activities took place Monday to Friday. In the morning all clients completed a feelings check with staff which enabled them to talk about anything their mood or any issues they had. It also allowed staff to ensure that extra support could be provided to those clients who needed it. This was followed by group sessions with addiction workers and support workers. We observed two group sessions; neuro-linguistic programming which was facilitated by staff who had been trained in this, and the wellness recovery action planning group. Neuro-linguistic programming is an approach to communication, personal development, and psychotherapy and aims to change certain negative beliefs that clients have about themselves. The groups were well structured and well facilitated by staff and we observed that clients were involved and motivated in the groups.

Staff were not aware of the National Institute for Health and Care Excellence guidelines that had been produced in relation to alcohol or substance misuse. For example National Institute for Health and Care Excellence guidelines on drug misuse in over 16's: psychosocial interventions or alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. However; we observed that good practice was taking place throughout the service and these included holistic therapies including reiki, acupuncture, counselling, group work, and family interventions. The clients we spoke to said they found these treatments beneficial.

A physical healthcare check was carried out by the consultant psychiatrist upon admission. Clients did not register with a GP while they were at the service due to the short term nature of their stay however staff would take clients to the local walk in centre, accident and emergency or call an ambulance depending if a physical health problem arose during their stay.

There were very limited outcome measures used in the service. The service had a database that was used to inform

them if the client had relapsed after discharge but they did not record any other treatment outcomes. The service did not submit data to the national drug treatment monitoring system which was used to assess and analyse outcomes for clients.

The Clinical Institute Withdrawal Assessment for Alcohol was completed upon initial assessment but not subsequently which meant that staff were not using a recognised tool to monitor a person's wellbeing throughout their detoxification programme which was not in line with national guidance and meant that clients withdrawal symptoms were not being properly monitored.

Medication audits were completed weekly and client files were audited within 72 hours of admission and then weekly, however medication audits did not detail which medicines were coming into the building. Audits were completed by the manager.

Skilled staff to deliver care

The staff at Ocean Recovery and Wellness Centre had a range of qualifications and experience in the alcohol and substance misuse field. The manager was a registered mental health nurse who had worked at the service for a year. Staff files contained certificates in courses such as counselling, Drug and Alcohol National Occupational Standards and emotional freedom techniques. These had all been completed in previous employment. Addiction workers had their own experience of addiction to draw upon when working with clients. Access to specialist training was not provided by the service.

The service had a range of sessional staff who provided treatments in reiki, acupuncture, counselling, music therapy and yoga.

The consultant psychiatrist for the service had received specialist training in substance misuse however we did not receive information to say they had received supervision from a substance misuse specialist doctor. National guidance indicates that this should be the case (Public Health England 2014; Royal College of Psychiatrists 2012).

The supervision policy stated staff should receive a one week induction, their first supervision session in four weeks and their second and third supervision sessions at four-six weeks and 12 weekly thereafter. The policy stated that appraisal should be after six months and then on an annual basis. We found that staff had received supervision within the time frames described in the policy but only three support staff of the eight employed had received an appraisal within the stated time frames which meant that staff were not being supported in their continuing professional development. We were informed that the manager of the service was supervised and appraised by the nominated individual for the service however they did not have a clinical background. There were no supervision records for the registered manager and we were told that these were not documented. The manager had not received an appraisal since commencement of employment.

The service did not have access to medical or nursing care on site every 24 hours, seven days a week. The registered manager was the only member of staff who was a qualified nurse, all other staff had no medical training apart from the doctor who only attended when the client was first admitted. At the time of the inspection staff were not trained in basic life support, the use of epipens or the use of rectal diazepam in the event of a seizure, however if there was an emergency the majority of staff said that an ambulance would be called. There had been no reported incidents around the need for access to medical or nursing care.

Multidisciplinary and inter-agency team work

There were multidisciplinary meetings that took place on approximately a monthly basis. These were led by the registered manager and support staff attended these. The meeting was not attended by the consultant psychiatrist. We saw meetings minutes for three team meetings. We found that there were discussions around medications, the day to day running of the service, staffing issues and issues that had been raised by clients.

Verbal handovers were completed at the start and end of every shift. These were not individually documented but relevant information was written in the communication book for all staff to see.

There were good working links with the local pharmacist that provided prescribed medications. There were no links with local GP services. Due to the short nature of their stay clients retained their GP in their local area. If clients had a problem with their health they were able to attend the walk in centre or the accident and emergency department if necessary. Links with other agencies varied due to clients ordinary place of residence.

Substance misuse services

Adherence to the MHA

The service was not registered to accept patients detained under the Mental Health Act, however the service had accepted clients with a history of mental health problems whose mental health was stable at the time of admission. Staff were aware of what to do if there was a deterioration in a client's mental health and had previously made referrals to the local home treatment team.

Good practice in applying the MCA

There was no Mental Capacity Act policy for the service at the time of our inspection however one had been completed shortly after our inspection. Staff had not had training in the Mental Capacity Act. All clients admitted the service were presumed to have capacity to undertake the treatment programme but there was an awareness that clients capacity could be temporarily impaired if they were intoxicated upon admission to the service. There was no procedure about what to do if there were issues with a client's capacity and staff were not aware of the principles of the Mental Capacity Act or what to do if a client's capacity were to change.

There were no clients subject to Deprivation of Liberty safeguards.

Equality and human rights

There were policies for equal opportunities and diversity in care. Both of these policies had been reviewed din January 2016, however neither policy included information on the Equality Act 2010. This meant that staff were not able to access current information on equality law. Staff had not received training in equality, diversity and human rights.

There were few blanket restrictions as the service used a philosophy of empowerment and encouraged clients to take responsibility for their own actions. Clients had to be escorted when out of the building during their admission, the use of drugs or alcohol were prohibited and intimate relationships were not allowed between clients. Mobile phones were not permitted to be used during group sessions. These restrictions were necessary and proportionate for the safety of the client and others and clients all signed to consent to these restrictions when they entered treatment.

Management of transition arrangements, referral and discharge

Clients were given useful organisations to contact should they choose to, and staff contacted services in the clients' local area with their consent. However some clients wanted to maintain confidentiality around their stay and this was respected by the service.

Are substance misuse services caring?

Kindness, dignity, respect and support

Staff respected clients and valued them as individuals. Feedback from clients was positive about the way staff treated them. Clients and those close to them told us that the care they received was exceptional and that staff went out of their way to provide high quality care.

There was good engagement between staff and clients. Staff were warm and friendly. They treated clients with dignity, respect and kindness during their interactions and the relationships between them were positive. Clients told us they felt supported and said staff cared about them. They described staff as friendly, approachable and helpful.

The staff ensured clients' dignity, privacy and confidentiality was always respected, for example, by knocking before they entered clients' bedrooms.

The staff we spoke with were able to explain the needs of individual clients and describe their care.

The involvement of people in the care they receive

On admission staff showed clients around the building and introduced them to other staff and peers. There was a clients handbook that contained information about the service and facilities and set out house rules.

Staff were committed to working in partnership with clients. They explained the structure and purpose of group sessions before the group started so that clients understood what they could achieve. Clients told us they understood their care and treatment. They said the staff supported them in planning their care and treatment, including planning for discharge.

The service had just introduced a new model of care called wellness recovery action planning that helped staff ensure clients were empowered to be partners in their care. We observed a care planning meeting where staff encouraged clients to think about their own needs and plan what they needed to do to achieve their goals. Sharing their

information encouraged clients to engage in planning their care. This was the first meeting using the new model. It was to be followed up with one to one meetings at which each client and their keyworker would make decisions about their treatment and aftercare; however, this had not yet been implemented and no care plans from this model were available for us to review.

We reviewed five clients' care records. Clients had three one-to-one sessions with their keyworker. We were told that the first session was used to review the client's initial support plan, record their progress and plan actions needed and the second to record progress against the planned actions. The third session was used to ensure all agreed areas had been completed and to develop an aftercare plan.

However, in most of the five records, the information gathered on admission had not been developed into plans for recovery or risk management. In two cases, the client had only just been admitted. Of the other three, only one contained some information about the client's goals. As the records were not complete, we were unable to establish how clients were involved in planning their own care.

We were told that clients who required advocacy support could contact a local advocacy service directly. None of the clients we spoke with had any knowledge of advocacy support. We noted that the contact details provided related to a befriending service that had ceased to operate 18 months previously. We did speak with an advocacy service that was part of the same umbrella organisation, which told us that no clients from this service had requested support in the 12 months prior to the inspection and they had not received any referrals from the provider.

Staff offered support to clients' families. They facilitated family support groups on request on visiting days or on discharge. They also offered family sessions in a one to one setting. We asked for carer details to ask their opinions of how the service included them but we were not provided with them. Clients had the opportunity to make suggestions, raise concerns and make requests. The service held weekly community meetings. These meetings engaged clients and encouraged communication. We saw minutes of four of these meetings that documented discussions about issues clients raised. We saw that issues raised in the meetings were acted upon by staff and managers.

There was a suggestions box in the reception area. This meant clients could raise issues anonymously if they wished. These were considered at the community meeting and, following discussion, a decision was made by the whole community.

On discharge, clients completed a quality questionnaire that gave staff feedback on the service but we did not see any system for acting upon feedback given. However we saw nine completed copies of questionnaires and found that feedback given was overwhelmingly positive especially with regard to staff.

Are substance misuse services responsive to people's needs?

(for example, to feedback?)

Access and discharge

The provider accepted referrals from a number of independent agencies. Clients were admitted from national locations. Staff told us they received very little information about most clients before they were admitted. They gathered most information themselves during the pre-admission assessment, which was carried out when the client arrived at the service. Following the assessment, they decided whether they would admit the client. For example, clients who also had physical or mental health needs would not be admitted. This meant that clients might have travelled long distances before knowing whether they would be admitted. The service did not have a written exclusion criteria but the registered manager stated that the service did not accept clients who were deemed to be complex. This included people who were acutely mentally unwell and those with a physical disability that could not be accommodated by the service.

Staff explained how the treatment programme worked and ensured that the client understood the underpinning ethos. This included an explanation of the house rules and expected standards of behaviour, such as abstinence. Clients were required to consent and accept these rules before staff offered them a place. They were also expected to sign a disclaimer in the event that they left the service before completing the programme.

The treatment programme extended over a period of seven to 28 days. It included a detoxification regime and psychotherapy sessions alongside holistic therapies. Staff

worked with the client to plan their treatment. They focused on helping clients to concentrate on their goals for recovery and the progress they had made towards the outcomes they wanted to achieve. This meant that staff ensured clients did not stay in treatment longer than necessary and promoted early discharge. Clients were encouraged to consider their objectives following discharge and supported in meeting these. This included developing support networks, coping strategies and recovery capital.

At 18 May 2016, 168 clients had been discharged from the service. The provider routinely attempted to follow up all clients within one week of discharge although some clients preferred to contact the service at their own discretion. Staff had contacted 83% of discharged clients.

There was an aftercare provided by the service which clients could access for up to a year after leaving the service. This was usually attended by a small group of ex-clients. The ex-client we spoke to said that they had attended this group and found it to be helpful.

The facilities promote recovery, comfort and dignity and confidentiality

There were communal areas and lounges as well as confidential areas used for group work and therapy sessions. There was access to well-maintained outdoor spaces. Clients could meet their visitors in the lounge areas. Mobile phones were permitted, which meant clients had privacy to make calls. There was a spa area with a jacuzzi and steam room.

Clients could personalise their bedrooms with their belongings, however bedrooms did not have secure storage spaces that clients could use. The provider stated that if locked storage were required this could be provided. All rooms were either ensuite or had exclusive use of a nearby bathroom. Male and female areas were not segregated but there was a policy that provided guidance for staff. The house rules were explained to clients prior to admission.

Clients told us the food was very good. Food and drinks were available 24 hours a day. There was a drinks machine and staff would make snacks and drinks for clients if they wanted something outside meal times.

Activity focused on promoting safe, early recovery. The treatment programme provided therapies for clients six days a week. There was a therapy timetable on display. Therapies varied from individual and group sessions such as neuro-linguistic programming, wellness recovery action planning and holistic therapies to communal and social activities such as group walks. The programme included free time and dedicated time for clients to spend with their key worker. There were sessions every morning, including Sundays, where clients reflected on the previous day and their feelings. Clients we spoke with told us that they found the activities beneficial and relevant to their needs.

Meeting the needs of all people who use the service

The environment was not fully accessible. There were no ramps and no lift to the upper levels. Staff made adjustments according to need, for example, for clients with reduced mobility. We saw that for one client who was admitted to the service with mobility problems they were given a downstairs room and personalised evacuation plan in the event of a fire.

Staff handed out information leaflets during group therapy sessions. The leaflets were written in clear, easy to understand language and included pictures. We did not see any information in different formats or languages although staff assured us that they could provide them if necessary.

We did not see local information displayed. Staff supported clients to develop their recovery capital and support network by identifying recovery communities within their home area.

Staff identified clients' cultural and religious needs through assessment. This allowed them to identify whether interpreter services were required and to work with the client and local services to provide appropriate support. The diversity policy stated that information could be provided to each client in writing in a language relevant to them.

Clients told us there was a good choice of food, which they said was delicious. Staff could arrange for specific dietary requirements relating to religious or physical health requirements, such as vegan and halal diets and for clients with allergies or medical conditions such as diabetes. They identified these needs in the assessment process. During the group therapy sessions, staff also discussed the health aspects of addiction, for example how the intake of sugar in alcohol could have a significant and dangerous impact on a clients' blood sugar levels. .

Substance misuse services

Staff supported clients to attend local places of worship if this was requested, although the clients we spoke with said they had no wish for it. The provider accepted clients with a range of religious beliefs.

Listening to and learning from complaints

All the clients we spoke with said they knew how to raise concerns. One client told us they had not received information about how to make a complaint but said they would approach staff if they felt the need to complain.

Information on how to make a complaint and how to contact the Care Quality Commission was displayed in the reception area.

There were three versions of the service user handbook which contained complaints information. The full one contained a small section on complaints and held correct information. The summary and bullet point versions mentioned complaints but stated incorrect information regarding the CQC's role in complaints.

There was a suggestions box in the hallway to enable clients to submit their complaints anonymously. Staff explained how they dealt with complaints from clients and families.

As a result of concerns raised by clients, improvements had been made. For example, the steps outside posed a potential tripping hazard so the provider had fitted visibility markers, a handrail and sensor light to mitigate the risk.

Staff told us they received feedback from issues raised through staff meetings. We looked at minutes from three staff meetings the last one being held in June 2016. In the records we reviewed we saw feedback from issues raised by clients around the Wi-Fi signal in the building.

The service had received 130 compliments in the 12 months prior to this inspection. We saw a compliments folder which contained cards and letters of thanks from clients who had undergone treatment at the service.

Are substance misuse services well-led?

Vision and values

The service listed the following set of statements which described their values relating to clients. These were that each client they supported had the fundamental right to:

- be regarded as an individual and given our special attention;
- be supported by people who are capable of understanding their needs and competent to meet those needs;
- be treated equally, and no less favourably than others;
- receive respect and understanding regarding their cultural, religious and spiritual beliefs;
- receive prompt attention in relation to all of their healthcare needs;
- be safe, respected and feel "cared for" at all times
- be informed about all important decisions that affect them, and to have an input into those decisions;
- be afforded privacy for themselves and their belongings;
- be afforded dignity, at all times,
- have the opportunity to think independently, and make their own choices;
- make a complaint about anything they feel is unfair or unjust, and to have that grievance listened and responded to.

  However staff we spoke to were not aware of the values of the organisation.

Staff were aware of who the senior managers in the service were and the manager informed us that the provider visited the service on a fortnightly basis to ensure that staff were kept up to date with developments in the service.

Good governance

The service did not have effective governance processes to manage quality and safety. There were quarterly management reviews which should have included the registered manager, deputy manager, team leaders, day support worker and night support worker however the registered manager stated the meeting was held at provider level only.

There was a lack of audits for the service to aid improvement There was a lack of audits to monitor compliance in all aspects of the service. The quality management system policy stated that there should be

two internal audits per year however none had been carried out in this time. The provider did not use key performance indicators and other indicators to gauge the performance of the team or the service.

We looked at over 40 policies and procedures for the service. These included whistleblowing, confidentiality, protecting clients' rights, recruitment, disciplinary procedure, grievance procedure, administration of medication procedure and complaints procedure. All of the policies and procedures had an issue date of November 2014 and a review date of November 2015. Of all the policies only two had been signed to say they had been reviewed. These were the diversity of care and recruitment of ex-offenders policies.

The manager felt they were given the freedom to manage the service but did not have administration staff to support them. They also said that, where they had concerns, they could raise them however there was no local or provider level risk register for the service.

Staff had not received mandatory training as documented in the policy and there was no access to specialist training.

Not all staff had fit and proper persons checks including disclosure and barring service checks, photographic identification and references.

The staff appraisal rate was 38%, which meant that staffs' continuing professional development was not being reviewed. All of the support staff had regular supervision in line with the supervision policy. We were informed that the manager of the service was supervised and appraised by the nominated individual for the service however they did not have a clinical background. Supervision was not documented and the manager had never received an appraisal since commencement of employment.

The service was not following guidance in the Medicines and Healthcare Products Regulatory Agency and best practice guidance in relation to medication management. The issues we found in relation to poor medicine management had not been identified by the service. Physical observations were not being recorded in line with the consultant psychiatrists' instructions. This meant that the safety of clients was compromised.

Leadership, morale and staff engagement

Sickness and absence rates were 2% in the period in the previous 12 months up to 18 May 2016 and remained low up to the time of the inspection.

There were no bullying or harassment cases and staff were aware of how to use the whistleblowing policy. They felt confident to raise concerns to either managers or senior managers and felt that any complaints would be dealt with in a fair manner. The staff we spoke to said they loved their job and that it was rewarding. Morale was good and the team worked well together. However there were few opportunities for leadership development and the registered manager had not been supported to access leadership courses, however some support staff took on some management responsibility if the registered manager was off work.

Commitment to quality improvement and innovation

Ocean recovery and Wellness Centre was not participating in any national service accreditation or peer review schemes at the time of the inspection.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve
Action the provider MUST take to meet the regulations:

- The provider must ensure that the mandatory training identified is sufficient to support staff to carry out their roles safely and effectively.
- The provider must ensure that all staff have the relevant fit and proper persons checks such as photographic identification, disclosure and barring service and references
- The provider must ensure that there are two adrenaline pens on site and that staff are trained in this
- The provider must ensure that there are resuscitation facilities at the premises
- The provider must ensure that there is a standardised method of accepting referrals to the service.
- The provider must ensure that there are enough medical equipment available such as syringes to administer medicines
- The provider must ensure that medicines are prescribedproperly and in accordance with clinical guidelines and legislation. The service was not following guidance in the Medicines and Healthcare Products Regulatory Agency.
- The provider must ensure that medicines administrations records are used in accordance with legislation and that all relevant information such as date of birth, address and allergy status is included.
- The provider must ensure that physical observations are being completed as directed by the consultant psychiatrist using a relevant assessment tool by staff trained in its use. When observations are outside normal parameters the relevant procedure should be followed.
- The provider must ensure that the medicines policy is reviewed and includes controlled drugs guidance as well as National Institute for Health and Care Excellence guidance.
- The prover must ensure that there is an effective system in place for auditing what stock of medicine is in the service, as quantities of medicines received were not recorded.
- The provider must ensure that fridge temperatures are recorded.
- The provider must ensure that systems are in place to identify shortfalls in standards of care to enable them to make necessary improvements.
- The provider must ensure that environmental risks are being effectively managed and mitigated.
- The provider must ensure that the service is fully compliant with health and safety requirements including actions of ligature risks, ensuring that there is adequate signage on fire exit doors and ensuring the safety of the third floor flat roof space.
- The provider must ensure that there is a system to demonstrate that policies in place for the operation of the service are being reviewed and updated to reflect current practice.
- The provider must ensure that the safeguarding policy states that CQC are to be informed of safeguarding alerts or concerns and that staff follow this.
- The provider must ensure that risk assessments completed by the service are detailed and include management plans for those clients deemed to be medium or high risk.
- The provider must ensure that care records are completed robustly and document recovery aspects and goals of treatment.
- The provider must ensure that appraisals have only been completed for all staff The provider must ensure that all staff receive documented clinical supervision as per the policy.

Outstanding practice and areas for improvement

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- The provider should ensure that all clients have a written plan for unexpected discharge from the service.
- The provider should ensure that policies are able to be easily located.
- The provider should ensure that staff are trained in the Mental Capacity Act.
- The provider should ensure that all clients have access to advocacy support.
- The provider should ensure that there is a system for acting upon client feedback upon their discharge.
- The provider should ensure that clients afforded privacy when receiving medication.
- The provider should ensure that there is a local and provider level risk register.
- The provider should ensure that the service user handbook provides correct information regarding the CQC's role in complaints.
- The provider should ensure that staff are aware of the organisations values

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2014 Premises and equipment How the regulation was not being met: The exit door from the third floor fire escape led to a flat roof and then down the external metal fire escape. The flat roof had a railing fence around it which was waist height and was not a solid structure. There was no signage on the exit door to state that it was only to be used in an emergency. This was a breach of Regulation 15(1)(e)

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2014 Fit and proper persons employed How the regulation was not being met: The provider was unable to provide information specified in Schedule 3 for each person employed at the service. Two permanent staff had no photographic identification All housekeeping staff and all but one of the sessional staff did not have disclosure and barring service clearance, photographic identification or references in place This was breach of Regulation 19 (3)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment** **How the regulation was not being met:** **The service did not have suitable arrangements in place for the administration and management of medicines. Staff had not been trained in the necessary skills to treat a patient in the event of an emergency. Records of controlled drugs were not always completed in accordance with the National Institute for Health and Care Excellence guidance. Fridge temperatures were not monitored. There was only one adrenaline pen despite recommended guidance from the Medicines and Healthcare products Regulatory Agency which stated there should be two. Physical observations of clients undertaking the detoxification regime had not been completed as directed by the doctor for some clients. The service did not assess client's withdrawal symptoms during the detoxification regime which was not in accordance with National Institute for Health and Care Excellence guidance. Prescription charts were not being used in accordance with legislation as they were not being signed by the doctor** **This was a breach of regulation 12(1)(2)(a)(b)(c)(f) and (g)**

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good Governance**

This section is primarily information for the provider

Enforcement actions

How the regulation was not being met:

Care records were poorly completed. They did not document recovery aspects and goals of treatment. The 'wheel of life' self-assessment tool implemented by the service was not in care records. Records for controlled drugs were not completed properly. The medicine administration record did not have space for the persons address or date of birth or allergies. It was unclear who was making changes on these records. There were no contemporaneous notes for medicines. Observations were not being recorded in line with the consultant psychiatrist's instructions and observations out of the normal range were not being escalated to the registered manager as per the administration of medicines policy. Observations were not being documented. There were no documented observations of a person's physical health using a recognised tool. There was no record of a plan for detoxification in one service user's record. Initial assessments from the all of the referring except one gave limited information on the presenting problems of the client and there was no standardised way of capturing this information. Systems were not in place to identify shortfalls in standards of care and making the necessary improvements. No internal audits had been carried out since August 2015. There were no identified quality improvement measures in place and no system to ensure the service was following best practice guidelines. The service was not following guidance in the Medicines and Health Products Regulatory Agency. The safeguarding policy did not state that CQC were to be informed of safeguarding alerts or concerns which meant that staff were not aware of the need to notify CQC. Environmental risks were not being effectively managed and mitigated. Ligature assessments did not identify ways to reduce or manage these risks. Policy management was poor. Of all the policies we looked at only two had been signed to say they had been reviewed. There were three different versions of the complaints policy available. The equal opportunities policy and diversity in care policy did not mention the most recent legislation of the Equality Act 2010. Two versions of the service user handbook had incorrect information regarding CQC involvement in complaints.

This was a breach of Regulation 17 (a)(b)(c)

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 Staffing** How the regulation was not being met: Mandatory training was not being provided in line with the training policy for the service. The majority of staff had not completed any training in the policy. Safeguarding training was not part of mandatory training but the safeguarding policy stated that all staff should be trained in this. There was not sufficient qualified staffs to provide care. The registered manager was the only qualified permanent member of staff which meant that the registered manager was always on call as there were no other staff with sufficient skills to cover for the manager. Two clients had not been given a necessary vitamin B1 injection due to the lack of qualified staff. There were no cover arrangements for the consultant psychiatrist if they were off sick or on annual leave. The registered manager for the service had not received an appraisal and three of the eight permanent staff had not received appraisal as per the policy. There was no documented supervision completed for the registered manager. The registered manager had verbal supervision from a person who was not a registered nurse or allied health professional. We did not receive information to confirm that the doctor had received supervision from a specialist substance misuse doctor. The service did not provide access to specialist training, staff paid for this themselves. This was a breach of Regulation 18 (2)(a)(b)