# Cranstoun - Oak Lodge

## Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

## Overall summary

We found the following issues that need to improve:

- The provider had not recognised the medicine training needs of staff and had not carried out criminal record checks in an appropriate time scale. Staff had not been provided training in the duty of candour, which came into effect in April 2015.
- The provider had not carried out an environmental risk assessment to identify risks in the environment that could affect clients and staff. Clients did not receive an induction covering how to use the equipment at the gym safely. There was no
- Staff relied on information from the referrer and did not always carry out comprehensive assessments of needs for clients themselves. records did not contain management plans for an unexpected treatment exit.
- Clients did not regularly receive a written copy of their recovery plan or have access to an independent advocate.

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

- There was a manager on call at all times and there was a clear system in place for reporting incidents.
- All clients we spoke with felt supported in their transition from detoxification services to this service and felt involved in their care.
- All staff received an annual appraisal of their performance at work and the provider supported staff members in leadership training and development.
- There was a clear system for recording and managing complaints about the service.

# Summary of findings

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# Cranstoun Oak Lodge

**Services we looked at:**
Substance misuse services

# Summary of this inspection

## Our inspection team

Lead inspector: Natalie Austin Parsons

The inspection team that inspected Cranstoun Oak Lodge consisted of two CQC inspectors, one CQC inspection manager, one expert by experience with experience of substance misuse services, one specialist advisor for substance misuse services and a CQC pharmacy inspector.

## Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive inspection programme of substance misuse services.

## How we carried out this inspection

To get to the heart of the experience of people who use services, we always ask the following five questions of every service and provider:

- 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 service and asked other organisations for information.

During the inspection visit the inspection team:

- visited the location to look at the quality of the environment and observe how staff were caring for patients
- Spoke with five clients
- Spoke with a deputy director from Cranstoun, the provider
- Spoke with the service manager and the team leader
- Spoke with three members of staff: a project worker, a volunteer and a trainee psychotherapist
- Observed a team meeting and a relapse prevention group
- Looked at the care records for seven clients
- Looked at a range of documents related to the running of the service including audits, risk assessments and staff appraisal and supervision records
- Carried out an in depth inspection of medication management

## Information about Cranstoun - Oak Lodge

Cranstoun Oak Lodge is a drug and alcohol rehabilitation service in south west London provided by Cranstoun. Places are funded by the local authority or privately by clients. Clients come to Cranstoun Oak Lodge after completing alcohol or opiate detoxification at another service. Cranstoun Oak Lodge provides a service for up to 14 men and women and provides a residential 12 week rehabilitation programme. The programme offers psycho-social interventions and one to one support from a keyworker.

The service is registered to provide the following regulated activity:

# Summary of this inspection

- Accommodation for persons who require treatment for substance misuse.

## What people who use the service say

Clients we spoke with were positive about the service. They described staff as respectful, polite, caring and interested in clients' wellbeing. Clients said that staff had been great, had made them feel welcome and had supported them in their transition from a detoxification service to this service. Clients said they received good care from staff and that they were aware of the support they could access. Clients also said they felt empowered to speak up if they felt there was an issue with their care and they could do this without fear of a negative impact on their care and treatment.

# 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 found the following issues that need to improve:

- Staff responsible for the management and administration of medicines were not suitably trained to recognise the appropriate side-effects, cautions and risks of treatment. Staff did not keep a daily audit record of the temperature of the room where medicines were kept, which meant there was a risk that the medicines were not stored in accordance with manufacturers' product licence conditions. The service did not have a protocol on the self-administration of medicines.
- Volunteer staff did not receive training in basic life support so would not be able to provide this support to clients if necessary. Records of staff training did not accurately reflect the mandatory training staff completed.
- The provider had not conducted criminal record checks in an appropriate time scale for all voluntary staff at the service.
- Client records did not contain management plans for an unexpected treatment exit.
- Contents of first aid boxes were not within date and not all first aid boxes included the correct contents.
- The provider did not have an organisational wide policy or risk assessments in relation to children coming onto the premises for visits. Staff had not received training in safeguarding children, although the manager had identified this shortfall and arranged for training to take place.
- Staff were unaware of their responsibilities under the duty of candour, which came into force in April 2015.
- The service had not carried out a formal environmental risk assessment to identify risks in the building and environment that could affect clients and staff. Staff had not given clients an induction covering how to use the equipment at the gym safely, which meant clients could have been harmed while using the gym equipment.
- Staff had not carried out an infection control audit at the service. There was a risk that clients were not being protected against the risks of infection.
- The service was in the process of changing the way that staff managed safeguarding concerns. Not all staff were aware of the new process. This meant that staff may not have been highlighting safeguarding concerns to the local safeguarding teams in a timely way, potentially putting clients at risk.

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

# Summary of this inspection

- All new clients were given a health and safety induction for the main building, although this did not include the gym.
- There was a manager on call at all times for staff on duty to contact.
- There was a clear system in place for reporting incidents, which staff understood.

## Are services effective?

We found the following issues that need to improve:

- Staff at the service did not carry out comprehensive assessments of needs for clients themselves, but relied on information from the referrer.
- Staff did not receive the number of supervision sessions per year that the provider required and volunteer staff did not receive any form of supervision or formal support.
- Staff recording of daily client notes was inconsistent and poor in some cases. Some information was missing from clients 'notes and staff had entered information several days after events had occurred meaning information was not stored by date of event in some cases.
- Clients did not have care or management plans in place that covered unplanned exit from the service. This put clients at risk if they left treatment suddenly.

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

- We saw staff using very good facilitation skills during a relapse prevention group, with a clear depth of knowledge for the topic.
- All staff received an annual appraisal of their performance at work.

## Are services caring?

We found the following areas of good practice:

- All clients we spoke with felt supported in their transition from detoxification services to this service and said that they had received good care.
- Clients felt involved in their care and treatment.
- All clients received an information pack on arrival to the service which contained information about the service.
- Clients had a daily meeting where they could give feedback on the service they received.

However, we also found the following issues that need to improve:

- Clients did not regularly receive a written copy of their recovery plan.
- Clients did not have access to an independent advocate.

# Summary of this inspection

## Are services responsive?

We found the following areas of good practice:

- Clients had access to therapeutic groups and other activities such as swimming sessions at the local leisure centre and regular yoga and mindfulness groups.
- Information about confidentiality was available to clients.
- Clients planned and prepared the meals and took into account other clients' preferences, cultural and religious needs.
- Staff supported clients with communication and literacy needs and attending places of worship.
- There was a clear system for recording and managing complaints about the service.

## Are services well-led?

We found the following issues that need to improve:

- The provider had not recognised the medicine training needs of staff or carried out criminal record checks in an appropriate time scale.
- Staff were unaware of their responsibilities under the duty of candour and also of the new system to manage safeguarding concerns.
- Supervision was not taking place regularly and staff had poor record keeping.
- The service had failed to notify the CQC of one incident in 2015.
- Records for training were not detailed and did not contain information about mandatory training. Training records for staff did not include mandatory training.
- Although there was a clear system of governance in place, there were ongoing inconsistencies that had not been attended to, for example the consistent recording and entering of progress and discharge notes.

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

- The provider supported staff members in leadership training and development.
- There were low rates of sickness amongst the staff group.

# Detailed findings from this inspection

## Mental Capacity Act and Deprivation of Liberty Safeguards

Training in the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) was not part of mandatory training for staff. Records contained appropriate documentation and timely assessment of consent to treatment and the sharing of information. There had been no DoLS applications in the 12 months.

# Substance misuse services

| | |
|---|---|
| Safe | |
| Effective | |
| Caring | |
| Responsive | |
| Well-led | |

## Are substance misuse services safe?

**Safe and clean environment**

- Staff carried out fire safety checks on the premises every day. Clients told us staff had shown them the fire exits when they were first admitted and that there was a practice fire drill once a week. Staff completed records for the fire drills which had taken place. Staff also checked smoke detectors each month and had records for these checks in 2015. The last fire risk assessment was completed in October 2013 and was valid for three years. There was a fire maintenance report available for October 2015. Fire extinguishers and fire escape signs were in place throughout the service.
- Staff kept a record of weekly checks for the contents and expiry dates of first aid boxes. There were three first aid boxes at the service. Although records showed that checks had taken place, most of the contents of all first aid boxes were out of date, with an expiry date of 2014. This included the solid solution kits, which are used to clean up spills of body fluids. One first aid box did not contain all the contents listed on its lid. In the first aid box in the client's kitchen, there were open plasters left in the box which meant that they were not sterile.
- On admission, staff provided clients with a health and safety induction for all areas apart from the gym. Staff had recorded this as complete in all client files. This induction included information about the fire drill and fire meeting point, how to use the tumble drier and washing machine, the dish washer and cooker and general kitchen hygiene.Hand gel was available at the entrance to the service and in the bathrooms.
- An internal inspection carried out by the provider in December 2015 had identified there was no blood spillage kit in the service and that clinical waste was being discarded in the normal waste. The provider took action immediately to remedy this following their internal inspection.
- The service did not routinely carry out a ligature risk audit of the environment. There were no ligature cutters present on site, which staff would use to cut through a ligature in an emergency. The service manager purchased ligature cutters immediately after the inspection.
- Staff had not carried out an infection control audit at the service. This meant there was potential that clients were not being protected from the spread of infection within the service and staff were not aware of the risks that clients and staff were exposed to.
- Staff did not carry out a formal environmental risk assessment. This would identify risks in the building and environment that could affect clients and staff. We noted risks in the environment including the door from the lounge to the garden which was a large pane of clear glass that could be mistaken for an open door.
- Male and female bedrooms were in separate areas and members of the opposite sex did not have to walk through areas occupied by the other sex to reach toilets or bathrooms. Separate male and female toilets and bathrooms were provided.
- Clients carried out house maintenance jobs and cleaned the environment once a week. The provider outlined 13 tasks on a maintenance sheet. Clients had colour coded mops for cleaning different areas. The service did not employ someone to clean the service. The bathrooms were not clean and the general appearance of the bathrooms was poor. The floor behind and around the toilet was not clean in one bathroom. Also in one bathroom there was heavy dust

on the top of the window frame and there was a toilet pedestal mat. This mat could present infection control issues. The string for the light switch appeared unclean and could also pose an infection risk.

- A legionella protocol detailed what actions staff should take each week and month to prevent legionella bacteria in unused bathrooms. There were records of these actions taking place in January 2016 and September 2015, but no other records for 2015.
- Staff carried out a weekly, monthly and quarterly building inspection to find areas that needed repairing. Staff kept a spreadsheet of maintenance issues and repairs that they reported to the property owner. They used the spreadsheet to keep track of progress and chase actions when needed. Staff said it was difficult to get repairs done quickly. The general decor of the service was old and paintwork had deteriorated in a number of rooms. Fixtures and fittings across the service showed wear and tear. One bedroom had a broken blind. There were dead insects visible in the kitchen light fitting.
- Records showed that an external company carried out safety testing of electrical appliances in March 2015. External companies inspected and tested emergency lighting in February 2015 and checked gas safety in June 2015.

**Safe staffing**

- Staff turnover was low. The four permanent staff had all worked at the service for several years and were experienced in delivering psychosocial interventions.
- A relief team of staff provided cover for staff sickness and annual leave. They had worked in the service for some time and were familiar with the routines, policies and procedures. This helped support continuity of care and a consistent therapeutic approach.
- At least two staff worked during the day from Monday to Friday. At weekends, one staff member worked alone. Overnight, one staff member was on duty. They 'slept-in' at night. Clients could wake staff if they needed to. All staff we spoke with told us they felt safe in the service, including when they were the only staff on duty. There were no records of risk assessments taking place around lone working.
- There was a manager on call at all times that staff could call on the telephone for support and advice. Clients could access an on-site staff member at all times.
- Two volunteer un-paid staff worked part time at the service during the days from Monday to Friday and carried out administrative roles. The provider regularly encouraged previous service users to work as volunteers within its services. This was a positive way to continue to support people after they were discharged, and also allowed current clients to be supported by those who had successfully completed the programme.
- The provider stated that they were operating at the minimum level of staffing but felt that the current level was safe and enabled them to provide an effective service. The service manager said they would be able to call in extra staff to the service if it was necessary to support the needs of the clients.
- All five clients we spoke with told us they thought there were enough staff to support them and staff had been accessible and available since they had been at the service. Clients said they felt safe at the service. Clients had a one to one meeting with their keyworker each week and told us that they had not experienced activities being cancelled due to a lack of staff.
- The provider outlined five mandatory training sessions for staff to complete every three years. These were safeguarding adults, information governance, health and safety, equality and diversity and data protection. There were an additional eight mandatory training sessions that the provider classified as being needed "as identified", depending on a person's experience and job role. These included drug and alcohol awareness and interventions, care planning and coordination and complex needs/dual diagnosis.
- The service manager held a list of training completed by staff, but this did not include information on mandatory training. There were no records confirming that staff had completed mandatory training. Records showed that one staff member had received training in one of the eight "as identified" training sessions in September 2014. All staff members had been trained in first aid and being a fire warden since 2013, but this was not listed on the provider's mandatory training. Staff we spoke with told us they had completed the required training.

- Managers received mandatory training relating to their role, such as managing staff performance and absence and carrying out effective supervision and appraisal. Records showed that the service manager and team manager had completed this training in 2015.
- Volunteer staff did not receive any training, including basic life support training. This meant in an emergency requiring first aid, volunteer staff might not know how to respond.Although volunteer staff did not work without a paid member of staff on shift, this increased the risk to clients at the service.
- Volunteers could not access the provider's intranet where policies were held. This meant they were potentially unaware of the provider's policies and would be unable to follow the provider's procedures, such as incident reporting and identifying safeguarding incidents.
- We reviewed the employment records of all five paid and five voluntary staff. Records showed that the provider had carried out criminal history and record checks from the disclosure and barring service (DBS) for all paid and voluntary staff.For paid staff, the provider had carried out DBS checks before they had started working at the service. For two paid staff members there were no written references on file. For four out of five volunteer staff, the provider had carried out their DBS check before their start date and there were two references on file for each volunteer. For one staff volunteer, the provider had carried out their DBS check 20 days after they started their volunteer role and there were no records of their references. This meant the provider had not conducted proper checks on all staff and volunteers before allowing them to work or volunteer at the service, which could have potentially put clients at risk.

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

- Written risk assessments were present for six of seven clients. These included a full risk assessment of drug use and included a blood borne virus assessment. For one client, the risk assessment in their notes was very brief. For one client who had been at the service over one month, the risk assessment recorded a history of particular risks but there was no detail about this in their file.Staff assessed risk as medium and did not record that they had reviewed the risks in two key work sessions in December 2015 and January 2016. There was no other documentation about the risks outlined for this client. Risk assessments were up to date for five of seven clients.
- There was a risk management plan in place for five of seven clients. For the two clients without a risk assessment, one client had been admitted to the service the day before the inspection and the other had been at the service for over three months.
- Staff confirmed that assessments, including risk assessments, were not always carried out by staff at Cranstoun Oak Lodge. Staff relied on external information where clients were referred from the detoxification service, Cranstoun City Road. Staff at Cranstoun City Road used an organisation wide initial risk screening tool and staff at Cranstoun Oak Lodge did not repeat the assessments.
- One client was admitted to the service the day before the inspection took place. There were no written notes available for this client, including any initial assessments.
- For one client, their risk assessment was present, but staff had entered it on the electronic record two weeks after the client's admission date, due to problems with the computer system. This meant that for those two weeks there was a risk that staff could not quickly access information on risk for this client, which could have put them at risk.
- The service manager said they ran refresher training in lone working and risk control in November 2015. This training was not present on the training record for staff.
- Staff told us that when a client wanted to plan a visit from or to a family member or friend, they had to complete a visit risk assessment form and the client group would discuss this at the weekly community team meeting. One client had these visitor risk assessment forms in their file. Where present, the client filled out the risk assessment forms and provided a lot of information.
- The provider allowed children to visit the service. However, there was no organisational policy or risk assessment for children coming onto the premises for

visits. The team leader advised there were "no go areas" in the unit such as the kitchen and bedrooms.There was no written policy on this, which meant there were no clear guidelines for staff and clients to follow.

- Staff were trained in de-escalation techniques for aggressive behaviour. Staff and clients told us they have never known physical violence to occur or experienced this at the service.Staff gave clients an information pack on arrival at the service, which included information on rules and policies around aggressive behaviour.All the clients we spoke with were aware of the policy and had seen in it their information pack.
- The service was in the process of changing the way staff managed safeguarding concerns. It was not clear how and whether managers had explained this to staff in the service. The deputy director explained that under the current process if staff identified safeguarding concerns they contacted the referrer or care manager. The new process meant that staff should contact local safeguarding teams directly with their concerns. A project worker we spoke with was not aware of the change in process. This meant staff may not have been highlighting safeguarding concerns to the local safeguarding teams in a timely way, potentially putting clients at risk.
- Staff said they received training in safeguarding vulnerable adults every two years. This training was not documented on the staff training records. Staff had not received training in safeguarding children. Managers had identified this gap in staff knowledge and skills and scheduled training for all paid staff in February 2016.
- Safeguarding concerns was a standing item on team meeting agendas. Where clients had care responsibilities, staff noted these in their case notes. A staff member told us they contacted the provider's lead for safeguarding for advice if they had any safeguarding concerns.
- Training in medicines management was not mandatory and no staff had completed this training. Staff responsible for the management and administration of medicines were not suitably trained to recognise the side-effects, cautions and risks of treatment and told us they would not be able to do this comprehensively.
- Overall, we found that staff administered medicines to clients in line with the provider's own medicines policy, although we found the medicines policy, updated in January 2016 to lack certain details. For example, there was no section explaining the arrangements or risk assessments for self-administration of medicines, even though at the time of inspection one client was self-administering medication.
- Staff recorded health and safety concerns in relation to medication in clients' notes. For example, we saw evidence of allergies and contra-indications documented for five clients. Contra-indications are situations where a client cannot have a specific medication as it could cause them harm. Staff documented relevant limitations such as a lack of literacy relating to a client's needs and abilities. This meant that staff explained written medicines instructions to service users verbally where necessary.
- Medicines were stored in a locked medicines cabinet in the staff room. Staff did not keep a daily audit record of the room temperature and confirmed that these did not take place. The provider's medicine policy did not outline this as necessary.This meant there was a risk that the service was not appropriately storing medicines in accordance with manufacturers' product licence conditions.
- The service did not have a separate fridge for storage of medicines.
- We checked the medicines administration records for all clients. Staff had administered medicines in accordance with the prescriber's instructions to ensure clients were not placed at risk.Where staff had not administered a medicine, (we saw four instances of these), staff had written a reasonable explanation in clients' notes.Medicines were available in sufficient quantities that minimised the risk of missing medicines treatment.
- Staff kept appropriate records on the disposal of unused medicines.
- The provider had actively worked with the GP to make sure that medicines treatment was safe. For example, a client's notes showed staff had quickly liaised with the client's GP to clarify the correct dosage of a medicine.
- The service did not operate a locked door policy. Staff outlined limits about when clients could leave the service, for example for the first week clients were encouraged to stay at the service.

- There was a building in the garden with exercise equipment that clients used as a gym. Staff had developed an induction checklist template for clients to sign before they used the equipment, but these were not present in any clients' files. No staff members were trained to induct clients in the safe use of the equipment. This meant that clients had not been trained to use the equipment and could potentially come to harm while using the equipment.

**Track record on safety**

- There was one serious incident at the service in April 2015 when a client using the service died very soon after leaving the programme early and suddenly without going through a planned discharge.
- Staff received feedback on the investigation of this incident and the service manager put an action plan in place. The action plan outlined eight points, four of which the service had completed, such as having thorough daily handovers between staff and identifying a named contact in the community mental health team. Four actions were still outstanding, including the development of a harm minimisation handbook and providing mental health training for the staff team. The action plan gave a deadline of March 2016 for the delivery of mental health training, but the three remaining outstanding actions did not have a completion date outlined.Staff met to discuss the incident after it took place and the organisation provided support to staff following this incident.

**Reporting incidents and learning from when things go wrong**

- There was a clear system in place for reporting incidents, which staff understood. Staff confirmed they knew how to report incidents. Incidents and accidents were a standing item on the agenda for team meetings. The service manager and team manager attended an incident reporting workshop in July 2015.
- We reviewed ten accident and incident forms that staff had completed between February and July 2015. Three of these incidents related to a client having a seizure. Two of these noted that staff had administered medication and called an ambulance. Staff did not record which medication they had given. This was not identified as incomplete recording on an incident form.
- Staff provided examples of learning from incidents that had occurred in other services provided by Cranstoun. A central incident group considered all incidents that occurred across services. A summary of incidents reviewed by the group was sent to service managers every month. They in turn shared the summaries and learning from the incidents with the staff team in staff meetings.
- Staff carried out a weekly audit of medicines administration. Staff said that the audit had been recently introduced as a result of shared learning from a medicines incident.

**Duty of candour**

- The manager and deputy director were unaware of their responsibilities under the duty of candour, which had come into force in April 2015.
- Paid and voluntary staff were not aware of the duty of candour and had not received training in this. There was no organisational policy in relation to the duty of candour.

## 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)

- Staff confirmed that for clients referred from the detoxification service, Cranstoun City Road, an assessment of need for each client was carried out by Cranstoun City Road staff. If the client was admitted from somewhere else, a trained member of Cranstoun Oak Lodge staff visited and assessed the client where they were, but there was no written record of this taking place. For example, for one client referred from the local authority, there was no assessment of needs present. Records indicated that for other clients, staff used the initial referral document as a source of information for the assessment of need.
- For six of seven clients there was a mental health assessment in their notes, although two of these assessments were brief. For the final client, admitted the day before our inspection visit, there was no mental health assessment.

- Three clients had evidence of very brief physical health assessments in their notes. The remaining four clients had no evidence of a physical health assessment taking place during their admission to the service. This meant staff had no record of the physical health needs of these four clients and would not be able to support them with any physical health needs.
- Staff told us they supported clients to register with the local GP after admission. The clients we spoke with told us they always had access to physical health care professionals when necessary. There was evidence in one client's notes that staff supported them in ongoing physical health treatment.We saw staff helping two new clients complete GP and dentist registration forms.
- Clients told us that staff did not provide information on sexual health. Staff had not identified this as an area of need and were not supporting clients in this.
- For all clients, there was a dual note system. Staff kept some client notes on paper and some on the electronic system. This could lead to increased risk for the client as staff may not have access to the information they need in a timely way and information recorded in one document may not be consistent withthe other.
- Five out of seven clients had a recovery plan present in their notes. For the two clients without a recovery plan, one was admitted the day before the inspection and one was admitted over a week before.
- The five recovery plans that were present were personalised, holistic and recovery orientated. They included clients' views, covered a range of problems and needs and included information on a client's strengths and goals. However, it was not clear from the records whether clients had received a copy of their recovery plan. Two clients told us they had access to their recovery plans through staff but had not received a written copy of it. Two other clients said they did not have access to their recovery plans.
- For two of the five recovery plans, there was no evidence that the staff and client had reviewed and updated the plan since the client had started using the service, which varied from between two and three months. Two staff told us that initial recovery plans should be updated within a client's first 30 days of admission, others were unsure of this time frame. Records showed that staff had only reviewed and updated one recovery plan in this time frame.
- None of the care records we reviewed contained care plans for unexpected treatment exit. As a result clients were potentially at risk in the event of sudden or unexpected discharge as they may not have been aware of the increased risks if they re-started drug use.
- Staff were not consistently recording daily progress notes. For one client, staff had entered multiple entries retrospectively. Staff entered notes from 12 days in September and October on one date in October. This meant the notes were all dated for the one day in October, which could cause confusion to staff trying to access information and may mean that notes added retrospectively were not as accurate as they could have been. In addition, three clients had three or more days where there were no entries in their notes at all, with no explanation for why staff had not completed these.
- In one person's records, staff had attached another client's discharge summary in error.
- The team told us they sent updates about the progress of clients to local authority care managers every four weeks. These updates were sent from staff email addresses and staff did not print a paper copy of the email for records. There was no method for the team manager to see this was taking place.
- For six of seven clients, there was a record of a confidentiality agreement in their notes. Information about confidentiality was also present in the information pack staff provided to clients on admission, which all five clients we spoke with told us they were aware of.

**Best practice in treatment and care**

- The service measured outcomes for clients by counting those who had successfully completed the 12-week programme. The deputy director estimated that 50% of clients using the service successfully completed the programme.Performance figures for 2015 showed that of clients who had a planned discharge, an average of 54% (19 of 35) of clients completed the programme between January and December 2015. The most successful completion rates were for clients following

the programme for alcohol addiction, at 64%. These figures were in line with national rates, the adult substance misuse statistics from the National Drug Treatment Monitoring System, based within Public Heath England, showed that the national completion rate or programmes was 52% in 2014-2015. The completion rate for alcohol only treatment was 61%.

- The provider's quality objectives for successful completion of the 12 week programme by the end of 2017 were for over 65%. Targets for 2015 and 2016 were for over 60%.

**Skilled staff to deliver care**

- Four members of staff provided support and an individual therapeutic timetable to clients. One member of staff was a British Association for Counselling and Psychotherapy registered psychotherapist, one was a gestalt psychotherapist and another was undertaking gestalt training. One member of staff had previously been a volunteer.
- We saw staff using very good facilitation skills during a relapse prevention group, with a clear depth of knowledge of the topic.
- An art psychotherapy student worked two days a week at the service and provided a weekly art therapy session. In the service user feedback survey in 2015, clients made positive comments about art therapy
- Staff could access relevant training as required, including motivational interviewing, "choosing to change", relapse prevention and management and brief solution based therapy. The four staff accessed an average of three additional trainings during their employment.
- One staff member told us they wanted more training in mental health issues. They noted that the clients admitted to the service increasingly had more complex needs, which included mental health problems as well as substance misuse concerns. A date for this training was not yet in place.
- All staff received an annual appraisal of their performance at work. Records of four staff confirmed that appraisals had taken place in 2015. Three of the four appraisals identified individual objectives for the staff member for the year and specific training and development needs.
- A staff member told us they received regular supervision from their line manager. This usually took place as planned. The supervision records of the four permanent staff showed that they had received one to one supervision between four and seven times in 2015. The manager explained that supervision was expected to take place every four to six weeks or about eight to 12 times a year. The number of supervisions provided to staff had fallen short of this number in the last year. We noted that supervision records for one member of staff were identical for two different supervision meetings several months apart. We pointed this out to the manager who said they would investigate this.
- The service held a staff consultancy group once a month with an external facilitator. The group provided support to staff in relation to their work with each other and with clients.
- Volunteer staff did not receive any form of supervision or support with their role. They did not meet formally with a manager in relation to their volunteering. Volunteer staff were able to meet informally with a manager, but these meetings were not recorded.
- Staff told us they had a weekly team meeting and kept minutes of these meetings. Minutes were available for 2015 and showed there were between one and four team meetings a month from April to December 2015, with an average of two a month. The service manager had developed a clear team meeting agenda that staff used from January 2016 onwards.

**Multidisciplinary and inter-agency team work**

- We observed a handover meeting and saw that all staff on duty attended. One staff member led the meeting and the group discussed all clients. Staff reviewed each client's progress and there was a focus on the clients where risks had increased. All staff were able to contribute to the discussion. Staff discussed the cultural needs of one client and looked at strategies to manage the possibility of a relapse.
- Staff had a handover meeting each day between the night and day shift. The manager had developed a handover meeting template that had been in use since December 2015. The new template covered the name of staff member who completed the form, the date, information about what medication was dispensed, any drugs tests clients had completed, other staff duties,

incidents or accidents, and an update on all clients. Staff typed the minutes and kept them in an accessible folder.Staff had made a thorough record of the handover meetings for the past month. This meant all staff had up to date information about clients when they started their shift and could provide relevant support to them.

- Two clients told us staff talked to them about getting support for housing issues. Staff said they were in the process of encouraging good links with supported housing and gave examples where they had supported clients to get interviews for supported housing.

**Good practice in applying the MCA** (if people currently using the service have capacity, do staff know what to do if the situation changes?)

- For six of seven clients, there was a record of consent to treatment and the sharing of information.
- There had been no deprivation of liberty safeguards applications in the 12 months before the inspection.

## Are substance misuse services caring?

**Kindness, dignity, respect and support**

- We saw staff speaking respectfully and politely with clients.
- Clients we spoke with said they had received good care from staff who had made them feel welcome, been polite and caring and were interested in clients' wellbeing.
- All clients we spoke with felt supported in their transition from a detoxification service to this service. Staff accompanied clients from door to door during their transfer.
- Results from a provider service user feedback survey from 2015 were positive. Eight clients completed 20 questions in the questionnaire. The service met all targets for a score of 3.5 out of five for all 20 areas apart from "being given information on mutual aid agencies", which had an average score of two. Questions about the service being open, confidential and safe and staff being approachable scored an average of four out of five. This was the same for questions about feeling supported and empowered. The highest score was for 'workers believing in your recovery'.

**The involvement of people in the care they receive**

- Clients told us they felt fully involved in planning their care and treatment. Two clients told us they had access to their recovery plans through staff but had not received a written copy of it. Two other clients said they did not have access to their recovery plans.
- One client was aware of a date for the review of their plan and felt they were encouraged to make changes to it when they wanted to.
- There was a daily clients meeting with allocated time for clients to give feedback about the service they received.
- Clients did not have access to an independent advocate. An advocate is someone who works independently of the provider and whose role it is to support service users to voice concerns or feedback about the service they have received.
- Clients we spoke with told us they felt empowered to speak up if they felt there was an issue with their care and they could do this without fear.
- Two clients told us that staff had asked if they would like to have their families involved in their care. Clients were able to outline who they consented to having information shared with and there were records of this in their notes. One client's records showed their family had visited them.
- All clients received an information pack on arrival at the service. This outlined the service house rules and other information about the service, including the complaints procedure. All the clients we spoke with had received this information pack.

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

**Access and discharge**

- Referrals to the service were usually received by the provider's central admissions and referrals team who

allocated them to the service. The service manager decided whether a client was suitable to admit to the service. There were no clear written admission or exclusion criteria that staff referred to when deciding whether to accept a referral.

- Staff told us that admissions to the service were often delayed while funding for the placement was sought and agreed. Staff said delays in discharge were uncommon.If a delay occurred, the client would stay at Cranstoun Oak Lodge, funded by the care manager, until the situation was resolved.
- After completing the 12-week rehabilitation programme clients were discharged back to the community team who were contracted to deliver after-care. The provider had policies and procedures written in 2013 that covered planned and unplanned discharges.
- Staff told us they did not start the discharge planning until clients had been at the service for at least seven weeks.Staff explained that if discharge planning started sooner it could distract clients from their treatment programme. One client had a discharge plan in place. For another who had been at the service for nine weeks, there was no evidence that staff had started discussing discharge planning with the client.
- Staff aimed to send discharge summaries to referrers within eight to ten days of discharge for clients who had completed the treatment programme. For clients who left the programme early, staff aimed to send discharge summaries within seven days.
- One client told us they had talked about aftercare with their keyworker.
- The service reported that 50 service users were discharged in the last 12 months.
- The average bed occupancy rate from July to December 2015 was 57%.From November to December 2015 the average occupancy rate was 36%.

**The facilities promote recovery, comfort, dignity and confidentiality**

- Two clients we spoke with felt the environment was comfortable. The communal areas such as the lounge and dining room were large enough to accommodate all clients at one time.
- There were therapy rooms available where clients could speak to a member of staff in private. Clients were able to make phone calls in private.
- Bedrooms were spacious and shared between two clients. Staff would make an assessment based on risk about which clients shared bedrooms if there were more than seven patients at one time.
- There was a large, well maintained garden to the rear of the service that clients could access through the lounge. Clients told us they had access to this garden and we saw this throughout the inspection.
- There was no designated area for clients to see visitors. Visits would take place in the dining room, lounge and garden, including visits with children.
- Clients were encouraged to take part in activities alongside the therapeutic groups. These included swimming sessions at the local leisure centre and regular yoga and mindfulness groups.
- Clients told us they were happy with the food and that they could get snacks and hot drinks when they wanted. Each week clients attended a meal-planning meeting that staff supervised. Clients went to the shops to buy food and prepared it daily.

**Meeting the needs of all people who use the service**

- There was no designated bedroom and bathroom for a client with physical disabilities or a lift at the service. The service manager said they would admit a client to another Cranstoun service which provided these facilities if necessary.
- One client spoke English as a second language. They told staff their concerns about writing in English, and staff provided support. Two clients told us they felt supported using their preferred method of communication.
- At the staff handover meeting staff discussed how to make learning material accessible for one client who had literacy issues.
- On admission, staff gave clients a written information pack and also explained information in the pack verbally.
- Clients using the service were supported to attend places of worship when they wished.

# Substance misuse services

**Listening to and learning from concerns and complaints**

- There was a clear system for recording and managing complaints about the service. Copies of the complaints procedure were available to clients. Staff discussed this with clients on admission to the service. The complaints procedure was written clearly and explained the different stages a complaint would pass through if someone was not satisfied with the initial response and wanted to take it higher within the organisation. Staff provided an example of a client raising a concern that was discussed by the service and resulted in a good outcome.
- There was one complaint in the service in the last 12 months. This concerned the flooring in the kitchen. The service responded quickly and changed the flooring within 24 hours.
- The provider reviewed complaints within its services at a monthly governance group.

## Are substance misuse services well-led?

**Vision and values**

- From talking to staff it was clear they had an understanding of the service delivered at Cranstoun Oak Lodge, but they had less knowledge and connection to the overall provider. Staff told us they did not have much contact with staff and managers from the head office in the organisation, but this had increased in recent months. The vision and values for the organisation was to save, change and rebuild lives through ambition, compassion, innovation and integrity.
- Staff were aware of changes that Cranstoun were making in relation to their provision of residential services.

**Good governance**

- The provider's senior management team met monthly. The central governance group and central incident review group also met every month and provided information to the senior management team on overall service performance and incidents across the organisation.
- A local incident review and monthly residential management meeting provided a mechanism for the oversight of the service. These meetings supported the flow of information from the service to the senior management team and vice versa. The registered manager attended the residential management meeting along with the deputy director and business manager from the central admissions and referrals team. The meeting reviewed occupancy levels in the service, performance in relation to targets, incidents, safeguarding concerns and complaints. The registered manager fed information back to the staff team at regular team meetings. Standardised agendas had been introduced to meetings to help them be more consistent, to ensure key information and concerns were discussed and previously identified actions carried out.
- The provider carried out regular care plan audits but these did not always lead to improvements. The findings of care plan audits from March and May 2015 showed poor outcomes over time with no significant improvements made to practice. There were ongoing inconsistencies in the recording and entering of progress and discharge notes. There had been no further audits since May 2015.
- Supervision was not taking place as regularly as the provider had outlined as necessary.
- Not all incidents that should have been reported to the CQC were reported in 2015, for example in May 2015 the service notified the police that one client was missing.The CQC were not notified of this contact with the police, which they should have.
- The provider told us that the deputy director and health and safety manager from the provider visited the service monthly and quarterly for a review. There were no reports or evidence that these visits had taken place in the past six months.
- Management had not identified the medicine training needs for staff and the need to keep a record of the room temperature where medicines were kept in order to ensure temperatures were in line with manufacturers' product licence conditions. Staff were not receiving the required amount of supervision and there was no plan to ensure record keeping improved.

**Leadership, morale and staff engagement**

# Substance misuse services

- There were low rates of sickness reported by the provider, which was 4% as of November 2015.
- Staff members were positive about working at the service and described an open and transparent culture. They noted many developmental changes were taking place in the service including the introduction of an electronic recording system.
- The service manager recognised that staff morale was low at the start of 2015 but felt this had improved more recently. Staff said morale was good and they enjoyed their roles.
- The whole staff team had been involved in a development day with staff from the provider's other rehabilitation service in December 2015. One staff member described this as very helpful and a chance to think about how they delivered the service.
- The provider was supporting the service manager to do Institute of Leadership and Management training, level 5, and supporting the team manager to do Institute of Leadership and Management training, level 3.
- One staff member told us the provider supported them to complete a counselling course outside work. The service had been flexible in allowing work patterns that supported this. They had also completed an NVQ level 3 in substance misuse, which was tailored to the needs of the service.

**Commitment to quality improvement and innovation**

- The service manager developed a service improvement plan in November 2015. This plan had nine actions and identified the staff responsible for actioning these. The actions were realistic and based on evidence.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the provider MUST take to improve

- The provider must ensure that first aid boxes have the correct contents and that the contents are within date.
- The provider must ensure that all clients have a written management plan for an unexpected treatment exit and that staff have discussed this plan with them.
- The provider must ensure that clients are not using the equipment in the gym unless shown how to use it safely and supervised by a trained member of staff.
- The provider must ensure that staff complete training in safeguarding children.
- The provider must ensure that staff responsible for the management and administration of medicines are suitably trained to recognise the appropriate side-effects, cautions and risks of treatment and that medicines management processes include protocols on self-administration of medicines.
- The provider must ensure that the storage of medicines is monitored appropriately.
- The provider must carry out an annual infection control audit with regard to compliance with practice in infection prevention and cleanliness. The provider must monitor any risks identified in the audit in order to protect clients against the risks of infection.
- The provider must ensure that they notify CQC of any incidents investigated by the police, without delay
- The provider must carry out appropriate checks on volunteers and staff employed at the service before they commence paid or voluntary positions.
- The provider must ensure that all staff are aware of their responsibilities under the duty of candour.
- The provider must carry out a formal environmental risk assessment to identify risks in the building and environment that could affect clients and staff.

### Action the provider SHOULD take to improve

- The provider should develop a policy outlining the procedures for assessing and managing the visiting of children.
- The provider should ensure that appropriate standards of cleanliness are maintained.
- The provider should provide basic life support training to volunteer staff.
- The provider should ensure that the mandatory training records of staff are kept up to date and are an accurate reflection of the training they have completed
- The provider should ensure that all staff understand how and where to record and store information so that the risks of keeping both paper and electronic records are minimised.
- The provider should ensure all staff are aware of how to manage a safeguarding concern.
- The provider should provide clients with information on sexual health.

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 (RA) Regulations 2014 Safe care and treatment<br><br>Care and treatment was not always provided in a safe way:<br><br>The provider did not monitor the storage of medicines appropriately<br><br>The provider's medicines management policy was not robust and did not contain a process for risk assessment for the self-administration of medicines for clients receiving care and treatment.<br><br>The provider had not ensured first aid boxes had the correct contents that were in date.<br><br>The provider had not ensured that clients were able to use the gym equipment safely.<br><br>The provider had not assessed the risk of infection or considered ways to mitigate any such risk.<br><br>The provider had not carried out a risk assessment of the environment to identify risks in the building and environment that could affect clients and staff.<br><br>The provider had not ensured all clients had written care plans for unexpected treatment exit.<br><br>This was a breach of regulation 12(1)(2)(b)(c)(e)(g)(h) |

This section is primarily information for the provider

# Requirement notices

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require treatment for substance misuse | Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed<br><br>The provider had not carried out relevant employment checks on the suitability of staff and volunteers in a timely way.<br><br>This was a breach of regulation 19(2) |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require treatment for substance misuse | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br><br>Staff had not received appropriate training as necessary to enable them to carry out their duties.<br><br>The service had not provided staff with training on safeguarding children.<br><br>The provider had not provided training to staff to administer medicines and identify and monitor side effects.<br><br>This was a breach of regulation 18(2)(a) |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require treatment for substance misuse | Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents<br><br>The provider had failed to notify the CQC of all incidents that affect the health, safety and welfare of people using the service. |

This section is primarily information for the provider

# Requirement notices

The registered person had failed to notify the Care Quality Commission, without delay, of an incident that was reported to the police.

This was a breach of Regulation 18

(1)(2)(f) of the Care Quality Commission (Registration) Regulations 2009.

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require treatment for substance misuse | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>Systems and processes must be established and operated effectively to ensure compliance with requirements.<br><br>Managers and staff were unaware of their responsibilities under the duty of candour and managers had not identified the need to comply with this.<br><br>This was a breach of Regulation 17 (1)(2)(a) |