Sanctuary Lodge

Quality Report

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Date of inspection visit: 13 October 2016
Date of publication: 12/12/2016

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

Ratings

Overall rating for this location

Are services safe?	
Are services caring?	
Are services well-led?	

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 provider had not completed a ligature risk assessment, and had not identified and replaced all ligature risks with non-ligature fittings.

Summary of findings

- Risk assessments were not accurate and up to date. Risk assessments did not always identify all risks posed by clients. Staff did not update risk assessments in line with the provider's policy.
- Medicines management processes were complicated and unsafe. We found 24 medication errors within the month's period prior to inspection. Twenty of these were documentation errors.
- Staff did not report all incidents. We found two incidents of missing medication that staff had not reported through the incident reporting process. Managers did not always investigate incidents thoroughly and they did not identify lessons learned from incidents.
- Staff were not supervised in line with the provider's policy. Senior managers were aware that this was an issue highlighted in the previous inspection but had not taken sufficient action to rectify this.
- The provider had not taken action to resolve issues identified in clinical audits. Staff identified risk assessments were not being updated. Managers had not taken action to improve this.
- The provider had not ensured they had completed all action plans relating to warning notices issued by the Care Quality Commission (CQC) in November 2015.

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

- The provider had ensured that staff were up to date with their mandatory training. Staff compliance with mandatory training was 93%.
- Staff treated clients with dignity, kindness, and respect. Clients told us that staff were compassionate, understood their needs and the barriers they may in their recovery.
- The provider had recruited a registered nurse. This was to help staff develop their clinical skills and to improve the quality of care within the service.

Summary of findings

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Services we looked at
Substance misuse/detoxification;

Summary of this inspection

Background to Sanctuary Lodge

Sanctuary Lodge is a detoxification and rehabilitation facility that can support up to 24 clients requiring a medical detox and rehabilitation programme. The provider admits both male and female clients. At the time of inspection the provider had 22 clients.

Regulated activities

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

At the time of inspection there was an acting manager for this service. They were waiting for a fit and proper person's interview with the Care Quality Commission (CQC) in order to become the registered manager. This was taking place the week after inspection.

We carried out a comprehensive inspection of the service on the 3 November 2015, and found them to be in breach of Regulation 13; Safeguarding service users from abuse and improper treatment, Regulation 17; Good governance, of the Health and Social Care Act (Regulated Activities) Regulations 2014 and Regulation 19; Fit and proper persons employed, of the Care Quality Commission (Registration) Regulations 2009. Because of these findings we issued a warning notice and the provider supplied us with an action plan for improvements. The action plan was due to be completed by the end of September 2016.

Our inspection team

The team that inspected the service comprised of CQC inspector Lee Sears (inspection lead), one CQC inspection manager, and one other CQC inspector.

Why we carried out this inspection

We inspected this service as a focused unannounced inspection following a comprehensive inspection of the service last year. This was to check to see whether they were now meeting the standards required by the Health and Social Care Act 2008 (regulated activities) regulations 2014. We looked at the safe, caring, and well led domains due to the breaches of regulation following the previous inspection.

How we carried out this inspection

To understand the experience of people who use the service, we asked the following questions about the service:

- Is it safe?
- Is it caring?
- Is it well led?

Before the inspection visit, we reviewed information that we held about the location.

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 16 clients within a focus group.
- spoke with the acting manager
- we spoke with the operations manager
- spoke with two support workers employed by the service.
- attended and observed the admission process for one client.

Summary of this inspection

- looked at seven care and treatment records, and 10 medicines records, for clients
- looked at policies, procedures and other documents relating to the running of the service.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We do not currently rate standalone substance misuse services.

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

- The provider had not removed all ligature points (A ligature point is anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation) in the bedroom areas. The provider had not mitigated this risk by completing a ligature risk assessment of the environment.
- Risk assessments were not always accurate and up-to-date. Staff did not regularly review risk assessments and they did not always contain necessary information such as previous risk history.
- Staff did not manage medicines in a safe way. We found a high number of medication errors reported. We found 24 errors within a one month period. Most of these were documentation errors.
- Staff did not report all incidents. We found two incidents where medication had gone missing and staff had not reported this on an incident form. Managers did not always investigate incidents thoroughly, and we found information missing from investigations.

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

- The environment was clean, tidy, and well maintained. Maintenance staff did weekly environment checks to identify any issues. Maintenance staff identified issues and took actions to rectify them.
- The provider had ensured that staff received mandatory training. This included training in safeguarding and medicines management.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Staff treated clients with respect, kindness, and dignity. Interactions between clients and the staff at the service were non-judgemental and meaningful.
- Clients told us they felt able to raise concerns with the keyworker and they would explore these sensitively.

Summary of this inspection

- Staff understood client's needs and barriers to recovery and shared their own experiences to benefit those in their care.
- The service had implemented a visiting policy for children, and a child friendly room, although encouraged these visits to take place off the unit whenever possible.

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

- Clients told us they did not always have enough 1:1 time with their named worker. When 1:1 time was planned clients told us it would often be cancelled and rescheduled.

Are services well-led?

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

- The provider had systems in place to share information with staff but did not use these to document discussions about lessons learnt from incidents.
- Governance systems and audits did not identify missing information into incident investigations. They did not identify when processes were failing, such as medication management systems.
- Audits identified areas for improvement such as the need for staff to update risk assessments in line with policy. However, there were no action plans to ensure that this would be done.
- The provider had not ensured that staff were supervised regularly, although this had been identified as a concern during the previous inspection. The provider was aware that the issue remained but had not taken action to supervise staff in line with their own policy.
- The provider had not ensured that all action plans relating to warnings issued by the Care Quality Commission in (CQC) in November 2015, had been completed.

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

- The provider had recruited a qualified mental health nurse to support staff to carry out clinical skills.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental capacity was not assessed appropriately on admission despite previous concerns during an inspection in November, 2015. Staff carried out mental state assessments that did not include a person's capacity to consent to treatment.

The Mental Capacity Act training compliance rate was 94%. Neither the staff nor manager knew how often this required updating.

Staff could not identify the five key principles of assessing capacity, despite recent training.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Substance misuse/ detoxification	N/A	N/A	N/A	N/A	N/A	N/A
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Notes

Substance misuse/detoxification

Safe	
Caring	
Well-led	

Are substance misuse/detoxification services safe?

Safe and clean environment

- There were blind spots throughout the unit. However, the provider carried out risk assessments and developed actions plans to reduce the risks these posed. For example if a client was at risk of self-harm or suicide, the provider would increase observation levels so that staff checked the client on regular intervals to keep them safe.
- There were some ligature points within client's bedrooms. These were located on the shower fixings in the bathroom. The provider had removed some of the ligature points identified within the last inspection, such as the light fittings on the wall and door retainers. Staff told us that if someone is at risk of ligature they would increase observation to reduce the risk. We asked to see the ligature audit but the provider could not produce this. Staff told us that this was part of the environmental risk assessment. We reviewed the environmental risk assessment, however this did not contain a ligature risk assessment. The provider had not taken sufficient action to ensure the safety of the environment.
- The clinic room was well stocked and staff had access to resuscitation equipment. The provider had recently purchased an automatic external defibrillator following a complaint from a client who had previous cardiac problems. The defibrillator was kept in the reception area so it was easily accessible. However, the provider had not trained staff in the use of the defibrillator. This meant that if there was an emergency, staff were not able to use the equipment provided. Senior staff told us that the provider had planned training for staff, within the next two weeks following on our inspection.
- All areas of the unit were clean, tidy, and well maintained. The provider had decorated the unit since the last inspection and the furnishings were all in good condition. Maintenance staff carried out weekly inspections of the environment and equipment to identify any issues. If staff identified issues, they took action to make the necessary repairs. We checked the maintenance audits and saw that this was happening regularly.

Safe staffing

- The provider had seven whole time equivalent (WTE), support workers. Two of these were senior support workers. There was one support worker vacancy that managers were actively recruiting to. The provider had recruited a qualified nurse following the action plan submitted to Care Quality Commission (CQC) after the inspection in November 2015. The nurse was waiting for all pre-employment checks to be completed before they could start at the service.
- The provider used one agency to manage staff shortages. Agency staff were regular and knew clients and the service well. This helped to maintain continuity of care provided to clients.
- The acting manager was able to adjust staffing levels to manage activity levels in the unit. The acting manager told us that he would increase staff if there were high observation levels, activities, or to support clients attending appointments. However, the service did not always have enough staff for clients to have regular one-to-one time. Clients told us that staff cancelled one-to-one due to staffing issues. Clients told us they were allocated one individual session per week but they did not feel that this was adequate. Staff told us that clients were able to request more time with staff and they would facilitate this where possible. Staff told us that if they could not see clients for one-to-one at the scheduled time, they would rearrange at a more appropriate time.
- The acting manager told us they did not cancel activities due to staffing issues. Senior staff told us that they divided clients into two groups. Both groups have different activities each day. If there were staff shortages, the therapist combined both groups so that they would not need to cancel activities.
- The provider had not experienced any incidents that would require restraint in the past year. However, 94% of

staff were trained in managing challenging behaviour. Following the previous inspection the provider increased the number of staff on nights from one staff member to two, with the second staff member being a sleep-in. This was in response to an incident at night when a client presented with behaviours that challenged.

- Medical cover during the day and night was not adequate. The consultant psychiatrist who worked with Sanctuary Lodge only attended the unit in the evenings. This meant that if a client was admitted in the morning they would have to wait over six hours before seeing a doctor. In records, staff admitted a client 11 o'clock in the morning, who saw the doctor at nine o'clock that evening. Staff admitted a client during the inspection. They arrived at 11:00 am. Staff told us the doctor would not be available to see them until after six o'clock that evening. The provider had access to a GP surgery who provided medical cover for routine medical check-ups. If there was a medical emergency, staff would have to call an ambulance.
- Staff were up to date with mandatory training. Mandatory training compliance was 93% and covered a range of topics including infection control, safeguarding, risk assessment, mental capacity act, care planning, and fire training. However, staff did not know how often they had to update their mandatory training. Systems were not in place to alert the acting manager when training needed to be updated. The manager told us they did not know how often staff needed to be updated. Following the previous inspection the provider had ensured that staff were given the appropriate training. However the lack of understanding of when staff would require updating meant that we could not be confident that staff's knowledge and competency would be regularly revisited.

Assessing and managing risk to clients and staff

- Staff undertook risk assessments of clients prior to admission. However, staff did not always update these in line with the provider's policy that indicated that staff should update client's risk assessments within the first week. We checked the client file audits for the previous three months which demonstrated that staff were not updating risk assessments regularly. Risk assessments were not always thorough. We found in one client's care records the risk assessments stated they were not a risk of suicide when there was a clear documented history of suicide attempts prior to admission. We found evidence in care records that where staff had identified risks, they had not documented any control measures to state how staff would manage the risk. We also found evidence in care records where sections of the risk assessment were not completed meaning information was missing. This meant that important information was not always available to enable staff to keep clients safe. Without this information staff would not know whether they needed to increase the level of observation for people potentially at risk.
- Blanket restrictions were in place around the use of mobile phones and computer equipment, as part of the treatment plan agreed with clients prior to admission. This was to encourage clients to take part in the daily therapeutic activities. If a client needed to make phone calls during the day, they could fill out a request form and request use of their mobile phone. We saw one client who had use of their mobile phone during the day.
- Following the previous inspection all staff received safeguarding training as part of their mandatory training. Staff told us that managers circulated quizzes and questionnaires to test their knowledge. However, despite this, staff we spoke to still lacked knowledge around their responsibilities in safeguarding vulnerable adults. Staff could explain how they would escalate concerns to managers but were unfamiliar with the processes of referral to the local authority and their own responsibilities. We saw evidence in admission assessments and care records about potential safeguarding risks. However staff had not acted on these or when they had identified risks, information was inconsistent and poorly recorded. This meant we could not be confident that staff had the appropriate understanding to safeguard vulnerable adults and children.
- The provider had a complicated medicines management procedure that had been ineffective in reducing medicine errors. Staff dispensing medicines had to sign in several places for each medication given. For example, if a client's medication came in two different dose tablets, staff signed a form for each tablet, and then signed the tablets out of the stock book. Regular medication audits highlighted a high number of documentation errors on medicines records. Between the 9 September 2016 and the 9 October 2016, 24 errors

were highlighted, 20 of these errors were where staff had miscounted, or incorrectly documented the amount of stock medication. One error was a dispensing error and two errors were regarding missing tablets.
- The provider had implemented a policy for children that visiting the ward following our previous inspection. This included a risk assessment prior to children visiting. However, the manager encouraged clients to spend time with children them away from the unit.

Track record on safety

- The provider had not had any serious incidents that required investigation in the last 12 months.
- The provider had made a number of safety improvements since last inspection. For example, they had changed the wall lights in the bedrooms to anti-ligature fittings. The provider had implemented mandatory training for staff, which included safeguarding training. Maintenance staff had begun to carry out weekly environmental audits to help maintain the safety of the environment.

Reporting incidents and learning from when things go wrong

- Staff did not report incidents in line with the provider's policy. For example, we could not find an incident form for missing medication staff identified during a medication audit. We spoke to the acting manager about this. The acting manager told us he was in the process of investigating it.
- Staff did not always investigate incidents thoroughly. We found one incident where the doctor had prescribed high dose of medication that was over four times above the British National Formulary (BNF) limits for a single dose for this medication. Staff decided to give a lower dose of medication and contact the doctor afterwards. Staff told us that the doctor agreed to review the dose of the medication and change it. The incident form action plan stated an e-mail had been sent to senior manager for investigation. We requested to see the investigation but senior management were not aware of it and they had not received email from the previous manager who was investigating the incident. Had staff given the prescribed medication there may have been significant consequences for the health of the client. In addition, staff made the decision to give part of the dose without additional medical guidance. Consequently, the provider could not demonstrate they had learned lessons from this incident to safeguard clients.
- Staff did not receive feedback from investigations into incidents and learning was not shared. Staff told us that managers shared feedback and learning in team meetings. We reviewed the minutes of the team meetings and could not find evidence that staff discussed incidents.
- Staff were debriefed after incidents. Staff told us that these happened following incidents or at the end of the day during handover, and that staff are given the opportunity to talk through what happened, what went well, and what could have done better. However, we did not see any documentary evidence of this.

Duty of candour

- The manager was able to outline responsibilities under the duty of candour. Staff we spoke with told us the importance of being open and honest with clients. However, the provider did not use complaints and investigations into incidents to highlight errors made and respond to clients with an apology.

Are substance misuse/detoxification services caring?

Kindness, dignity, respect and support

- Staff were kind, caring, compassionate and treated clients with dignity and respect. We observed the admission process for a client and staff explained the process to the client and told them what they could expect from the service. Throughout the process, staff treated the clients with dignity and respect. We also held a focus group which was attended by 16 clients. During this group, clients explained that staff were very approachable, open-minded, kind, and very helpful.
- Staff had a good understanding of client's needs. Staff we spoke to were able to explain the differing needs of their client group and this was reflected in recovery plans. Many staff at the service had previously been through recovery themselves, and were able to use their own experiences to support clients.

The involvement of clients in the care they receive

Substance misuse/detoxification

- Clients were orientated to the unit as part of the admission process. Staff allocated new clients to a buddy. This is someone who has been at the service for some time and helps to familiarise the new client to the unit. They also help them get used to the daily activities and routines. We observed the admission process and saw that clients were familiarised appropriately to the unit.
- Clients were actively involved in their recovery plans and risk assessments. Managers allocated a keyworker whose responsibility was to complete the care plan and risk assessments within the first week, with the client. Clients met with their key workers on a weekly basis to discuss and update their care plans and risk assessments. We reviewed seven care records. These showed that clients had been involved in the writing and reviewing of care plans. The assessments of client's needs also involved information received from family members when this was appropriate to ensure that staff had the information needed to support them.
- The provider held community meetings on a weekly basis. We reviewed the minutes from four community meetings. During these meetings clients were able to tell staff of any issues or concerns that they had. Staff would document within the minutes what actions they would take, and staff reviewed these in the following weeks meeting where it was documented what actions had been taken.

Are substance misuse/detoxification services well-led?

Vision and values

- Staff were aware of the providers visions and values. The provider gave staff a handbook which sets out the visions and values as well as expected behaviour.
- Staff were able to tell us who senior managers within the organisation were, and told us that senior managers visited the unit frequently and were very visible.

Good governance

- Staff received mandatory training and this was up-to-date. The manager kept a spreadsheet of mandatory staff training attended so he could monitor this. However, both the manager and staff were unaware as to how frequently training should be renewed and updated.
- Staff were not supervised in line with the provider's policy of every six weeks. We checked the supervision records of all staff and found that some staff had not received supervision for over three months. We spoke to the manager who told us that they were aware of the need to improve supervision and were working on implementing an action plan to ensure that this was carried out in line with their supervision policy.
- There was an appropriate amount of staff who had the appropriate skills and experiences each shift. The provider was in the process of employing a qualified nurse to improve the quality care and treatment provided to clients. The provider had appointed a candidate and was waiting for the necessary references and disclosure barring service (DBS) checks.
- Managers did not share lessons learnt from incidents and complaints with staff. Staff told us the managers shared lessons learned from investigations within team meetings. We looked at four months of team meeting minutes. We could not find any evidence that managers had discussed lessons learned with staff. The provider had not ensured that staff were able to learn from incidents and make necessary improvements to care practices so that clients benefitted at the service.
- The provider could not access the safeguarding log prior to September 2016. The provider was unable to show us evidence of how they managed and monitored safeguarding concerns prior to this date. The acting manager had started his own safeguarding log which showed there were two safeguarding referrals made in September. We looked at the records for these two safeguarding referrals which showed that staff had not followed the appropriate safeguarding procedures in line with the provider's policy. Information was poorly recorded, and the referral had not been followed up to ensure that those requiring safeguarding were appropriately supported.
- The provider was not following the guiding principles of the Mental Capacity Act, 2005. The provider told us they had introduced new capacity forms to use on admission. However, the form was a mental state assessment rather than a mental capacity assessment form. This meant that the provider was not assessing client's capacity prior to signing important documentation, a concern we raised during the previous inspection.
- The acting manager felt he had sufficient authority to carry out his role and had access to administration

support. During the previous inspection we found that no administration support had been available to the registered manager which had impacted on their ability to carry out their duties.

Leadership, morale and staff engagement

- The two staff we spoke to knew the whistleblowing process. Staff told us that they felt they would be able to raise concerns without fear of victimisation and that management listened to their concerns and acted upon them.
- Staff morale was good and staff felt happy within their role. Staff we spoke to told us that they enjoyed working at the service and the work gave them job satisfaction. They told us there were opportunities for training and development within their role. Staff said the team worked well together and there was a lot of mutual support.
- The acting manager was open and transparent about issues the service faced. We saw that they responded to complaint's raised by clients within 28 days, in line with their complaint's procedure. However, some concerns were not addressed such as lack of 1:1 time and information cited on the provider's website about services offered, being misleading. The provider had not reviewed this information following the complaints in terms of how they could improve information provided or the service that client's felt they should be offered.
- Staff were offered the opportunity to give feedback on services and service development, and attended monthly team meetings in which they are able to give suggestions on areas of improvement. We saw meeting minutes where this happened regularly.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that staff complete thorough risk assessments and that they update these regularly to reflect current risks.
- The provider must ensure that they carry out a ligature risk assessment and take necessary action to remove identified ligature risks.
- The provider must ensure that medicines management procedures are safe and take measures to reduce medication errors.
- The provider must take action to make improvements when staff identify issues in clinical audits.
- The provider must ensure staff follow safeguarding procedures and are aware of their responsibilities in safeguarding vulnerable adults and children.
- The provider must ensure that appropriate investigations are carried out following incidents, and that lessons learnt are identified and shared with staff to improve the safety of the service.
- The provider must ensure they supervise and appraise staff regularly in line with their policy.

Action the provider SHOULD take to improve

- The provider should ensure they take necessary and proportionate action in relation to any identified failings identified from complaint investigation.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **Risk assessments did not record and plan for all identified risks. Staff did not update these in line with the provider's policy.** **This was a breach of regulation 12 (2) (a) (2) (b)**

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 **The provider had not carried out a ligature risk assessment for the environment and had not identified all potential ligature risks.** **This was a breach of regulation 12 (2) (d)**

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 **Medicines management processes were complicated and unsafe. There was a high number of medication errors identified.** **This was a breach of regulation 12 (2) (g)**

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Despite recent training, staff could not explain their responsibilities regarding safeguarding people from abuse. Staff did not always act on concerns and information was inconsistent and poorly documented.

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 The provider had not taken action to rectify issues that staff identified in clinical audits. This was a breach of regulation 17 (2) (b)

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 Managers did not always investigate incidents thoroughly to assess, monitor, and mitigate the risks relating to the health, safety, and welfare of service users. They did not identify lessons learned from incidents. This was a breach of regulation 17 (2) (b) (f)

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 Staff were not supervised in line with the providers policy. Some staff had not had supervision for 3 months. The provider's policy was every six weeks. This was a breach of regulation 18 (2) (a)