

# 1st Stage House

## 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

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

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

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

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

### Overall summary

We do not currently rate independent standalone substance misuse services.

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

- The service did not have formal written risk assessments to ensure that their volunteers were fit to work with the client group. A number of volunteers had commenced working at the service without a criminal records check or a written risk assessment of their suitability to work with the client group. The service did not have policies in place to routinely update the criminal records of the staff.
- The service did not have robust procedures to deal with the disposal of clinical waste.
- There were no carbon monoxide detectors in the property. The one fire door was ill-fitting and there were no fire extinguishers in the property.
- The service did not have a system to check that the residents cleaned the property properly and food hygiene was maintained to a satisfactory standard.
- There were low completions rates of all mandatory training for volunteers except professional boundaries.
- The provider did not offer specialist training relevant to the client group. The service did not provide staff with training in substance misuse, mental health or domestic violence. These issues regularly presented themselves in this particular client group.
- The service admitted adults only. Staff were provided with safeguarding adults training but did not provide staff with training in safeguarding children. However, a

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number of the clients had children or had contact with children. The lack of training in safeguarding children meant that staff and volunteers might not identify possible safeguarding concerns.

- None of the staff had a clear understanding of how the principles of the Mental Capacity Act would be relevant to their role.
- Risks assessments were not robust, none of the risk assessments/care plans looked at the risks of overdose post opiate detox, which was a particular risk for this client group. Staff did not undertake contingency planning in a robust manner and did not plan in advance what action they would take place should a client leave the service unexpectedly.
- The provider's medicines policy was not robust and did not offer guidance on action to be taken in an event of a medicines incident out of hours or how to support clients who could no longer self-administer or what action should be taken before giving clients over the counter medication.

However we also found the following areas of good practice:

- The staff consistently modelled the values and visions of the provider. They were committed to ensuring that the clients using the service were supported. A range of therapeutic interventions and activities that promoted health and recovery were provided by the service. Clients were encouraged to undertake activities to improve employability. The service liaised with other organisations when necessary and advocated for the clients when necessary.

- The provider had no waiting list and staff were able to admit clients without delay. They accepted referrals for clients throughout the United Kingdom and were able to provide free treatment to individuals who could not secure funding. Clients who successfully completed the 1st stage of treatment were offered a place at the provider's second stage house.
- The service supported clients through a range of therapeutic interventions and activities that promoted health and recovery. The service had implemented a buddying system, which assisted new clients to receive informal support from other clients who were further along the recovery programme. This peer support was helpful to new clients. The house also had a senior peer. This was a client who was further along in their treatment and was able to offer additional support and guidance to other clients.
- The provider had complied with housing legislation and had licensed the property as a house in multiple occupation. This meant that the property met government guidelines regarding the suitability of the accommodation for people to share and that the providers were considered "fit and proper" to manage this type of housing.
- The provider supported staff to undertake additional studies and attend events to enhance their career development.
- The service had governance systems in place to ensure that learning was shared across the organisation as a whole. Staff were positive about the local management and felt supported to undertake additional qualifications

# Summary of findings

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# 1st Stage House

**Services we looked at**

Substance misuse services

# Summary of this inspection

## Background to 1st Stage House

1st Stage House is a male only residential rehabilitation service for up to nine men who have had substance misuse problems. The provider is Hope Worldwide and the first stage recovery house forms part of their “One Day at a Time” programme. At the time of our inspection there were five clients using the service. Clients paid for their treatment, were funded by the local authority or were offered free treatment by Hope Worldwide. The programme is based on a model of recovery which is being used in the United States of America and has been running for over 10 years. As part of the programme, clients were also offered therapeutic interventions at the day service which was located nearby.

The service registered with the CQC in 2011. There was a registered manager at the time of the inspection.

The current service is registered to provide accommodation for persons who require treatment for substance misuse.

The service was previously used as the 2nd Stage recovery house and it was inspected in February and July 2013. The service was found to be meeting essential standards at that time. Essential Standards are now known as fundamental standards.

This latest inspection was undertaken using our new methodology.

## Our inspection team

The team that inspected the service comprised of three CQC inspectors, one specialist adviser who was a nurse with experience of working in substance misuse services, one CQC pharmacy inspector and an expert by experience. An expert by experience is a person who has

personal experience of using, or supporting someone using, substance misuse services. This service was inspected at the same time as the service’s 2nd Stage House and the team was split across the two locations.

## Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme to make sure health and care services in England meet the Health and Social Care Act 2008 (regulated activities) regulations 2014.

## How we carried out this inspection

To understand the experience of people who use services, we ask the following five questions about every service:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people’s needs?
- Is it well led?

Before the inspection visit, we reviewed information that we held about the location, asked other organisations for information.

During the inspection visit, the inspection team:

- visited 1st Stage House
- visited the day service based which was based at other premises nearby
- spoke with five clients

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- spoke with five members of the management team, including the registered manager, service manager and the chief executive.
- spoke with three peer support volunteers who were working at the service on the days on the inspection
- attended and observed a community meeting, a therapeutic group and the weekly breakfast meeting
- reviewed five care and treatment records, including medicines records for clients
- looked at policies, procedures and other documents relating to the running of the service.

## What people who use the service say

We spoke with five clients. Their feedback was very positive about the service and the staff. They felt that the staff and volunteers were supportive and had a good understanding of their needs.

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## The five questions we ask about services and what we found

We always ask the following five questions of services.

### **Are services safe?**

We do not currently rate standalone substance misuse services.

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

- The service did not have clear protocols and procedures to minimise the risks of infection. Their procedures for disposing of clinical waste were not robust.
- The service's medicines policy was not robust.
- The service did not have a system to check that the residents cleaned the property and food hygiene was maintained to a satisfactory standard.
- The property had three first aid boxes. They contained out of date items and staff had not checked the contents.
- There were no carbon monoxide detectors in the property which was contrary to the recommendations made by the Health and Safety Executive (HSE). The service stated that there had been a carbon monoxide detector in the kitchen, but could not clarify when it had been removed and by whom.
- There were no fire extinguishers in the property. The provider stated that they had been asked to remove them as a result of a house in multiple occupancy licensing inspection, but was unable to provide documentary proof of this. During the inspection the service did try to contact the organisation who conducted the inspection to obtain a copy of their recommendations but was unable to do this. One of the fire doors was ill-fitting and may not have performed correctly in the event of a fire.
- Not all staff and volunteers had criminal records checks prior to commencing employment. There was no evidence of the provider carrying out a risk assessment on these individuals to assure themselves that the prospective employee/volunteer was deemed safe to work with the clients.
- Not all volunteers adhered to the provider's lone working policy.
- The provider trained staff in safeguarding adults only. The provider had made the decision not to provide staff and volunteers with training in children's safeguarding because they were an adults only service. However, a number of the clients had or had contact with children. The lack of training in safeguarding children meant that staff and volunteers might not identify possible safeguarding concerns.

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- The staff did not undertake crisis planning with the clients and there were no contingency plans made to support clients who wished to exit the service early.

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

- The service had complied with housing legislation and had licensed the property as a house in multiple occupation. This meant that the property met government guidelines regarding the suitability of the accommodation for people to share and that the providers were considered “fit and proper” to manage this type of housing.
- The service had a designated safeguarding lead, who was able to provide support and guidance to staff and volunteers who had safeguarding concerns.
- There were robust processes to review incidents and learn from them.

## Are services effective?

We do not currently rate standalone substance misuse services.

- The service did not keep a stock of naloxone for people using the service following opioid detoxification. This medicine is used to prevent death if a client relapses and uses drugs.
- Client care plans lacked clear recovery focused objectives with time scales and it was not always clear what progress they had made at the service.
- Staff not did have sufficient knowledge and were not able to explain how they would support clients who were experiencing the range of physical symptoms related to post detoxification and there was a risk that they might not respond appropriately if clients displayed these symptoms.
- None of the staff had a clear understanding of the Mental Capacity Act and how it applied to their work with clients.

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

- The clients had access to individual and group therapy. Clients were given support to deal with cravings, anger management and relapse prevention.
- The service provided cognitive behavioural therapy (CBT) groups for clients, which was recommended by the National Institute of Health and Care Excellence guidance CG51. The provider encouraged clients to attend self-help groups and there was evidence of clients attending Narcotics Anonymous, Alcoholics Anonymous and Cocaine Anonymous.
- The provider had improved their supervision arrangements and staff were receiving supervision more regularly.



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- The provider supported staff to undertake additional studies and attend events to enhance their career.

## Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Clients were very positive about the support and kindness from the staff. They also told us that they felt safe and had been able to participate in their recovery planning.
- The service had regular forums for clients to feedback about issues, which they wished to raise. Staff provided clients with feedback regarding the issues that had been raised.
- Staff we spoke with had a good understanding of the individual needs of clients. There were many examples of staff and volunteers supporting clients who were experiencing difficulties, which might have impacted on their recovery.

## Are services responsive?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- There was no waiting list for a place at the service. The service allowed prospective clients to visit the programme before admission, which meant that they had a good understanding of what the programme entailed.
- The service could offer free treatment to clients who had no access to funding.
- Clients could have one to one counselling in other languages if English was not their first language.
- Therapy sessions and programmes were delivered throughout the week. There were a range of activities available throughout the week and weekend which promoted health and fitness.
- The service had a visible complaints policy and clients told us that they knew how to make complaints.

## Are services well-led?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Staff told us that they felt supported by the service management and the organisation.
- The staff and volunteers modelled the visions and values of the provider in the work they undertook with clients.

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- The organisation's governance structures meant that there was oversight, sharing and learning of relevant information across the organisation.

# Detailed findings from this inspection

## Mental Capacity Act and Deprivation of Liberty Safeguards

- The service had a mental health policy, which was dated May 2016. It outlined the principles of the Mental Capacity Act. None of the staff had completed training related to the Mental Capacity Act and Deprivation of Liberty safeguards. None of the staff had a clear understanding of how the principles of the Mental Capacity Act would be relevant to their role. This meant that there was a risk that staff would not understand their own roles in assessing capacity when necessary.

# Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

## Are substance misuse services safe?

### Safe and clean environment

- Hope Worldwide provided a residential rehabilitation programme. The 1st Stage House provided accommodation for clients and the rehabilitation group work and other activities took place off site. The local authority had licensed the property as a house in multiple occupation. This meant that the property met government guidelines regarding the suitability of the accommodation for people to share and that the providers were considered “fit and proper” to manage this type of housing. As part of the licensing process the local authority had assured themselves that the landlords (provider) had no criminal convictions and had not breached landlord legislation or codes of practice.
- The accommodation was over three floors. The accommodation had three shared bedrooms and one single room. The residents were able to lock their personal belongings securely in their bedrooms. Staff had keys and could open the bedroom doors in an emergency. The lounge, dining room, kitchen and bathrooms were communal.
- Clients undertook the cleaning of the property on a rota basis. As part of their orientation to the service, the staff provided clients with information on basic food safety and hygiene. The service did not have a formal system to check that the clients cleaned the property and that food hygiene was maintained to a satisfactory standard. One fridge contained uncovered raw meat, which was stored directly above vegetables. The second fridge contained out of date food. Both fridges were unclean and the door strips had food debris embedded in them.
- The microwave used by the clients was also unclean. This presented a risk of contamination and poor food hygiene. A client cleaned the microwave after we brought this to the service’s attention.
- The property had three first aid boxes. They contained out of date items and staff had not checked the contents. The Health and Safety Executive (HSE) does not provide guidance on how often first aid box should be checked but does recommend that items in first aid boxes should be checked and items replaced by the expiry dates given and expired items should be disposed of safely.
- The service undertook health and safety checks of the building. The electrical and gas appliances had been safety tested within the last 12 months.
- The provider’s most recent fire risk assessment was dated 20/7/2015. The manager said that because of advice from the inspector undertaking the house in multiple occupancy inspection, they had removed all the fire extinguishers from the property. The service was not able to provide documentary proof of this and did not appear to have robust fire safety plans in place. During the period of the inspection, the provider made attempts to contact the individual who gave them this advice to request that the information relating to the removal of the fire extinguisher be put in writing. The provider was unable to obtain this information. After the inspection, the provider said that they would put a fire extinguisher in the property and provide training on how to use it. Monthly fire drills and alarm testing took place. However, the records did not document how long it took the building to be evacuated and who was present during the fire drills. The provider could not provide assurances that all clients had participated in at least one fire drill during the three months they resided at the property and were familiar with the evacuation

# Substance misuse services

procedures. The property had been fitted with fire doors. However, the fire door to the dining room was ill fitting and may not have effectively reduced the risk of smoke and fire from entering the room.

- There were no carbon monoxide (CO) detectors in the property. The HSE recommends the fitting of CO detectors in properties as a way of giving tenants advance warning of CO in the property. The provider stated that they had previously had a CO detector in the property but it had not been affixed to the wall and had been removed by somebody. They were unable specify when this had happened and did not have any records of when it had last been tested. The absence of a CO detector meant that clients would not have been aware of when CO levels in the house had risen to dangerous levels and that there was a need to evacuate.
- Staff undertook urine screening tests to ensure that clients had not used substances that were prohibited by the programme. The service did not have robust processes to minimise the risk of infection. There were no paper towels so that individuals could dry their hands thoroughly after urine screening tests. Additionally the service did not have robust processes to ensure that the used urine swabs and the pots used to collect urine were disposed of properly. The member of staff undertaking the tests brought the used clinical waste back to the day centre and disposed of the items in a bin. The lack of proper processes to dispose of clinical waste presented an infection control risk.
- The service emphasised the importance of safeguarding adults. Staff gave clients information on the importance of safeguarding and it was made clear that there was an expectation on them to report any safeguarding concerns they had. The service had a safeguarding lead that provided staff and volunteers with advice around safeguarding and liaised with the local authority. Although there were low completion rates of safeguarding training, all the staff and volunteers were aware that they could seek support from the safeguarding lead if they were concerned. They were aware of the types of incidents which would constitute a safeguarding adults concern.
- Clients at the recovery house were supported by a range of staff and volunteers. There were four staff who worked Monday to Friday to support clients. There were a number of sessional staff that provided counselling and yoga. There were nine volunteers. The input provided by volunteers was significant. Volunteers undertook keyworking sessions with clients. Volunteers provided out of hours support to clients and there was a paid member of staff on call to deal with any emergencies that occurred.
- The service was not staffed 24 hours a day. The volunteers and staff visited the house routinely every Monday and Friday to meet with the clients. Wherever, possible the service tried to ensure that two volunteers visited the house on these days, which was in line with their lone working policy. On the occasions where volunteers were working in isolation in the house they were required to contact a member of the management team by phone when they arrived and when they left the house and sign the visitors' book with the times they arrived and left the house. Two volunteers we spoke with said that they sometimes went to the house on other days. They stated that they did not always telephone the management team to let them know they had visited the house.
- We checked the personnel files of 14 individuals who were employed or working as a volunteer at the service. The service was still in the process of obtaining criminal records checks for four staff/ volunteers. These four individuals were working within the service and had day to day contact with the client group. The manager stated that due to some volunteers having had experience of homelessness it was sometimes difficult to get a criminal record check. There was no written evidence of what steps the service had taken to risk assess these four staff/ volunteers to assure themselves that they posed no risk to the clients using the service. This placed clients at risk of avoidable harm.
- Mandatory training included health and safety, safeguarding of vulnerable adults and prevention of blood borne viruses. The completion rate of all training for volunteers below 77%. Although training in blood borne viruses was mandatory none ( 0%) of the volunteers had been trained. A number of the volunteers had lived experience of substance misuse, however, the service had identified that they should still receive training in drugs and alcohol, at the time of the inspection 11% of volunteers had received this training.

## Safe staffing

- There were no vacancies at the time of inspection. In the past 12 months, the vacancy rate had been 17%, which equated to two members of staff leaving the organisation.

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- The completion rate for safeguarding adults training for both staff and volunteers was 71%. The completion rate for emergency first aid was 64%. The client group at the recovery house was particularly vulnerable and the poor completion of mandatory training amongst the staff and volunteer group meant that staff might not recognise and respond appropriately to issues affecting clients.

## Assessing and managing risk to clients and staff

- Clients had a telephone assessment prior to admission, which allowed the staff to get a good understanding of the needs of the clients. Staff and volunteers undertook initial risk assessments of clients and ongoing assessment on a monthly basis. This was a new process and provider hoped that this would standardise the assessment process and ensure consistency.
- The service managed the risk of relapse by asking clients to agree to random drug testing as this was identified as a potential risk to both the client and other clients. There were clear protocols that staff followed if a client tested positive for illicit drugs. This included re-administering the test and removing the client from the house and accommodating them elsewhere to ensure that their drug use did not present a risk to other clients in the house. Unexpected exits happened infrequently and were normally due to a client relapsing. Staff were reluctant to use crisis planning with clients, as they did not want to focus on the possibility of the client failing to complete the programme. This meant that the staff did not have any contingency plans in place to support clients who were experiencing a crisis and there was a risk that staff might not respond appropriately. There were up to date risk assessments in the files. None the risk assessments/care plans looked at the risks of overdose post opiate detox, which was a particular risk for this client group.
- The service did not offer any pharmacological treatments for detoxification or substitute prescribing. Clients had undergone detoxification before being accepted into the service. The provider did not employ staff that could prescribe medicines, which was in line with their management of medicines policy. There were no arrangements for the “bulk storage and dispensing of medicines” in the recovery houses. Clients had to self-administer their own medication. The medicines policy did not contain any guidance on what should happen if someone already admitted into the service was no longer able to self-administer. Staff told us that this had never happened. Staff were able to explain what they would do to ensure clients’ safety if there was a medicines incident. However, the medicines policy did not contain any guidance on the action to be taken in the event of a medicines incident at the recovery houses if staff/volunteers were not on site. With the lack of policy and clear guidance, there was a chance that they would not respond appropriately if there was an incident or if issues arose regarding self-administration.
- Staff contacted the client’s own GP when they were admitted to the service. This allowed staff to find about the client’s prescribed medication and any other health conditions that they might have. The staff supported clients to register with a local GP who would deal with any health issues the clients had.
- At the beginning of each week, each client provided a list of prescribed medicines to the provider. At the end of the week, a member of staff reviewed this list to check whether people had managed to self-administer all of their medicines.
- Clients who were prescribed medicines were supported to self-administer their medication by staff. The service gave each person a lockable container to store their medicines safely, as some of the rooms were shared.
- We reviewed the medicine list for the clients in the service. There was no information on what clients’ prescribed medicines were for. For one client the list of medicines changed from week to week. No reason was recorded for the changes to their medicines, and why medicines had been stopped and others started. The medicines policy stated that clients should disclose changes of medication to their key worker or the house management team at the earliest opportunity. Staff said that clients did not always disclose changes to their medicines. This meant that staff were not always able to offer the best form of support to clients around their medication or to clients who had co-morbidities. The term “comorbidity” describes two or more disorders or illnesses occurring. Clients with comorbidities can require more complex clinical management.
- A small supply of non-prescribed over the counter (OTC) medicines for minor ailments was kept on site. The OTC medicines were kept secure in a locked box and the keys were held by the senior peer. If a client felt unwell out of hours the senior peer contacted the duty worker and would be authorised to give clients the OTC medicines. Some clients were already taking prescribed medicines. The medicines policy did not prompt staff or

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volunteers to seek advice from a pharmacist or doctor before these OTC medicines were supplied to clients, to ensure there were no negative interactions between the client's prescribed medications and the OTC remedies.

- The provider did not offer training in safeguarding children because it was an adult service. However, a number of the clients were parents or had contact with children. The lack of training in safeguarding children meant that staff and volunteers might not identify possible child safeguarding concerns.

## Track record on safety

- There had been one serious incident which was related to a theft. The staff had reported this incident to the police and the charities commission.

## Reporting incidents and learning from when things go wrong

- Incidents were a regular agenda item at the staff meeting and there was evidence of learning taking place as a result. There had been five incidents between July 2015 and February 2016. One of these incidents was categorised as a serious incident requiring further investigation.
- Three incidents related to the loss of small amounts of money or property, these were investigated internally and actions were taken to reduce the likelihood of a similar thing happening again. For example in the most recent incident, the provider had reviewed the process of keeping money secure at the house. The service and now had a more secure method of keeping the money safe on site and clients were able to lock valuables in a safe..
- The staff had an opportunity for a debrief after serious incidents. This included meeting with staff and separate meetings, if appropriate, with volunteers.

## Duty of candour

- The service did not have a duty of candour policy but understood the importance of being open, transparent and apologising when things went wrong. For example, as a result of mis-communication, a client had not received an aspect of their therapy. The service had apologised and identified what they needed to do to ensure that a similar thing did not occur again.

## Safe and clean environment

- Hope Worldwide provided a residential rehabilitation programme. The 1st Stage House provided accommodation for clients and the rehabilitation group work and other activities took place off site. The local authority had licensed the property as a house in multiple occupation. This meant that the property met government guidelines regarding the suitability of the accommodation for people to share and that the providers were considered "fit and proper" to manage this type of housing. As part of the licensing process the local authority had assured themselves that the landlords (provider) had no criminal convictions and had not breached landlord legislation or codes of practice.
- The accommodation was over three floors. The accommodation had three shared bedrooms and one single room. The residents were able to lock their personal belongings securely in their bedrooms. Staff had keys and could open the bedroom doors in an emergency. The lounge, dining room, kitchen and bathrooms were communal.
- Clients undertook the cleaning of the property on a rota basis. As part of their orientation to the service, the staff provided clients with information on basic food safety and hygiene. The service did not have a system to check that the clients cleaned the property and that food hygiene was maintained to a satisfactory standard. One fridge contained uncovered raw meat, which was stored directly above vegetables. The second fridge contained out of date food. Both fridges were unclean and the door strips had food debris embedded in them. The microwave used by the clients was also unclean. This presented a risk of contamination and poor food hygiene. A client cleaned the microwave after we brought this to the service's attention.
- The property had three first aid boxes. They contained out of date items and staff had not checked the contents. The Health and Safety Executive (HSE) does not provide guidance on how often first aid boxes should be checked but does recommend that items in first aid boxes should be checked and items replaced by the expiry dates given and expired items should be disposed of safely.
- The service undertook health and safety checks of the building. The electrical and gas appliances had been safety tested within the last 12 months.
- The provider's most recent fire risk assessment was dated 20/7/2015. The manager said that because of



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advice from the fire assessor, they had removed all the fire extinguishers from the property. The service was not able to provide documentary proof of this and did not appear to have robust fire safety plans in place. After the inspection, the provider said that they would put a fire extinguisher in the property and provide training on how to use it. Monthly fire drills and alarm testing took place. However, the records did not document how long it took the building to be evacuated and who was present during the fire drills. The provider could not provide assurances that all clients had participated in at least one fire drill during the three months they resided at the property and were familiar with the evacuation procedures. The property had been fitted with fire doors. However, the fire door to the dining room was ill fitting and may not have effectively reduced the risk of smoke and fire from entering the room.

- There were no carbon monoxide (CO) detectors in the property. The HSE recommends the fitting of CO detectors in properties as a way of giving tenants advance warning of CO in the property. The provider stated that they had previously had a CO detector in the property but it had not been affixed to the wall and had been removed by somebody. They were unable specify when this had happened and did not have any records of when it had last been tested. The absence of a CO detector meant that clients would not have been aware of when CO levels in the house had risen to dangerous levels and that there was a need to evacuate.
- Staff undertook urine screening tests to ensure that clients had not used substances that were prohibited by the programme. The service did not have robust processes to minimise the risk of infection. There were no paper towels so that individuals could dry their hands thoroughly after urine screening tests. Additionally the service did not have robust processes to ensure that the used urine swabs and the pots used to collect urine were disposed of properly. The member of staff undertaking the tests brought the used clinical waste back to the day centre and disposed of the items in a bin. The lack of proper processes to dispose of clinical waste presented an infection control risk.
- The service emphasised the importance of safeguarding adults. Staff gave clients information on the importance of safeguarding and it was made clear that there was an expectation on them to report any safeguarding concerns they had. The service had a safeguarding lead that provided staff and volunteers with advice around

safeguarding and liaised with the local authority. Although there were low completion rates of safeguarding training, all the staff and volunteers were aware that they could seek support from the safeguarding lead if they were concerned. They were aware of the types of incidents which would constitute a safeguarding adults concern.

## Safe staffing

- There were no vacancies at the time of inspection. In the past 12 months, the vacancy rate had been 17%, which equated to two members of staff leaving the organisation.
- Clients at the recovery house were supported by a range of staff and volunteers. There were four staff who worked Monday to Friday to support clients. There were a number of sessional staff that provided counselling and yoga. There were nine volunteers. The input provided by volunteers was significant. Volunteers undertook keyworking sessions with clients. Volunteers provided out of hours support to clients and there was a paid member of staff on call to deal with any emergencies that occurred.
- The service was not staffed 24 hours a day. The volunteers and staff visited the house routinely every Monday and Friday to meet with the clients. Wherever, possible the service tried to ensure that two volunteers visited the house on these days, which was in line with their lone working policy. On the occasions where volunteers were working in isolation in the house they were required to contact a member of the management team by phone when they arrived and when they left the house and sign the visitors' book with the times they arrived and left the house. Two volunteers we spoke with said that they sometimes went to the house on other days. They stated that they did not always telephone the management team to let them know they had visited the house.
- We checked the personnel files of 14 individuals who were employed or working as a volunteer at the service. The service had applied for the criminal records checks for nine staff/volunteers after the individual had commenced in employment. The service was still in the process of obtaining criminal records checks for four staff/ volunteers. These four individuals were working within the service and had day to day contact with the client group. The manager stated that due to some volunteers having had experience of homelessness it



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was sometimes difficult to get a criminal record check. There was no written evidence of what steps the service had taken to risk assess these four staff/ volunteers to assure themselves that they posed no risk to the clients using the service. This placed clients at risk of avoidable harm.

- Mandatory training included health and safety, safeguarding of vulnerable adults and prevention of blood borne viruses. The completion rate of all training except health and safety and fire marshal training was below 58%. The completion rate for safeguarding adults training was 57%, for prevention of blood borne viruses it was 36% and the completion rate for emergency first aid was 7%. The client group at the recovery house was particularly vulnerable and the poor completion of mandatory training amongst the staff and volunteer group meant that staff might not recognise and respond appropriately to issues affecting clients.

## Assessing and managing risk to clients and staff

- Clients had a telephone assessment prior to admission, which allowed the staff to get a good understanding of the needs of the clients. Staff and volunteers undertook initial risk assessments of clients and ongoing assessment on a monthly basis. This was a new process and provider hoped that this would standardise the assessment process and ensure consistency.
- The service managed the risk of relapse by asking clients to agree to random drug testing as this was identified as a potential risk to both the client and other clients. There were clear protocols that staff followed if a client tested positive for illicit drugs. This included re-administering the test and removing the client from the house and accommodating them elsewhere to ensure that their drug use did not present a risk to other clients in the house. Unexpected exits happened infrequently and were normally due to a client relapsing. Staff were reluctant to use crisis planning with clients, as they did not want to focus on the possibility of the client failing to complete the programme. This meant that the staff did not have any contingency plans in place to support clients who were experiencing a crisis and there was a risk that staff might not respond appropriately. There were up to date risk assessments in the files. None the risk assessments/care plans looked at the risks of overdose post opiate detox, which was a particular risk for this client group.
- The service did not offer any pharmacological treatments for detoxification or substitute prescribing. Clients had undergone detoxification before being accepted into the service. The provider did not employ staff that could prescribe medicines, which was in line with their management of medicines policy. There were no arrangements for the “bulk storage and dispensing of medicines” in the recovery houses. Clients had to self-administer their own medication. The medicines policy did not contain any guidance on what should happen if someone already admitted into the service was no longer able to self-administer. Staff told us that this had never happened. Staff were able to explain what they would do to ensure clients’ safety if there was a medicines incident. However, the medicines policy did not contain any guidance on the action to be taken in the event of a medicines incident at the recovery houses if staff/volunteers were not on site. With the lack of policy and clear guidance, there was a chance that they would not respond appropriately if there was an incident or if issues arose regarding self-administration.
- Staff contacted the client’s own GP when they were admitted to the service. This allowed staff to find about the client’s prescribed medication and any other health conditions that they might have. The staff supported clients to register with a local GP who would deal with any health issues the clients had.
- At the beginning of each week, each client provided a list of prescribed medicines to the provider. At the end of the week, a member of staff reviewed this list to check whether people had managed to self-administer all of their medicines.
- Clients who were prescribed medicines were supported to self-administer their medication by staff. The service gave each person a lockable container to store their medicines safely, as some of the rooms were shared.
- We reviewed the medicine list for the clients in the service. There was no information on what clients’ prescribed medicines were for. For one client the list of medicines changed from week to week. No reason was recorded for the changes to their medicines, and why medicines had been stopped and others started. The medicines policy stated that clients should disclose changes of medication to their key worker or the house management team at the earliest opportunity. Staff said that clients did not always disclose changes to their medicines. This meant that staff were not always able to offer the best form of support to clients around their

# Substance misuse services

medication or to clients who had co-morbidities. The term “comorbidity” describes two or more disorders or illnesses occurring. Clients with comorbidities can require more complex clinical management.

- A small supply of non-prescribed over the counter (OTC) medicines for minor ailments was kept on site. The OTC medicines were kept secure in a locked box and the keys were held by the senior peer. If a client felt unwell out of hours the senior peer contacted the duty worker and would be authorised to give clients the OTC medicines. Some clients were already taking prescribed medicines. The medicines policy did not prompt staff or volunteers to seek advice from a pharmacist or doctor before these OTC medicines were supplied to clients, to ensure there were no negative interactions between the client’s prescribed medications and the OTC remedies.
- The provider did not offer training in safeguarding children because it was an adult service. However, a number of the clients were parents or had contact with children. The lack of training in safeguarding children meant that staff and volunteers might not identify possible child safeguarding concerns.

## Track record on safety

- There had been one serious incident which was related to a theft. The staff had reported this incident to the police and the charities commission.

## Reporting incidents and learning from when things go wrong

- Incidents were a regular agenda item at the staff meeting and there was evidence of learning taking place as a result. There had been five incidents between July 2015 and February 2016. One of these incidents was categorised as a serious incident requiring further investigation.
- Three incidents related to the loss of small amounts of money or property, these were investigated internally and actions were taken reduce the likelihood of a similar thing happening again. For example in the most recent incident, the provider had reviewed the process keeping money secure at the house. The service and now had a more secure method of keeping the money safe on site and clients were able to lock valuables in a safe..

- The staff had an opportunity for a debrief after serious incidents. This included meeting with staff and separate meetings, if appropriate, with volunteers.

## Duty of candour

- The service did not have a duty of candour policy but understood the importance of being open, transparent and apologising when things went wrong. For example, as a result of mis-communication, a client had not received an aspect of their therapy. The service had apologised and identified what they needed to do to ensure that a similar thing did not occur again.

## 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)

- Volunteers undertook key working sessions with clients. These sessions were intended to provide holistic support to clients to help them make positive progress. Each client’s timetable included therapeutic and group work sessions. The service provided groups which covered a variety of topics including dealing with cravings, anger management and relapse prevention.
- All clients had care plans. Care records were completed in paper files. Staff stored these files in a locked cabinet.
- We reviewed five care records in detail. The therapy manager completed the risk assessments and the keyworkers completed the care plans. The staff updated the care plans on a regular basis with some being updated weekly. There was evidence that staff discussed the risks of blood borne viruses with all clients. There were up to date risk assessments in all file. However, in two of the records the information about risks was sparse. For example, the staff member identified that the client had posed a risk to another person. However, it was not clear if the client was likely to have future contact with this individual. In two records, there was information about the client’s previous drug history but there was no mention of quantity or frequency of drug taking. None of the risk assessments or care plans looked at the risks of overdose post opiate detox, which was a particular risk for this client group.

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- All care plans had objectives but they were not recovery focused or specific, measurable, achievable, realistic or time bounded, (SMART). SMART objectives allow clients and the support workers to identify realistic personalised goals, which can be reviewed easily to identify when progress has been made, which can help with a client's motivation towards change. The lack of SMART objectives in the clients' care plans meant that it was not always clear what progress had been made. The therapy manager had identified that improvements were required with regards to the care planning and the setting of objectives.
- Some clients had recently undergone detoxification from drugs, which meant that they might experience physical symptoms of withdrawal, such as sleep disturbance. Staff were able to explain clearly what they do to support people with sleep disturbance. People can also experience other symptoms such as diarrhoea, nausea, stomach cramps and pain. Staff were not able to explain how they would support clients who were experiencing other physical symptoms related to detoxification and there was a risk that they might not respond appropriately if clients displayed these symptoms.
- Where clients had additional health needs, the staff made referrals to secondary health care services such as mental health services.

## Best practice in treatment and care

- The service based its model of care on a programme used in the United States, which emphasised the importance of peer support, personal accountability and tough love. Additionally it used the empathic communication model, which was used in Norwegian health care settings. The model of communication enabled clients to release their emotions in a safe space, rather than use substances to self-medicate, build trust and respect and provide an environment for sharing and problem solving.
- In accordance with the National Institute of Health and Care Excellence (NICE) guidance CG51, the provider also provided cognitive behavioural therapy (CBT) groups for clients. The therapy manager ran these groups and received appropriate external supervision in line with NICE guidance. The service encouraged clients to attend self-help groups and there was evidence of clients attending Narcotics Anonymous, Alcohol Anonymous and Cocaine Anonymous. Clients attended these groups

in the community, which gave the clients the opportunity to receive support from individuals who were abstinent from drugs and alcohol and were positive role models.

- The provider did not keep a stock of naloxone for clients following opioid detoxification. Naloxone prevents death if an individual relapses and uses drugs. National guidance recommends, "all services working with drug misusers should have an emergency protocol in place that covers the management of drug overdoses. This should include rapid ambulance call and competent preservation of a clear airway, and include protocols for the emergency administration of interim naloxone while awaiting the arrival of the ambulance". (Drug misuse and dependence: guidelines on clinical management, Department of Health [DH], 2007)". However, staff gave clients advice about the dangers of overdose post opioid detoxification but this information was not routinely noted in the care plans or risk assessments.
- Staff carried out audits, including financial audits and health and safety. A recent audit of care plans had identified that improvements were required and the therapy manager was in the process of identifying what training was required for the key workers. Additionally members of the senior management team had undertaken a number of quality assurance visits to the service.

## Skilled staff to deliver care

- The service supported clients with a variety of needs and as a consequence needed a skilled workforce. The provider supported a number of volunteers to undertake qualifications in health and social care, which would enable them to improve their work performance. Three of the volunteers and staff group had training in substance misuse and mental health. However, there was no mandatory training related to substance misuse and mental health which were issues that regularly presented themselves in this particular client group. The lack of training, meant that staff and volunteers might not support clients appropriately.
- Staff had not received supervision regularly until the beginning of 2016 due to changes in staffing. This had improved and the staff received regular one to one and group supervision. All staff who had completed a year of employment had received an appraisal.
- The service supported staff to undertake additional studies and attend events to enhance their career. The

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previous therapy manager had been supported to study at post graduate level and the current service manager was undertaking a management qualification. The service manager had also attended the United Kingdom and European Symposium on Addictive Disorders, which focused on current thinking around issues of substance misuse, care and treatment. A number of volunteers were undertaking national vocational qualifications in health and social care.

## Multidisciplinary and inter-agency team work

- No medical care was provided directly at the service, but staff in the service liaised with secondary health care services as necessary. For example, when clients needed to attend appointments at local acute hospitals. The staff shared information with these services with the consent of the client. The service also liaised with referrers when necessary and other third sector organisations.

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

- The provider had a mental health policy, which was dated May 2016. It outlined the principles of the Act. None of the staff had completed training related to the Mental Capacity Act and Deprivation of Liberty safeguards. None of the staff had a clear understanding of how the principles of the Mental Capacity Act would be relevant to their role. This meant that there was a risk that staff would not understand their own roles in assessing capacity when necessary.

## Equality and human rights

- The service provided training in equality and diversity and emphasised the importance of accepting all individuals.
- The service was solely open to men but the provider had a mixed gender staff group.
- The service said they would not exclude transgender men.

## Are substance misuse services caring?

### Kindness, dignity, respect and support

- All the clients that we spoke with told us that they felt safe at the project and were aware that they were able

to leave when they wished. They told us that they knew about the rules of their tenancy, which they agreed to on admission. For example, the service did not allow drugs and alcohol in the premises.

- Newly admitted clients were assigned buddies. The buddies were clients who were further along in their treatment. The buddies provided newly admitted clients with additional support and reassurance.
- For the first 30-40 days after admission, clients were discouraged from having contact with their family unless there were exceptional circumstances. For example, the service supported a client whose family member was unwell. Staff understood that the stress that the client was experiencing could have triggered a relapse. In these circumstances the staff gave the client additional support which included accompanying the client to visit their relative in the hospital and additional counselling sessions.
- Staff we spoke with had a good understanding of the individual needs of clients. There were numerous examples of the staff liaising with criminal justice agencies, solicitors and the benefits agency as a way of supporting clients who were experiencing difficulties.

### The involvement of clients in the care they receive

- A number of clients were estranged from their families and friends due to their history of substance misuse. As a consequence, the service did not routinely provide support to families and carers unless expressly asked to do so by the clients. However, the service acknowledged the important role that families and friends provided to clients who were in recovery and held an annual family day.
- Staff met with clients weekly for key working sessions to discuss their progress and identify areas that might be posing difficulties. Clients also had one to one review meetings with staff quarterly. The review meetings had a standard agenda that included an item for clients to give formal feedback around their care and treatment. Clients attended a variety of therapeutic groups and had weekly key work sessions. Staff gathered feedback regarding the service by asking the clients to complete feedback forms and verbally at the end of therapeutic sessions. Additionally staff gathered feedback from community meetings, which were held at the recovery house. The provider used the feedback to improve the service.

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- The provider had recently set up a service user forum, which would include clients from the 1st Stage House and 2nd Stage House, another of its services. The provider intended to use the forum as a space to discuss how they could improve the care provided at both services. Recent feedback from the clients was that there was a need to improve communication when staff made changes to the therapy programme.

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

## Access and discharge

- There was no waiting list for a place at the 1st Stage House. The service admitted clients from across the country. Planned admissions took place in the majority of cases. The provider admitted clients once they had completed their medical detoxification from illicit substances. Prospective clients were also able visit the day service where therapy sessions took place. This meant that prospective clients could meet with the clients and staff prior to admission, which gave them a good understanding of what the programme entailed.
- Funding for treatment came from a variety of sources, which included local authorities and self-funders. The service also provided free treatment to those who could not access funding, through the provision of bursary beds. At the time of the inspection, a number of the clients were accessing the service through the provision of a bursary.
- Clients remained at the service for approximately three to four months. They then moved into 2nd Stage House as part of an on-going treatment programme.
- Staff tried to identify clients experiencing difficulties with remaining abstinent through regular key working sessions and daily contact with the clients. If a client relapsed through using non-prescribed drugs or drinking alcohol, staff asked the client to leave the house and provided them with temporary accommodation elsewhere, which was normally bed and breakfast accommodation. During that time, the service ensured that the client would be supported in the community by contacting other organisations including the local homeless persons unit.

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

- There were limited facilities at the service for clients to have therapy sessions. Clients had therapy sessions, one to one meetings or group work sessions at the day service, which was located in another building. The facilities available to clients at the house were a communal lounge, dining room, kitchen and garden, which were accessible 24 hours a day.
- The provider service had a pay phone that clients could use to make calls. Staff allowed clients to have their mobile phones after they had been in the programme for at least 30 days. The service made this clear to clients upon admission. These blanket rules for clients were intended to ensure that they focused on the initial stages of recovery and were not distracted by outside influences.
- The service was non-smoking. If clients wished to smoke, they had to do this in the garden. Staff did not offer smoking cessation sessions but supported clients who wished to stop smoking by signposting them to appropriate services.
- The volunteers were available to accompany clients if they had appointments or wished to go for a walk or shopping. The activities timetable was posted in reception area. The clients also had access to range of activities and were encouraged to get fit and healthy as part of their recovery. Activities included yoga sessions and support to access a local gym. One Day at a Time also had an annual challenge, which involved staff, volunteers and clients getting involved in activities, this included mountain climbing.
- Clients' belongings could be stored securely. Items of value could be stored in the service safe. Staff kept a log of the items that were stored in the safe.

## Meeting the needs of all clients

- The service was a faith based organisation but supported clients from differing faiths and would accompany clients to places of worship if required. The service did not stipulate that the staff and volunteers had to be practising Christians.
- The service was not wheelchair user friendly. The service could not admit clients who used wheelchairs or had significant mobility issues due to the bedrooms and bathrooms being upstairs. There was no scope to adapt the rooms on the ground floor to enable the service to



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admit clients with mobility issues. The day service where therapies were provided was not wheel chair user friendly either. If a prospective client was identified as having mobility difficulties, they were signposted to other substance misuse services by the provider.

- The clients self-catered and there was a cooking rota. This meant that clients could eat food that was specific to their cultural and religious needs. The service celebrated the diversity of cultures at the weekly big breakfast meeting by providing food from around the world. This weekly meeting gave the clients the opportunity to meet others who were further along in their recovery and receive peer support and encouragement.
- Staff delivered group work and therapy sessions in English. However, the service was able to support individuals whose first language was not English. For example, they had paid for a therapist who spoke Polish for a client.

## Listening to and learning from concerns and complaints

- Information on how to complain was readily available to the clients and there was evidence that they knew how to complain. Clients raised complaints initially with frontline staff and there was a three-stage process for reviewing and investigating. During the first stage, the service manager dealt with the complaint and there were clear time frames to investigate and respond to the complainant. If the complainant remained unsatisfied they could escalate their complaint to the chief executive who had to provide a response within 21 days. If the issue remained unresolved then the complainant could contact the Parliamentary Health Service Ombudsman or the Housing Ombudsman.
- The service had received two formal complaints in the 12 months prior to inspection. The provider did not uphold either complaint and they were not referred to the Parliamentary Health Service Ombudsman or Housing Ombudsman. Despite not upholding the complaints, the provider had improved some of their processes. Improvements included improving the procedures around keeping an inventory of the clients' items, which were kept in the safe.

## Are substance misuse services well-led?

### Vision and values

- The provider's vision and values were rooted in their faith based ethos. The aim was to assist people who were in difficulty, to support clients to make changes in their lives and to help them make a new start. The service had reviewed their values and was in the process of implementing new values. The new values included striving for excellence, and being open and transparent in the work they undertook with clients. We observed staff modelling these values during the inspection. At the time of inspection, these new values were awaiting sign off. Although the new values were not on display, the provider ensured that prospective staff were aware of the new values and visions by including a mission statement in the recruitment pack. When staff moved away from the values of the organisation, the management stated that they would address this in supervision.

### Good governance

- The service was part of the One day at a time (ODAAT) services, which was part of Hope Worldwide, which was the registered provider. Hope Worldwide provided services to vulnerable communities in the UK and abroad. The provider did not have any other drug treatment services in the UK.
- The service had a two-tier leadership model, which consisted of a trustee board and a senior management team. Five people sat on the board of trustees and they came from a range of professional backgrounds. The provider was currently recruiting more board members with other types of experience to enhance the work undertaken by the provider. For example, the provider was seeking to recruit an individual who was in recovery as a way of utilising their expertise by experience and ensuring that the voice of clients was reflected in the work of organisation at all levels. There was also an action plan for trustee members to become more involved in the work undertaken by the organisation. Attendees at the board meeting and senior management meetings discussed information relating

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to the running of the service, which included staffing, complaints and incidents. This meant that there was oversight, sharing and learning of relevant information across the organisation.

- Members of the senior management team provided feedback to the staff regarding incidents during the twice-weekly team meetings. This gave staff the opportunity to discuss the learning from incidents and review any actions that arose as a result.
- Staff had not received supervision regularly until the beginning of 2016 due to changes in staffing. However, this had improved following recent appointments to the management team. The provider had ensured that there were other forums (for example the team meeting) where staff could raise and discuss aspects of the work they undertook. For example, the therapy manager accessed external peer supervision.
- There was an organisational risk register, which covered both strategic and operational issues. Risks included what would happen if they lost the premises, for example. The service had a business continuity plan, which was updated May 2016. The plan addressed how to continue operating in the event of a disruption to service. The team reviewed the risk register during the six weekly management meeting and looked at how best to mitigate potential risks within the service. The

management team also used this six weekly meeting to discuss strategic objectives. The board had just approved a new strategic objective to create targets and the process for monitoring this.

## **Leadership, morale and staff engagement**

- There had been changes in the senior management team over the past 12 months. The previous service manager and therapy manager had left. The chief executive had covered the post of the service manager and this had allowed them to become more involved in the day to day running of the service. The service had recently appointed a new service manager and therapy manager. The senior management team were highly visible to the clients, staff group and volunteers and were located at the day service. The staff and volunteers we spoke with told us that there was strong morale amongst the team and that they felt fully supported by all aspects of management.
- The service had low levels of sickness. There had only been one member of staff who had been on long-term sick leave. The provider had supported this individual in returning to work through a phased return and making reasonable adjustments.
- The provider did not conduct a staff survey. However, all staff we spoke to stated that they could raise issues with the management team and felt that they would be listened to.

# Outstanding practice and areas for improvement

## Outstanding practice

- The service provided bursary beds for clients who could not access funding for treatment from other sources.

## Areas for improvement

### Action the provider **MUST** take to improve

#### Action the provider **MUST** take to meet the regulations:

- The provider must ensure that they have robust processes to manage infection control risks and dispose of clinical waste.
- The provider must ensure that staff complete their mandatory training
- The provider must ensure that there are carbon monoxide detectors in the service, in line with the recommendations from the HSE
- The provider must ensure that there are criminal records checks for staff and volunteers prior to commencing employment and where there are difficulties in obtaining this that a robust written assessment of risk takes place to provide assurances that the individual does not pose a risk to the clients in the service.
- The provider must ensure that staff have sufficient training and skills to provide care and support to client in respect of substance misuse and mental health concerns The provider must ensure that ensure that staff and volunteers are aware of the procedures and processes in place that safeguard children.
- The provider must ensure that they have robust fire safety procedures and that the clients are aware of the procedures.
- The provider must ensure that all clients have clear risk and crisis management plans which have the identified risks and wishes of the individual in the

event of the crisis and liaise with support services such as funding authorities, social care and local primary and secondary health care services to ensure that crises can be managed and planned for. The provider must ensure that risk assessments/care plans outline the plans to minimise the risk of overdose post opiate detox.

- The provider must ensure that the medicines policy is robust and has guidance on how to support clients who can no longer self administer. The provider must ensure that there is clear guidance as to what action should be taken if there is a medicines incident out of hours. The provider must ensure that they record why changes to client's medication have been made. The provider must ensure that the medicines policy outlines what action staff should take if they wish to give a client OTC medication.

### Action the provider **SHOULD** take to improve

- The provider should consider keeping a supply of Naloxone in accordance with NICE guidance.
- The provider should consider providing staff with training on the principles of the Mental Capacity Act.
- The provider should ensure that there are robust processes in place to ensure that there is good food hygiene.
- The provider should ensure that staff and volunteers adhere to the lone working policy.
- The provider should ensure that care plans have clear and time bounded objectives in care plans.



## 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

Accommodation for persons who require treatment for substance misuse

#### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The provider had not ensured that all staff and volunteers who supported clients had completed their mandatory training. For example, there were low completion rates for safeguarding adults training and no child safeguarding training.

Regulation 18(1)(2)(a)

#### Regulated activity

Accommodation for persons who require treatment for substance misuse

#### Regulation

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

The provider had did not have processes in place to ensure that all staff and volunteers had a criminal records checks or had a written risk assessment completed prior to employment. They could not provide assurances that all staff and volunteers working with clients did not pose a risk.

Regulation 19(1)(2)

#### Regulated activity

Accommodation for persons who require treatment for substance misuse

#### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

The provider did not have carbon monoxide detectors in the first stage recovery house.

Fire procedures were not robust

Regulation 12 (d)

This section is primarily information for the provider

## Requirement notices

### Regulated activity

Accommodation for persons who require treatment for substance misuse

### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

There was a lack of assessment of risks to clients in a crisis and associated crisis plans

Staff lacked mental health awareness training.

The provider did not provide training to staff in substance misuse awareness or the physical health symptoms that may occur in individuals who had undergone detox.

Staff lacked appropriate skills and competence to support the client group.

There were poor infection control processes.

The provider's medicine policy did not provide clear guidance on how to manage medicine incidents that took place out of hours. There was no guidance prompting staff or volunteers to seek advice from a pharmacist or doctor before giving over the counter medicines to clients.

Regulation 12 (2) (a)(b)(c)(h)