Yeldall Manor

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 medicine management processes in the service were generally safe but there were gaps in process and policy that did not fully assure us that clients would always be kept safe from harm. There was no process in place to report, record, act on or monitor significant events, incidents and near misses in relation to medicines.
- We did not see evidence that baseline blood tests were carried out prior to prescribing medicines for detoxification.
- The new clinic room was not connected to running water but the provider recognised that this was a high priority.
- There was no incident policy or separate recording of any safeguarding concerns that meant that these incidents could potentially be missed.
- Records could not be easily accessed as they were split up and kept in several separate places. This meant that key risk information was not readily accessible.
- Clients were risk assessed prior to admission to Yeldall Manor. However, risks assessments were not updated or reviewed at any point while the client was under the care of the service. This meant that any escalation in risk was not formally recorded in a

Summary of findings

way that would make key information readily accessible to other staff members. There were no risk assessments in place for clients going on weekend leave or risk management plans for unexpected treatment exit.

- There was a lack of audits undertaken to review and improve on aspects of care and treatment, which the provider acknowledged. There were no audits completed for infection control or to review whether prescribing was in line with national guidance.
- Mandatory training for staff was limited in range. The percentage of staff who had received an appraisal in the previous 12 months was 64%. Senior managers were taking steps to address all of these issues.

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

- The staff audited the quantities of medicines on a regular basis and had good processes to account for all medicines on site. There was good staff awareness of and monitoring of withdrawal symptoms. The doctor assessed clients on pre-admission with a full assessment within 24 hours to assess their appropriateness for alcohol detox. The service supported clients to register with the same local GP within 48 hours of admission
- The provider reported that there were no safeguarding incidents over the past 12 months. Staff had an awareness of safeguarding and knew how to escalate any concerns. There were operational policies in place for safeguarding adults and children at risk.
- The provider had a duty system with four senior managers rostered to be on call 24 hours, seven days a week outside of working hours and the prescribing doctor was available 24 hours. Staff were able to identify who to contact in the event of urgent client need or an emergency.
- All of the staff and volunteers at Yeldall had Disclosure and Barring Service (DBS) checks or the relevant national criminal records checks appropriate for their country of origin.
- The service provided a work based programme and training for clients. Clients had the opportunity to be interviewed and then trained by staff for jobs within Yeldall Manor. Clients told us they felt comfortable in the environment with lots of space and rooms to allow clients the option of more quiet time if needed. There were a range of leisure options for clients to access.
- Clients told us they were treated with compassion, respect and kindness and that they had the opportunity to influence change. Clients told us they knew how to complain and this was included in the client's handbook on admission.
- The provider offered a bursary for those who could not get local authority funding and was exploring a new way of funding such as 'Social Impact Bonds' that the provider hoped would make them more responsive to clients' needs.

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Our judgements about each of the main services

Service	Rating	Summary of each main service
Substance misuse services		See overall summary.

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Background to Yeldall Manor

- Yeldall Manor is a 24-bedded male only residential rehabilitation centre, set in 38 acres of Berkshire countryside near Reading. The service is a charity organisation operating under the provider Yeldall Christian Centres. It received referrals from local authorities across the UK and also self-funded clients. The provider had set up a bursary fund for people unable to secure local authority funding and could support and average of two to three people on the programme.
- The service provided opiate detoxification using methadone, alcohol detoxification using diazepam, and a residential rehabilitation programme. Yeldall Manor was registered with the Care Quality Commission to provide the regulated activity 'Accommodation for persons who require treatment for substance misuse'. Within their registration they offered a 24-week first stage programme. Clients were able to move on to the second and third stage programmes that were not required to be registered with the Care Quality Commission where they could access further support and the possibility of supported accommodation, work and training support.
- Yeldall Manor also offered interactive group work, teaching groups and one to one therapy with a trained counsellor. Clients had access to recreation facilities, a work-based programme and additional training opportunities such as help with numeracy, literacy and machine operating.
- As a Christian centre, Yeldall Manor had a religious/ Christian focus and clients were encouraged to attend church as part of their recovery. The service had clear exclusion criteria and did not accept clients who were at particularly high risk or would not find benefit from the structure and ethos of the service.
- We last inspected this service in July 2014. The service met most of the essential standards at that inspection. However, the provider had not ensured that people's care and treatment were planned in a way that would meet people's individual needs and ensure their health and welfare. Where care was planned the instructions to all the staff involved in people's care were not always sufficient to ensure they knew how to provide the appropriate treatment safely and consistently as people's needs changed. We found that the service had partially addressed some of these key issues. The provider acknowledged that there was more work to be done.

Our inspection team

The team that inspected the service comprised CQC inspector David Harvey, (inspection lead), two other CQC inspectors including a pharmacist inspector, one nurse with a background in substance misuse services and an expert by experience. An expert by experience is a person who has personal experience of using, or supporting someone using, substance misuse services.

Why we carried out this inspection

We 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.

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How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- looked at the systems in place for managing medicines. We spoke to staff involved in the governance and administration of medicines, and examined eight people's medicine charts and records
- looked at the quality of the physical environment, and observed how staff were caring for clients
- spoke with four clients
- observed the admission of a new client to the service
- observed a client support group and an autobiographical workshop that were attended by a total of 17 clients
- spoke with the registered manager and the operations manager (Programme Leader)
- spoke with three staff members including one volunteer
- attended and observed a daily planning meeting
- collected feedback using comment cards from two clients
- looked at four care and treatment records
- looked at policies, procedures and other documents relating to the running of the service

What people who use the service say

Clients told us they felt safe despite some challenging behaviours as staff were mostly visible or nearby during the day and most of the night. They felt confident that staff were able to deal with any challenging situations well. Clients told us that staff had good boundaries and were approachable. Clients told us they had more freedom as they progressed through the stages. They liked the recovery focus of the service and that the counselling was in depth. Others mentioned that the 'leave' privileges were a good idea and liked being able to use the bikes at the service to visit external services themselves.

Clients told us they felt able to feedback on the service and were involved in decisions about how the service ran via the weekly client board meeting. Many felt that Yeldall Manor offered a nurturing work-based programme that helped them integrate into society and gain independence.

Some clients felt that the rules in Yeldall Manor were too numerous and restrictive and others felt that the groups offered could be more 'interactive' and varied.

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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 independent standalone substance misuse services.

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

- The provider had a clear 'detoxification client assessment protocol' and the doctor was aware of National Institute for Health and Care Excellence guidelines. However, we did not see evidence that baseline blood tests were being carried out prior to prescribing medicines for detoxification. This meant that the doctor could not identify clients that were at risk of medical complications. This was a breach of a regulation. You can read more about it at the end of this report.
- The medicine management processes in the service were generally safe but there were gaps in process and policy that did not fully assure us that clients would always be kept safe from harm. There was no process in place to report, record, act on or monitor significant events, incidents and near misses in relation to medicines. Blank prescription forms were stored securely in the clinic room but there was no tracking of these to provide assurance that they were all present and accounted for. This was a breach of a regulation. You can read more about it at the end of this report.
- Staff monitored fridge temperatures; however, they did not record a daily temperature. The provider was aware of this and had purchased a new fridge and a system to capture daily minimum and maximum recordings.
- The service kept accurate and consecutive controlled drug records for receipt and supply but these were not in line with national guidance. At the time of the inspection there were no controlled drugs held and the provider had since introduced a register to manage the receipt and supply of controlled drugs.
- We did not see any entries in the medical notes to show that informed consent had been obtained for medicine that was prescribed off-label; medicine prescribed to treat something other than it was licensed for. However, the provider told us they were actively improving the medical assessment forms.
- The provider told us that they supported clients to access blood borne virus (BBV) testing via the sexual health clinic at the local acute hospital. However, none of the care records we looked at mentioned that staff had discussed this option with clients.

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- There were no infection control audits undertaken and the new clinic room was not connected to running water. The facilities manager was on leave and we were not given a date for when this would be addressed by but the provider recognised this was a high priority. These were breaches of a regulation. You can read more about it at the end of this report.
- Clients were risk assessed prior to admission to Yeldall Manor. However, the risk assessment was not updated or reviewed at any point while the client was under the care of the service. This was a breach of a regulation. You can read more about it at the end of this report.
- Yeldall Manor did not have an incident reporting policy or procedure and staff recorded incidents in a generic incident diary but not elsewhere. This meant that past incidents could be forgotten about with no process to enable the sharing of learning from incidents. This was a breach of a regulation. You can read more about it at the end of this report. There were no serious incidents reported by the provider during the previous 12 months.
- The provider did not have a process in place to separately record or monitor any safeguarding concerns or referrals. Safeguarding information was contained within the client's care records that were not readily accessible to all staff. This was a breach of a regulation. You can read more about it at the end of this report.
- The building and grounds had a number of ligature risks throughout. The provider's ligature risk assessment identified what they would do to minimise the risks to clients and did not accept clients who had attempted suicide in the previous six months. However, as clients' risks assessments were not reviewed or updated on an on-going basis, there was the possibility that an emergence of suicidal intention would not be recorded in a way that would be readily accessible to other members of the team.
- The range of mandatory training on offer was limited and the provider acknowledged that this was an area for improvement. However, all staff had completed a minimum of safeguarding level one training and all staff in non-desk based roles had received first aid training, with a named first aider on site. Staff who had access to medicines had completed a level two safe handling of medicines course.

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

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- The staff audited the quantities of medicines on a regular basis and had good processes to account for all medicines on site. Staff recorded essential information about the client such as allergies to medicines. There was good staff awareness of and monitoring of withdrawal symptoms.
- The provider reported that there were no safeguarding incidents over the past 12 months. Staff had an awareness of safeguarding and knew how to escalate any concerns. There were operational policies in place for identifying safeguarding adults and children at risk.
- We saw that the provider implemented weekly and monthly checks on the environment and fire systems, such as fire doors, alarms and extinguishers and a maintenance schedule was in place. There was a health and safety code of practice in place and this included a protocol for children visiting the site. The provider had a policy and procedure in place that included the requirement of regular checks and the booking in of children when on site.
- The provider had a duty system with four senior managers rostered to be on call 24 hours, seven days a week outside of working hours and the prescribing doctor was available 24 hours. Staff were able to identify who to contact in the event of urgent client need or an emergency.
- All of the staff and volunteers at Yeldall had Disclosure and Barring Service (DBS) checks or the relevant national criminal records checks appropriate for their country of origin.
- Volunteers had the opportunity to undertake the same training as substantive staff and were 'shadowed' by a substantive staff member for approximately three to six months before they were left alone with clients.
- Yeldall Manor had a duty of candour policy in place that listed the action staff should take with an emphasis on the need to remain open and transparent.

Are services effective?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- The prescribing doctor had a good awareness of National Institute for Health and Care Excellence (NICE) guidelines and was able to give a verbal rationale regarding the choice of medicines prescribed. The doctor at the service prescribed medicines approved by NICE for reduction from opiates.
- Medicines administration records contained observation sheets and the provider was using a formal measure of withdrawal

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symptoms; the clinical institute withdrawal assessment of alcohol score (CIWA-Ar) and the Clinical Opiate Withdrawal Scale (COWS) to measure symptoms for opiate withdrawals over a period of time.

- Staff used the TOPs (treatment outcome profiles) tool to measure change and progress in key areas of a client who used the service's life such as substance use, mood, crime, social life and health.
- All assessments of a client's physical and mental health were undertaken pre-admission to Yeldall Manor. As the service did not employ mental health professionals, it did not accept clients with severe or complex mental health problems. Staff followed the pathway for referring clients to local mental health or crisis services.
- All of the client notes we saw demonstrated the use of recognised tools such as Severity of Alcohol Questionnaire. All of the notes we looked at showed evidence of consent to treatment, sharing of information and confidentiality agreement. All of the care plans were present and reviewed regularly.
- The service had a clear exclusion criteria and did not accept clients who were at particularly high risk or would not find benefit from the structure and ethos of the service. The exclusion decisions were in place to ensure client safety. Yeldall Manor could refer patients within the 'Choices Loop', a group of 15 similar services offering substance misuse support.
- The service provided a work based programme and training for clients. Clients had the opportunity to be trained then interviewed by staff for jobs within Yeldall Manor. Clients had access to 1:1 counselling sessions with either a registered or trainee counsellor in house.
- The provider had updated their supervision policy, provided training for all line managers and had audited the supervision of staff. The audit showed that all staff were receiving supervision in line with the policy.
- Staff felt supported by senior management and had opportunities to discuss issues within team meetings.
- Yeldall Manor compared favourably to other similar services in England for not allowing clients to wait more than six weeks for admission, according to data from the National Drug Treatment Monitoring System.

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

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- None of the four clinical records we looked at showed evidence of a prescribing rationale, regular medical reviews or care reviews with the rest of the team. However, the doctor attended multidisciplinary meetings to discuss clients when required.
- The percentage of staff who had received an appraisal in the previous 12 months was 64%. Senior managers had audited this and were in the process of making changes to the appraisal system.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Clients told us they were treated with compassion, respect and kindness.
- The majority of clients had positive feedback about the service and their opportunity to influence change.
- We observed two groups that were well facilitated, safe and supportive.
- The timetable of activities included leisure and shopping trips, groups, work therapy and cleaning activities. Staff and clients completed a run to raise money for a client holiday to Wales. Staff and clients saw this as a very positive experience and felt it boosted morale.
- We observed the induction of new client during our visit and saw that staff were warm and empathic in their approach. Staff provided clients with information and a fellow client provided peer support to help them settle in during the first week.
- Keyworkers completed care plans with the client and clients told us they had a copy of their care plan.

Are services responsive?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- The provider offered a bursary for those who could not get local authority funding and was exploring a new way of funding such as 'Social Impact Bonds' that the provider hoped would make them more responsive to client's needs.
- There were 82% of clients who were currently not using substances a year after completion.
- Clients told us they felt comfortable in the environment. There was lots of space and a number of rooms to allow clients the option of more quiet time if needed. There were a range of leisure options for clients to access.

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- Clients were encouraged to engage with recovery groups, there were posters on walls advertising these and external groups were hosted on site. Clients felt able to speak in confidence with fellow peers or members of staff.
- Clients told us they knew how to complain and this was included in the client's handbook on admission. There was an operational policy for the complaints procedure. The provider used a spread sheet to monitor and follow up formal complaints. However, as the level of formal complaints was low, the service was also working on a new system for capturing lower level complaints.

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

- Clients told us they would have liked a wider range of activities and groups and suggestions included mindfulness and reading groups. Senior management were aware of the feedback on groups and planned to explore the group structure further.

Are services well-led?

We do not currently rate standalone substance misuse services.

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

- There was a lack of governance to ensure that policies and procedures were in place to safeguard and manage changing client risks. There was no process in place to record, monitor and learn from incidents or safeguarding concerns.
- Record keeping was paper based and structured in a way that made it difficult for staff to access client records or key risk information as different parts of the record were located in different parts of the building that only certain staff members had access to.
- The medicine management processes in the service were generally safe but there were gaps in process and policy that did not fully assure us that clients would always be kept safe from harm.
- There was a lack of audits undertaken which senior management acknowledged. The service told us that there had been three audits within the previous six months.

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

- Senior management had a good grasp of what changes were needed and had started addressing some of these concerns. They demonstrated a willingness to work with the Care Quality Commission to improve standards.

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- The chief executive was also the registered manager for the service and felt confident to raise issues with the board of trustees.
- The provider reported a low rate of total permanent staff sickness 2% overall and a substantive staff turnover of 16%.
- All of the staff and volunteers at Yeldall had Disclosure and Barring Service (DBS) checks or the relevant national criminal records checks appropriate for their country of origin.
- Staff described the team as 'happy' with good staff support and senior management support. Staff described it as one of the better places they have worked. There was a whistleblowing policy in place.

Detailed findings from this inspection

Mental Health Act responsibilities

- The service was not registered to accept clients detained under the Mental Health Act. If a client's mental health were to deteriorate, staff were aware of who to contact and would follow the pathway for referral to the local mental health teams and crisis teams.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Yeldall Manor provided training in the Mental Capacity Act through electronic learning. Senior managers had received additional training and acknowledged that further training for staff was required. All staff, with the exception of kitchen and garden based staff, and desk-based non-therapeutic staff had completed bespoke in-house training on the Mental Capacity Act.
- Staff recorded initial consent to sharing information with others. They checked clients' understanding of their treatment on admission and capacity was presumed. Staff could describe what action they would take if a client's situation changed.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

- Yeldall Manor is a large building dating back to the 1890s set in large, well-maintained grounds. Most of the furnishings appeared to be in good repair and all areas were clean. Clients assisted with the cleaning of the building. The building's structure meant that access for clients with physical disabilities was limited. Therefore, the service did not accept clients whose physical disabilities were severe enough to mean they would not be able to access all parts of the building or engage in work-based activities.
- The provider had recently installed a new clinic room that was clean and well organised with individual drawers for each client's medicine charts. However, there was no running water connected to either the water supply or waste disposal and staff were not able to tell us the date the water would be connected by. This meant that staff could not wash their hands in the clinic room. A water cooler, plastic cups and mugs were available in the dining room next to the clinic room, and it was expected that clients would bring water to the clinic room to take medication. The provider told us that they were working to get the sink connected quickly and that it was a high priority. There were no hand sanitisers in the clinic room but staff wore gloves when administering medicine.
- Staff used the 999 service in the event of an emergency, as they had not been trained to use emergency medicines, such as Naloxone. Naloxone is an emergency medicine used to treat an opioid overdose. However, the provider did not accept high risk clients who were likely to require this intervention. Crisis procedures were clearly displayed in the medicine room in relation to alcohol detoxification, alcohol withdrawal symptoms and deteriorating mental health.
- We did not see an environmental risk register but the provider had implemented weekly and monthly checks on the environment and fire systems, such as fire doors, alarms and extinguishers and a maintenance schedule was in place.
- The building and grounds had a number of ligature risks throughout. The provider's ligature risk assessment identified where the potential ligature risks were and what level of risk they presented. The ligature risk assessment also identified what they would do if a client's risk changed and included contacting the local mental health crisis service. Potential risks were also managed in part by the provider's exclusion criteria of not accepting a client who had attempted suicide in the previous six months. However, as clients' risks assessments were not reviewed or updated on an on-going basis, there was the possibility that an emergence of suicidal intention would not be recorded in a way that would be readily accessible to other members of the team.
- There was a health and safety code of practice in place listing key operations and aspects of safety for using machinery, electrical equipment and personal protective equipment. Work activities for clients were subject to risk assessments and training was given in the safe use of tools, work equipment and machinery. The facilities manager oversaw health and safety on site with the support of an external Health & Safety consultant. The provider kept accident reports for accidents and injuries around the site. The service was undertaking a review of all health and safety policies to ensure that their policies and practice were aligned.

- The health and safety code of practice included a protocol for children visiting the site. A responsible adult was required to accompany children at all times. The provider had a policy and procedure in place that included the requirement of regular checks and the booking in of children when on site.

Safe staffing

- Yeldall Manor had 27 substantive staff, five volunteers and 16% turnover of all substantive staff leavers. There were 4% whole time equivalent vacancies and an overall sickness rate of 2%.
- The provider did not employ nurses so support workers and non-clinical staff administered medicines to the clients. All staff administering medicines recently received training on the safe use of medicines but the service could not demonstrate evidence of a robust system for assuring staff competence. However, there was a plan to introduce a system of competency certificates.
- The provider had a duty system with four senior managers rostered to be on call 24 hours, seven days a week outside of working hours and no more than an hour away. The prescribing doctor was available 24 hours. Staff were able to identify who to contact in the event of urgent client need or an emergency; GP or 999.
- There were staff on duty 24 hours per day, seven days a week with sleeping night cover and a senior member of staff "on call" at all times. Staff members held dual roles, such as keyworker and medicine lead and staff would cover each other's work in the event of staff sickness or leave. Senior management adjusted staff levels according to specific need, for example at busy times of day, if a client's detoxification posed an increased risk or when certain groups took place. The provider did not accept clients who were likely to require an inpatient detoxification.
- The provider told us that volunteers were 'shadowed' by a substantive staff member for approximately three to six months before they were left alone with clients. We checked six staff files and all had Disclosure and Barring Service (DBS) checks in place. All of the staff and volunteers at Yeldall had DBS checks or the relevant national criminal records checks appropriate for their country of origin.
- The range of mandatory training on offer was limited and the provider acknowledged that this was an area for improvement. However, all staff had completed a minimum of safeguarding level one training and all staff in non-desk based roles had received first aid training, with a named first aider on site. Staff who had access to medicines had completed a level two safe handling of medicines course. There was also e-learning available for staff in relation to infection prevention and control and mental capacity act essentials. Volunteers had the opportunity to undertake the same training as substantive staff.
- The provider had an operational policy for 'aggression towards staff' that referred to the need for training; however, there was no management or prevention of violence or aggression training in place.

Assessing and managing risk to clients and staff

- The gates to the Yeldall Manor estate were locked each night to make unauthorised access difficult.
- The provider had a clear 'detoxification client assessment protocol'. The doctor assessed clients on pre-admission with a full assessment within 24 hours, where possible to assess their appropriateness for alcohol detox. However, we did not see evidence that baseline blood tests were not being carried out prior to prescribing medicines for detoxification. There was no evidence of recent toxicology reports therefore the doctor could not identify patients that were at risk of medical complications or people who were not suitable for residential detox in the clinic.
- The staff audited the quantities of medicines on a regular basis and had good processes to account for all medicines on site.All the medicines we checked were stored securely, however we found one vial of adrenaline that was out of date. When we discussed this with the provider, they told us that they were going to amend their emergency medicines audit and checking form to include the expiry date of the medicines to prevent the mistake happening again.
- The provider generally stored medicines securely and safely. Staff monitored the temperatures of the two domestic fridges that were used for storing medicine. However, they did not record a daily maximum and minimum temperature to assure themselves that medicines that required refrigeration were always

stored at the correct temperatures. We saw that both fridges were just outside of the recommended temperature range of 2°C and 8°C for storing medicines. The provider was aware of this and had purchased a new fridge and a system to capture daily minimum and maximum recordings. There was equipment in place to monitor a client's weight, heart rate and blood pressure.

- Staff recorded medicine incidents in an incident diary and these were usually resolved very quickly. However, there was no formal assessment or review of incidents to identify trends or patterns. The provider did not conduct any specific medicines audit such as completion of medicine charts or prescribing. They had not notified the CQC of any medicine incidents.
- The provider had started a system to ensure that at least one member of staff was on medicine duty during the day who had been trained in 'Care of Medication' and were up to date with this training. Staff recorded essential information about the client such as allergies to medicines and had good awareness of and monitoring of withdrawal symptoms. There were clear thresholds for withdrawal so staff were aware that they could contact the doctor if clients required extra medicines such as diazepam, vitamins, acamprosate or thiamine.
- The medicine management processes in the service were generally safe but there were gaps in process and policy that did not fully assure us that clients would always be kept safe from harm. The service had a psychotropic medicines and operational medicines policy both written in 2015, but these did not include any prescribing policy or protocols. The provider had already identified that the medicines policy was out of date and was taking action to update it.
- The prescribers were using prescribing regimes as part of the detox programme that were tailored to the individuals' clinical needs. Staff used a two-way check against the dispensed medicines to ensure the medicine charts were correct but did not check this against the original prescription, which they held copies of. The provider told us they were going to introduce a three-way check: medicine chart-medicine-prescription to ensure that medicines were administered correctly.
- The doctor did not check or sign the medicine charts; the medicine policy did not include the need for this to happen and presented a potential risk of administration errors. However, we did not see any examples where the medicine chart did not match the doctor's original prescription. There were a number of times when missed doses were not explained but they had been noted and the provider had implemented an additional daily check for those medicines that were deemed critical.
- The service occasionally used medicine outside of its marketing authorisation to address other symptoms. We did not see any comment in the notes on how informed consent had been obtained for this or any medicine that was prescribed outside of its marketing authorisation. The provider told us they were actively improving the medical assessment forms.
- Access to methadone was via supervised consumption in the pharmacy. The prescriber preferred the use of methadone instead of buprenorphine and would only consider changing to buprenorphine if the client was already taking this. The reason for this decision was the possibility of the medicine change causing discomfort to the client. The service used diazepam for alcohol detoxification as they had experienced difficulties obtaining chlordiazepoxide; another medicine used in alcohol detoxification. Prior to administering diazepam, the doctor checked the client's withdrawal state and took the client's blood pressure and heart rate.
- The service prescribed medicines for clients to be taken 'as and when required'. The clinic used a basic tool to decide when to administer "when required" medicines but these were not supported by protocols, which the provider had already identified as a requirement. They did not contain sufficient detail for the staff to be able to make decisions about how to safely administer the as required medicines, for example, how long to leave between doses or if it was safe to administer certain medicines together. We were told and we saw that the staff would check previous administration to ensure clients were not over using any medicine or if they needed to be seen by a doctor.
- There was also a system of administering homely remedies to clients. Homely remedies is another name for a non-prescription medicine that is available over

the counter in community pharmacies.These were delivered in the same way as "when required" medicines, but there was no protocol or policy to support their supply to clients.

- Blank prescription forms were stored securely in the clinic room but there was no tracking of these to provide assurance that they were all present and accounted for.
- The service kept accurate and consecutive controlled drug records for receipt and supply but these were not in line with national guidance. At the time of the inspection there were no controlled drugs held. The provider has now introduced a register to manage the receipt and supply of controlled drugs.
- Prior to and during a client's admission to the service, the in house admission team requested key risk information externally and completed a risk assessment. However, the risk assessment was not updated or reviewed at any point while the client was under the care of the service. This meant that any escalation in risk was not recorded in a way that would make key information readily accessible to other staff members. Staff and senior managers told us they were all aware of the risks to clients and discussed these in the daily team meetings and in supervision.
- There were no risk assessments in place for clients going on weekend leave or risk management plans for unexpected treatment exit. Senior managers told us that they would assess the client's request to leave the service early and would attempt to manage the process. This included listening to the reasons the client wanted to leave and discussing the options. If the client still wanted to leave, the service completed a checklist and a premature leavers' form and the service would attempt to ensure the client had alternative options such as housing and access to other services.
- The paper based client records were split up and kept in three or four locations across the building. Therefore, key information would not be readily accessible to other staff members. Counsellors worked with clients as the main keyworker. The counsellors kept their notes in locked cupboards to which they kept the key. We requested to see three sets of client notes but senior staff were only able to locate one of these. The provider told us that counsellor notes were confidential and therefore kept separately to the other parts of the client file. There was no system to record daily progress such as progress towards recovery, activities attended or whether there had been family contact. The counselling notes we looked at varied in style but did not reference the client's care plan or the key risks.
- The provider told us that they supported clients to access blood borne virus (BBV) testing via the sexual health clinic at the local acute hospital. We saw that the service recommended testing for BBV in the client handbook that clients received on admission. However, none of the four care records we looked at mentioned that this option had been discussed with clients.
- A local pharmacy supplied medicines to named clients. We saw a medicine log for all medicines received in to the clinic and for medicines returned to the pharmacy or clients. These entries were signed by two people. The pharmacy took back unwanted medicines and medicines were not disposed of locally. The pharmacy also supplied methadone to patients daily for supervised consumption at their premises except for Sundays and Bank Holidays, when these doses were held by the provider and consumption was supervised.
- Drug urine testing was carried out in the toilet room and stored safely, however there was limited privacy as the toilet room door was not expected to be locked during testing. This was in line with the service's expectations of openness and honesty as part of the contract they held with clients. The service used multi-test kits but if the test showed as positive then a single test kit would be used.
- There were random and regular drug and alcohol tests, as well as room searches if necessary to ensure that the house remains drug and alcohol free and safe for clients in their recovery.
- The provider reported that there were no safeguarding incidents within the service over the past 12 months. Staff had an awareness of safeguarding and was trained to at least level one in safeguarding. Staff knew the process for escalating any safeguarding concerns and senior managers had developed a good working relationship with the adult safeguarding board at the local authority who provided staff training. There were operational policies in place for safeguarding adults and children at risk and staff had good awareness of these.

Substance misuse services

- The provider did not have a process in place to separately record or monitor any safeguarding concerns or referrals. Safeguarding information was held within the client's care records that were not readily accessible to all staff. Safeguarding was not a standing item on the team meeting agenda; however, staff told us they felt confident to discuss any safeguarding concerns at each meeting.

Track record on safety

- There were no serious incidents reported by the provider during the previous 12 months.

Reporting incidents and learning from when things go wrong

- Yeldall Manor did not have an incident reporting policy; incidents were verbally discussed at team meeting each morning then recorded in a generic 'incident diary'. The incident diary also included general diary entries for each day such as whether clients participated in groups or how they spent their time. Incidents were not recorded elsewhere or followed up which meant that they could be forgotten or missed. This also meant that there was no process in place for the service to learn from past incidents.
- Senior managers told us that they reinforced the correct protocol during daily team meetings and took any issues of concern to the monthly team therapeutic meeting (a forum in which all keyworkers could discuss the progress of clients and look at objectives). The provider recognised that incident reporting was a requirement and they had already requested tools and training to implement correct incident reporting procedures.

Duty of candour

- Duty of candour is a legal requirement that means providers must be open and transparent with clients about their care and treatment. This includes the duty to be honest with clients when something goes wrong. Yeldall Manor had a duty of candour policy that listed the actions staff would be expected to take with an emphasis on the need to remain open and transparent.

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

Assessment of needs and planning of care

- The independently contracted doctor made the prescribing decisions but although this followed national guidance, the provider did not have a process to assure them that the prescribing was safe for people that used the service. None of the four records we looked at showed evidence of a prescribing rationale, regular medical review or care reviews with the rest of the team. However, the provider's exclusion policy meant that only low risk or stable clients were accepted for treatment with the service. The doctor was trained in substance misuse and attended multidisciplinary meetings to discuss clients when required.
- Individual clients were regularly reviewed and every attempt was made to obtain previous medical history including medicines use. Medicines administration records contained observation sheets and the provider was using a formal measure of withdrawal symptoms; the clinical institute withdrawal assessment of alcohol score (CIWA-Ar).
- All assessments of a client's physical state were undertaken preadmission to Yeldall Manor and the service requested information relating to clients' physical health. Only clients undergoing detoxification received a full physical health assessment on admission and received on-going physical care. Yeldall Manor supported clients to get registered with the same local GP within 48 hours of admission. Clients we spoke with told us they felt able to get a doctor's appointment within 24 hours and that staff adequately monitored their physical health in between times. All clients had the option to register with a local dentist.
- All assessments of a client's mental health were undertaken preadmission to Yeldall Manor and the service requested information from the client's GP regarding the client's mental health. As the service did not employ mental health professionals, it would not accept clients who had severe or complex mental health problems. The service monitored a client's mental health needs and followed the pathway for referring clients to local mental health or crisis services and clients had access to appropriate medicine.

- All of the care plans were present and reviewed regularly. Three of four were personalised and holistic however none were recovery oriented in that they did not refer to client strengths or recovery capital. Recovery capital focuses on the individual resources (social, physical, human and cultural), which are necessary to begin and maintain recovery from substance use, abuse, and dependence.

Best practice in treatment and care

- The prescribing doctor had a good awareness of National Institute for Health and Care Excellence (NICE) guidelines and was able to give a verbal rationale regarding the choice of medicines prescribed. The doctor at the service prescribed medicines approved by NICE for reduction from opiates. We saw two examples of prescribing for alcohol withdrawal and one for opiate detoxification and the medicines prescribed were in line with national guidelines and there was a Clinical Opiate Withdrawal Scale in use for measuring symptoms for opiate withdrawals over a period of time.
- The service completed a check count of medicines but pharmacy did not audit medicines at Yeldall Manor. The provider acknowledged that there was a general lack of audits and they planned to address this. The service did not undertake a record keeping audit. Staff used the TOPs (treatment outcome profiles) tool to measure change and progress in key areas of a client who used the service's life such as substance use, mood, crime, social life and health. A supervision audit was carried out regarding the frequency of supervision and showed that all staff were receiving supervision in line with the supervision policy.
- Observations sheets were held with medicines administration records and the provider used a formal measure of withdrawal symptoms i.e. CIWA-Ar. This is a ten-item scale used in the assessment and management of alcohol withdrawal. All of the client clinical notes we saw demonstrated the use of recognised tools such as Severity of Alcohol Questionnaire. There was a list of dates at the front of each set of care notes listed the client's progress through the programme. All of the notes showed evidence of consent to treatment, sharing of information and a confidentiality agreement.
- The service provided a work based programme and training for clients. Clients had the opportunity to be interviewed and then trained by staff for jobs within the service, such as machine operators, kitchen staff (with cooking overseen by employed chef), estate and grounds work.
- Staff offered smoking cessation advice but staff respected clients' individual choice.
- Clients had access to 1:1 counselling sessions with either a registered or trainee counsellor and 'The Counselling Ethical Framework' supported care in the therapeutic aspects of the programme.

Skilled staff to deliver care

- The prescribing doctor had been revalidated, had received an annual appraisal and had Royal College of General Practitioners certificates (part 1) for 'alcohol and drug management'. The doctor had provided in-house detoxification awareness training to the rest of the team.
- Keyworkers in the service included trainee counsellors or counsellors with a diploma in counselling and accredited with the British Association for Counselling and Psychotherapy (BACP). The service stated that it used the BACP framework but was able to adapt to individual client need. The service was also accredited with the Association of Christian Counsellors. The counsellors had a weekly counselling supervision meeting for counsellors to explore best practice. They took part in the monthly 'therapeutic' team meeting; a forum where all keyworkers discussed the progress of clients and look at objectives. Counsellors also offered internal training to staff members.
- Nine staff had had completed a 'working with addictive behaviours' course endorsed by the Open College Network.
- External coaching in leadership for senior managers was available and they had attended a global leadership summit.
- The percentage of staff who had received an appraisal in the previous 12 months was 64%. Senior managers were addressing this and had rolled out a new appraisal form to make the process more efficient. The provider had updated their supervision policy, provided training for all line managers and had audited the supervision of staff. The audit showed that all staff were receiving

supervision in line with the supervision policy. Staff told us that supervision was emotionally and practically supportive and they felt able to raise concerns in supervision or at team meetings. This included raising issues at the monthly therapeutic team meeting; a meeting for all keyworkers to discuss the progress of clients and look at objectives. Staff felt supported by senior management.

Multidisciplinary and inter-agency team work

- The service had links with local mental health and crisis teams with a clear pathway of referral displayed for staff to follow. If a client was already under the care of local mental health services, Yeldall Manor would endeavour to maintain joint working. The service also had links with the local GPs and pharmacies, the probation service, the local authority and local Narcotics Anonymous and Alcoholics Anonymous services. The provider worked closely with substance misuse services in the local area.

Good practice in applying the Mental Capacity Act

- Yeldall Manor provided training in the Mental Capacity Act through electronic learning. Senior managers had received additional training and acknowledged that further training for staff was required. All staff, with the exception of kitchen and garden based staff, and desk-based non-therapeutic staff had completed bespoke in-house training on the Mental Capacity Act.
- Staff recorded initial consent to sharing information with others. Staff checked clients' understanding of their treatment on admission but did not document this as on-going in all clinical records. However, staff could describe what action they would take if a client's situation changed.

Adherence to the Mental Health Act

- The service was not registered to accept clients detained under the Mental Health Act. If a client's mental health were to deteriorate, staff were aware of who to contact and had links with local mental health services, including crisis intervention teams.

Equality and human rights

- There was no staff training in equality and human rights. However, the provider had recent operational policies on Diversity and Anti-Discrimination and Equal Opportunities.

Management of transition arrangements, referral and discharge

- The internal admissions team were responsible for gathering risk information and compiling a risk assessment for new clients. The service made their exclusion criteria clear and did not accept clients who were at particularly high risk or would not find benefit from the structure and ethos of the service.
- The exclusion decisions were in place to ensure client safety. Yeldall Manor was part of a 'Choices Loop', a group of 15 similar services offering substance misuse support. If a client's needs fell outside of Yeldall Manor's remit, or the service felt that the client would benefit more from being placed elsewhere, the Choices Loop offered alternative options.
- The service accepted referrals from local authorities across the country as well as self-referrals from clients already known within the local community and within local churches. Some clients had used the service on numerous occasions.
- According to data from the National Drug Treatment Monitoring System (NDTMS), Yeldall Manor compared favourably to other similar services in England for not allowing clients' to wait more than six weeks for admission.

Are substance misuse services caring?

Kindness, dignity, respect and support

- Clients told us they were treated with compassion, respect and kindness.
- We observed an 'autobiography group' where clients are given the opportunity to look back over their life and give an account of their story. The group was safe and supportive to assist clients with emotions that writing an autobiography can explore. We also observed and a client support group which focussed on peer support and advice, with open and mutually supportive discussion about individual fears and the sharing of ideas around work and volunteering.

- New clients were allocated a fellow client as a peer to show them around and help them settle in during the first week. Clients were required to sign a contract on admission and clients were given information about what would be expected of them during their time at the service.

The involvement of clients in the care they receive

- The provider offered a work based programme and the opportunity of training for clients. Clients had the opportunity to be interviewed and then trained by staff for jobs within the service, such as machine operators, kitchen staff (with cooking overseen by an employed chef), estate and grounds work.
- The timetable of activities included leisure and shopping trips, groups, work therapy and cleaning activities. The service was structured to include three work-based days and the remaining days were designated as leisure days or group days.
- Staff and clients had jointly completed a run to raise money for a client holiday to Wales. Staff and clients saw this as a very positive experience and felt it boosted morale.
- The majority of clients and staff had positive feedback about the service and their opportunity to influence change.
- There was a weekly client board meeting to raise issues and ideas and the chair of this attends the staff team meeting to feedback. The service encouraged four and 16 week feedback from clients in the form of a questionnaire. A recent analysis of feedback received at four weeks showed that showed that the highest scores were in the welcome clients received from staff and other clients. The lowest scores were around a lack of information about what to bring and a lack of contact with people outside Yeldall Manor.
- The service provided examples of changes that were implemented directly because of client feedback that included increased telephone calls in the first two weeks of the programme. Clients had told staff that they would like to see more groups and more variety in these groups, so the service had arranged and delivered 'group facilitation' training for therapeutic staff and were reviewing the types of groups on offer.
- Family visits and telephone contact was encouraged by service with the option in place for family or friends to join clients for meals. If appropriate, clients were able to bring a family member into their counselling session. The service could arrange special visiting arrangements for clients' families where supervised visits were necessary.
- Keyworkers completed care plans with the client and clients told us they had a copy of their care plan.
- We observed the induction of a new client during our visit and saw that the client was encouraged to talk openly and staff demonstrated warmth and empathy in their approach. Clients were given a pack on admission that included a handbook with information on the service's culture and ethos, the complaints procedure and what the programme would offer. The
- The service did not routinely support clients to access external advocacy; clients had the option of talking to ex-clients and staff, as well as a community psychiatric nurse if under mental health services. Clients were encouraged to self-advocate with support from staff. A number of staff had been through the recovery programme at Yeldall themselves.

Are substance misuse services responsive to people's needs?

(for example, to feedback?)

Access and discharge

- The provider submitted the details of 18 referrers and stakeholders. The service received a mixture of referrals from local authorities UK wide and self-funders who were known to the service through local communities or local churches. The provider offered a bursary for those who could not get local authority funding and was exploring 'Social Impact Bonds'; a new way of funding that the provider hoped would make them more responsive to client's needs. 'Social Impact Bonds' were intended to help the service assist clients to achieve specific agreed outcomes rather than use the time-limited approach.
- There were 82% of clients who were currently not using substances a year after completion. There were a total of 61 substance misuse clients discharged from the

service in the previous 12 months. A total of 43 (70%) of these clients were followed up within seven days of discharge. One client did not come for treatment in the previous 12 months.

- The second and third phases of the programme were available for clients where appropriate following completion of the first phase at Yeldall Manor. The second and third phases were not required to be registered with the Care Quality Commission. These further phases enabled clients to gain increased independence, with support for accommodation, volunteering, work and access to benefits where applicable. Yeldall Manor had capacity for 24 clients in the first stage however there were 19 clients when we visited.

The facilities promote recovery, comfort, dignity and confidentiality

- Clients told us they felt comfortable in the environment. There was lots of space and a number of rooms to allow clients the option of more quiet time if needed. There was a fellowship lounge for prayer and fellowship meetings, two TV rooms and a number of group rooms. Clients had access to a range of internal and external activities that included the use of games consoles, musical instruments, a pool table, table tennis, an outdoor swimming pool, a tennis/badminton court, a football pitch and a gym. However, clients told us that the outdoor swimming pool was broken.
- Clients told us they would have liked a wider range of activities and groups and suggestions included mindfulness and reading groups. Senior management were aware of the feedback on groups and planned to explore the group structure further.
- Clients were encouraged to engage with recovery groups, there were posters on walls advertising these and external groups were hosted on site. Clients felt able to speak in confidence with fellow peers or members of staff.
- Yeldall Manor imposed restrictions to privacy that aligned with the service's ethos and programme. The clients' handbook on admission referred to these and clients signed a contract on admission. There were three telephones in public areas of the building with the agreement that clients told staff who they were going to call. Mobile phones were not permitted and access to television and the internet were restricted in the initial phase of the programme. Bedroom doors were left unlocked and personal possessions kept in a locked drawer in main office. The toilet door was left unlocked when clients were required to provide urine samples. Staff told us that clients could personalise their bedrooms as long as this remained within the ethos of the service.

Meeting the needs of all clients

- Yeldall Manor offered a male only Christian based programme with an emphasis on engaging with God and the church with a requirement to attend. Clients signed a contract on admission. The service incorporated an 'infringement system' that clients could read about in the handbook on admission. The infringement system functioned by means of staff giving clients a chit (a slip of paper with written details of an infringement) if a house rule or condition of residence was broken. There was a maximum number of chits allowed before the service implemented disciplinary action that could lead to dismissal. Clients had the opportunity to contest chits.
- The service's exclusion criteria excluded clients who might have difficulty understanding or speaking English and clients with severe physical or mental health difficulties. The provider required clients to attend church as part of recovery process. The provider stated that people from all faiths were welcome and the majority of clients that went to Yeldall Manor were non-Christians but that it was unusual for strong adherents to other religions to want to go to Yeldall Manor, given the service's Christian ethos. The service did not have access to information in different languages and the kitchen was not set up for separate food preparation to enable them to provide halal or kosher diets. The building's structure meant that access for clients with physical disabilities was limited and all clients would be expected to be able to participate in the service's work-based programme.
- The provider told us that occasionally rules could be flexible to accommodate a client's individual circumstances and gave us an example of when they allowed extra family visits above the usual entitlement for a client who needed to talk through issues with his with family.

- Clients had access to additional training opportunities such as help with numeracy, literacy and machine operating.

Listening to and learning from concerns and complaints

- Two formal complaints had been made in the previous 12 months; one was resolved and one was still on-going. Neither of these had been referred to the Parliamentary and Health Service Ombudsman (PHSO). We saw that one complaint was about a staff member's attitude and lack of empathy around a client's personal health issues.
- The provider used a spread sheet to monitor and follow up formal complaints. However, as the level of formal complaints was low, the service was also working on a new system for capturing lower level complaints. Senior managers told us that any complaints mentioned in the clients' feedback questionnaire were logged, investigated and discussed in team meetings. There was an operational policy for the complaints procedure.
- Clients told us they knew how to make a complaint and this was clearly highlighted in the client's handbook on admission. Staff and clients aware they could share their experience with the Care Quality Commission and this information was displayed in the building.
- The provider stated that they did not keep a record of compliments received

Are substance misuse services well-led?

Vision and values

- As stated in the client handbook, Yeldall Manor's vision was to 'see men set free from addiction and living a new life in Christ'. The service's mission was also clearly stated in the handbook; 'to glorify God through offering healing, wholeness and hope to men with drug and alcohol problems'.
- Staff we spoke to identified strongly with the vision and mission of the service. However, staff told us that the service did not force religion upon the clients. The provider stated that the ethos of the programme was the principle that people have care needs, security needs as well as significance and worth. The provider hoped to stabilise clients by meeting their needs and introducing boundaries via the structured and disciplined programme.

Good governance

- There was a lack of governance around ensuring policies and procedures were in place to safeguard and manage changing client risks. The service had a safeguarding policy but no incident reporting policy. Incidents and safeguarding were not recorded in a way that ensured that these would be followed up by the service. Learning was not formally shared within the team or documented in a format that could be accessed later.
- Record keeping was structured in a way that made it difficult for staff to access client records. This meant that key risk information was not readily accessible. There were also gaps in how medicine errors were recorded and communicated. However, senior management seemed prepared to be open and transparent and keen to work towards meeting required standards.
- The medicine management processes in the service were generally safe but there were gaps in process and policy that did not fully assure us that clients would always be kept safe from harm.
- There was a lack of audits undertaken which senior management acknowledged. The service told us that there had been three audits within the previous six months. There had been an audit of supervision with regard to the frequency of staff supervision. This audit allowed senior managers to gain better oversight of supervision compliance and the service had also began to make changes to the way appraisals were carried out.
- We last inspected this service in July 2014. The service met most of the essential standards at that inspection. However, the provider had not ensured that people's care and treatment were planned in a way that would meet people's individual needs and ensure their health and welfare. Where care was planned the instructions to all the staff involved in people's care were not always sufficient to ensure they knew how to provide the appropriate treatment safely and consistently as

people's needs changed. We found that the service had partially addressed some of these key issues. The provider acknowledged that there was more work to be done.

- All of the staff and volunteers at Yeldall had Disclosure and Barring Service (DBS) checks or the relevant national criminal records checks appropriate for their country of origin. Home Office guidelines stated that the DBS can't access criminal records held overseas but that an employer may request a criminal records check processed through the DBS as part of its recruitment process.
- The chief executive was also the registered manager and felt confident to raise issues with the board of trustees.
- The service had a risk register for corporate, governance, operational and external risks. The most recent risk register highlighted nine medium governance risks.
- The majority of the senior leadership team, including the chief executive had over 20 years experience in the sector and some senior managers had been through the programme themselves. They engaged with other centres in the sector through networks such as Choices, ISAAC and Recovery Group UK.

Leadership, morale and staff engagement

- The provider held monthly senior leaders meetings, quarterly meeting with line managers and quarterly meetings for all staff.
- There was a whistleblowing policy in place.
- Staff described the team as 'happy' and that they are always there for each other, sharing workloads at busy times or if someone is off sick. Staff told us that senior management also assisted when possible and always checked that staff were managing okay. Staff described it as one of the better places they have worked and that they felt supported by senior management.
- The provider reported a low rate of total permanent staff sickness 2% overall and a substantive staff turnover of 16%.
- Senior managers attended a Global Leadership Summit event in Bracknell in October 2016.

Commitment to quality improvement and innovation

- The service had implemented a bursary for clients unable to self-fund or get access to local authority funding. The service was also exploring 'Social Impact Bonds' which was a payment by results/outcomes based funding. The provider told us that they had engaged with a local substance misuse commissioner regarding this.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must embed processes for reporting, recording, acting on and monitoring significant medicine events, incidents and near misses.
- The provider must ensure all clients are safe to undertake detoxification in line with national guidance, including the taking of baseline blood tests prior to prescribing medicines for detoxification.
- The provider must introduce a system to track blank prescriptions in line with national guidance.
- The provider must ensure that there is running water in the clinic room and that infection prevention and control audits are carried out and recorded to enable staff to learn from the results and make improvements to the service.
- The provider must ensure that there is an incident reporting policy and procedure in place.
- The provider must ensure that there is a procedure to record and monitor safeguarding incidents.
- The provider must ensure that there is a system in place for staff to access client care records when needed.
- The provider must ensure that risk assessments are reviewed and updated after admission.

Action the provider SHOULD take to improve

- The provider should ensure all missed doses on the prescription and administration charts are investigated and recorded. The provider should ensure there is a robust system to check medicine charts are accurate. The provider should ensure that all medicines in stock are in date and safe for use.
- The provider should ensure that there is a system in place to monitor fridge temperatures where medicines are stored.
- The provider should implement audits to review whether prescribing is in line with national guidance including the use of Naloxone.
- The provider should review policies, protocols and procedures relating to safe administration of medicine and prescribing off-label use of medicines to ensure they are all up to date.
- The provider should record all clinical decisions in the clients' care notes.
- The provider should ensure that staff receive regular appraisals.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not embed processes for reporting, recording, acting on and monitoring significant medicine events, incidents and near misses. The provider did not ensure all clients were safe to undertake detoxification in line with national guidance. Prior to commencing a client on detoxification treatment the provider did not ensure routine blood tests were carried out. The provider did not have an incident reporting policy or procedure in place and the recording of incidents was done in a way that meant they could potentially be missed and not escalated. There was no separate procedure in place to record and monitor safeguarding incidents. The provider did not ensure that risk assessments were reviewed or updated after the admission of a client. The provider did not assess the infection control risk. At the time of our inspection there was no water connected to the clinic room which presented a potential infection control risk. Regulation 12 (1), (2) a, b , c, h.

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 17 HSCA (RA) Regulations 2014 Good governance Blank prescription forms were stored securely in the clinic room but there was no tracking of these to provide assurance that they were all present and accounted for.

This section is primarily information for the provider

Requirement notices

The provider did not ensure that there was oversight of record keeping; client care records were split up kept in separate places and were not updated. Not all staff had access to the care records which meant that access to key risk information could be difficult. The provider did not audit record keeping practices.

Regulation 17 (1), (2) c, d, f.