Cranstoun - Trelawn 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:

- At the last inspection in September 2016, we identified that staff were not always completing client's risk information appropriately or in enough detail. During this inspection, we found that the quality of risk assessments and management plans was inconsistent.
- Clients' risk assessments and care plans did not always identify risks associated with clients' physical health. Care plans did not always specify how best to support clients with complex physical health needs.
- After the service had been inspected in September 2016, the provider had undertaken a service risk assessment in response to our findings. However, the provider had not reviewed the service's risk assessment since December 2016.
- The provider had identified a range of formal audits that needed to be undertaken to ensure that the quality and safety of the service was monitored. The provider had not fully implemented the schedule of audits.
- The service was not routinely using early unplanned exit plans for clients. Clients were not being given

Summary of findings

information as to how to minimise the risk of overdose should they decide to leave treatment early. Clients who have recently undergone alcohol or drug detoxification are at increased risk of overdose.

- Staff were not having regular documented supervision. This meant that staff did not have regular monthly one to one support in line with the provider's supervision policy.
- Staff were not routinely monitoring the temperatures in the medicines and food fridges. Staff were not undertaking regular fire drills, routine checks of fire equipment and checks on emergency lighting.
- At the last inspection in September 2016, we found that there were a number of medicine errors in the service that had not been reported or acted upon. During this inspection, we found that there had been 17 medicine errors reported between February 2017 and May 2017. We found that staff had not identified two medicines errors.

However, the service had made some improvements since our last inspection in September 2016. We found the following areas of good practice:

- During the inspection undertaken in September 2016, we found that medicines management was unsafe. Multiple medicine errors had occurred. The service had not assessed staff as competent to dispense medicines. During this inspection, we found that the provider had trained staff in medicines management.
- At the last inspection in September 2016, we noted that staff had a poor understanding of safeguarding adults and children. During this inspection, we found that the provider had trained staff in safeguarding adults and young people. All staff knew how to make safeguarding referrals.
- At the last inspection in September 2016, we found there were low completion rates of mandatory training. During this inspection, we found that the completion rates of mandatory training had improved.
- At the inspection in September 2016, we asked the provider to improve their pre-employment checks. The provider had improved their recruitment processes and there were now procedures in place to ensure that pre-employment checks were completed for new staff.
- When the service was inspected in September 2016, we identified that the provider's governance processes did not ensure the safety and quality of the service. Since that inspection, the provider had reviewed their governance processes. The new processes were not fully embedded at the time of this most recent inspection, though work had begun on this. The provider had begun the process of reviewing their policies to ensure that they were in line with best practice guidance.
- At the last inspection in September 2016, we found that the service was not reporting all incidents that occurred in the service. During this inspection, we found that the service had acted on the findings of the September 2016 inspection. The service was reporting and reviewing all incidents that happened in the service.
- When we inspected the service in September 2016, we identified that clients' care plans were not specific or measurable. During this inspection, we found that the service was introducing new care planning documents. The new plans allowed clients to identify specific measurable goals. The process was not fully embedded at the time of this inspection.
- At the last inspection we found that the staff working in the service did not understand the principles of the Mental Capacity Act. During this inspection, we found that the service had acted on the findings of the September 2016 inspection, and had provided staff with training in the Mental Capacity Act.
- When the service was inspected in September 2016, we found that the service was not clean. During this inspection, we found there was regular cleaning of the service. Staff were monitoring the cleanliness of the service.
- At the last inspection in September 2016, we found that food was being stored incorrectly in the fridge. During this recent inspection, we found that the service was now storing food items on the correct shelves in the fridge.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Substance misuse/ detoxification		Start here...

Summary of findings

Contents

Cranstoun - Trelawn House

Services we looked at
Substance misuse/detoxification;

Summary of this inspection

Background to Cranstoun - Trelawn House

Cranstoun – Trelawn House provides a residential rehabilitation service for people who have substance misuse problems. The service can accommodate 15 clients. At the time of our inspection, there were nine clients in the service.

The service received referrals from statutory agencies from inside and outside of London. Different local authorities funded clients in the service on an individual client basis.

Cranstoun – Trelawn House is registered to provide:

Accommodation for persons who require treatment for substance misuse.

There was a registered manager in post at the time of the inspection.

The service was last inspected between the 20 and 22 September 2016. The inspection in September 2016 was an announced comprehensive inspection and part of our national programme of inspections. We found that there were concerns about the safety of the service and issued four warning notices. We also issued a number of requirement notices, which the provider was required to address.

Our inspection team

The team that inspected the service comprised two CQC inspectors and a CQC pharmacist specialist

Why we carried out this inspection

We undertook this inspection to find out whether Cranstoun Trelawn House had made improvements since our inspection in September 2016. Following the inspection we told the provider must take the following actions to improve the service:

- The provider must ensure that best practice in medicines management is followed. All staff who dispense medicines must be trained and assessed as competent to do so.
- The provider must ensure that all staff, including bank staff, undertake all mandatory training. The provider must ensure that mandatory training is provided for all areas where staff require core skills and knowledge.
- The provider must ensure that all clients have a risk assessment on admission to the service. Risk assessments must include detailed information, and when risks are identified, clients must have a risk management plan.
- The provider must ensure all staff know how to recognise safeguarding matters. All staff must know how to make a safeguarding adults and safeguarding children referral. All safeguarding referrals must be recorded as incidents.
- The provider must ensure that all appropriate pre-employment checks are undertaken for all staff.
- The provider must ensure that all incidents occurring in the service are identified and reported.
- The provider must ensure that an integrated governance system is in place for the service. This must include regular audits and a service risk assessment.
- The provider must ensure that clients' care plans are specific and measurable and reflect clients' involvement.
- The provider must ensure that food is used and stored in a way that minimises risks to clients.
- The provider must ensure that the service is clean. The provider must be able to demonstrate how cleaning is undertaken and the frequency.

Summary of this inspection

The warning notices related to:-

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment, Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment, Regulation 17 HSCA (RA) Regulations 2014 Good governance and Regulation 18 HSCA (RA) Regulations 2014 Staffing.

The requirement notices related to:-

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care, Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment and Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed.

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?

As this was a focused inspection, we looked at aspects of Safe, Effective, Caring, Responsive and Well-led.

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

During the inspection visit, the inspection team:

- visited the service and looked at the quality of the physical environment
- spoke with two clients
- spoke with the registered manager and the deputy director
- spoke to the registered manager for the Cranstoun City Roads service. The registered manager of this service provided advice and training regarding medicines to the staff at Trelawn House. The City Roads service is another service which the same provider operates.
- spoke with two staff members employed by the service provider
- spoke with one volunteer
- attended and observed one hand-over meeting
- looked at six care and treatment records
- looked at fifteen medicine records for clients using the service
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the service say

- We spoke with two clients. They said the staff were kind and available to talk to when needed. The clients were complimentary about the therapies that were offered at the service.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We do not currently rate standalone substance misuse services.

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

- When the service was inspected in September 2016, we identified that staff were not always completing client risk information appropriately or in enough detail. Some clients did not have risk management plans. During this inspection, we found that all clients had risk management plans. However, the quality of risk assessments and management plans was inconsistent. Staff completing the assessments did not always identify and plan for physical health risks.
- Staff did not undertake regular checks on fire and emergency lighting equipment.
- Staff were not always monitoring the room and fridge temperatures.
- At the last inspection in September 2016, we found that staff had not maintained accurate medicines administration records for clients. During this inspection, we found that medicines administration records for two clients were incomplete and this had not been identified by staff. Seventeen medicines incidents had occurred since February 2017 in the service.

However, we found the following areas of good practice:

- At the last inspection in September 2016, we found that staff had not been trained in medicines management. During this inspection, we found that the provider had trained staff in medicines management. Staff had been assessed as competent to support clients whilst they took their medication.
- At the last inspection in September 2016, we noted that staff had a poor understanding of safeguarding procedures. During this inspection, we found that the provider had trained staff in safeguarding adults and young people. Staff now discussed safeguarding concerns as part of their daily meetings. All staff knew how to make safeguarding referrals.

Summary of this inspection

- At the last inspection in September 2016, we noted that there were low completion rates of mandatory training. During this inspection, we found that the completion rates of mandatory training had improved. Staff had the core skills and knowledge necessary for their role.
- When the service was inspected in September 2016, we found that the service was not reporting all incidents that occurred in the service. During this recent inspection, we noted that there had been improvements, the service was reporting and reviewing all incidents that happened in the service.
- At the last inspection in September 2016, we found that the provider was not undertaking satisfactory pre-employment checks. During this inspection, we found that the provider had reviewed their recruitment processes and there were procedures in place to ensure that pre-employment checks were undertaken on all new employees.
- When the service was inspected in September 2016, we found that the service was not clean. During this inspection, we found that there was regular cleaning of the service. Staff were monitoring the cleanliness of the service.
- When the service was inspected in September 2016, we found that food was being stored incorrectly in the fridge. During this recent inspection, we found that the service had improved the storage of food in the fridge.

Are services effective?

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

- When we inspected the service in September 2016, we found that staff were not having regular documented supervision. During the inspection in May 2017, we found that the service had not made improvements. Staff were still not having regular documented supervision.
- When we inspected the service in September 2016, we identified that clients' care plans were not specific or measurable. They did not reflect clients' involvement and preferences. Staff did not always give clients a copy of their care plans. During this inspection, we found that the service was introducing new care planning documents, which allowed clients to identify specific goals that could be measured. The new care planning documents allowed the client to be fully involved in the care planning process. The provider had not fully embedded the process at the time of this inspection.

Summary of this inspection

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

- The service had acted on the findings of the September 2016 inspection, and had provided staff with training in the Mental Capacity Act.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Staff had a good understanding of clients' needs. We observed that staff treated clients with dignity and respect.

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

- It was not always clear from the files whether clients had been offered of a copy of their care plans.

Are services responsive?

We do not currently rate standalone substance misuse services.

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

- Not all clients had an unplanned early exit plan. It was not always clear what clients should do if they left treatment early. Clients who have recently undergone detoxification are at high risk of overdose.

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

- When the service was inspected in September 2016, we found that the service had not undertaken a service risk assessment. During this inspection, the provider had undertaken a service risk assessment but had not reviewed it since December 2016. The provider could not be assured that risks were being managed in a timely manner.
- The provider had identified a range of formal audits that needed to be undertaken to ensure that the quality and safety of the service was monitored. However, at the time of the inspection in May 2016, very few of these audits had been completed.

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

Summary of this inspection

- The inspection in September 2016 identified that the provider's governance systems for the service were not effective. During this inspection, we found that the provider had reviewed their governance processes. Managers reviewed governance at a local level. The senior management team met to review incidents, trends, and issues relating to the service. The processes were not fully embedded at the time of this most recent inspection.
- When the service was inspected in September 2016, we found that the provider had not reviewed their policies on a regular basis. The policies did not reflect best practice guidance. During this inspection, we found that the provider had begun the process of reviewing their policies to ensure that they were in line with best practice guidance.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

When we inspected the service in September 2016, we noted that 23% of staff had undertaken training in the MCA. We asked the provider to take steps to address this. The provider had organised for staff to undertake further MCA training. When we re-inspected the service in May 2017, we found that 100% of permanent and relief staff had undertaken MCA training. All the staff we spoke with had an understanding of the basic principles of the MCA and understood how it might relate to the clients in the service

Substance misuse/detoxification

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse/detoxification services safe?

Safe and clean environment

- During the inspection in September 2016, we identified that the service was not clean. The clients undertook the cleaning but there was no staff oversight to ensure that it had been done thoroughly. During this inspection, we found that the service had made improvements. The service had implemented a daily checklist for cleaning. The clients undertook the cleaning of the service and members of staff were responsible for checking that it had been done. The cleaning checklist identified which member of staff was responsible for doing the daily checks. Staff made a note on the checklist when they had not been able to complete a task or an additional task was required. For example, emptying the fridge of expired foods or if some cleaning tasks could not be undertaken. We reviewed the cleaning checklists and noted that the clients cleaned the service regularly.
- At the last inspection in September 2016, we found that the provider's infection control policy did not reflect best practice. The policy did not mention blood spillage kits and there were none available in the service. This did not follow best practice in a service where clients are at increased risk of having blood borne viruses. During the inspection in May 2017, we found that the provider had reviewed and changed the service infection control policy. Body fluid spillage kits were available in the service. The updated infection control policy provided staff with clear instructions about the safe management of spillages of blood or bodily fluids.
- When the service was inspected in September 2016, we noted that the service had not followed the provider's infection control policy. There were no infection control audits undertaken in the service. This meant that staff had not assessed or managed infection control risks within the service, which could have put clients at risk. During this inspection, we found that the service had an infection control action plan. The service had used the action plan to identify the infection control risks and the actions staff needed to take to address these risks. The action plan had 15 identified actions. The provider had completed nine actions, five were in progress and one was outstanding. The outstanding action was to complete the infection control audit. The date for completion of the audit was August 2017.
- During this inspection, we found that staff were not checking the fire alarm on a weekly basis. There was a gap in the records between the 17 April 2017 and the 22 May 2017. Staff were not testing the emergency lighting on a monthly basis. There was a gap in the records between the 4 December 2016 and the 24 April 2017. The provider stated that the service should have a fire evacuation every six months. The service completed a fire evacuation on the 15 July 2016 but had not scheduled another within six months. This was not in line with the provider's policy. The service could not be assured that fire safety procedures and equipment were safe.
- When we inspected this service in September 2016, we found that raw meat was being stored above cooked food in the fridge. This was not in accordance with food hygiene guidance. We found during this inspection, that food was being stored correctly in the fridge. The staff were monitoring the temperatures of food fridge and taking remedial action when the temperature was outside the recommended ranges. However, they were not doing this consistently. Staff had not checked the

fridge temperatures on eight occasions in April 2017 and on two occasions in May 2017. The storage of food at incorrect temperatures could increase the risk of food poisoning.

- Medicines were stored securely. Staff checked the temperature of the medicines fridge during the week but not always during the weekend. Staff had not recorded the medicine fridge temperatures on nine occasions in April 2017 and seven occasions in May 2017. On two occasions the fridge temperature was outside the recommended temperature range. It was unclear what action staff had taken to remedy this. Medicines should be stored at recommended temperatures to ensure that they are effective.
- Staff recorded the room temperatures where medicines were being stored. However, staff were not doing this consistently. Staff had not recorded the room temperature on 11 occasions in May 2017. Staff could not be assured that the room temperatures had been within the recommended range and suitable for the storage of medicines at all times.

Safe staffing

- At the last inspection in September 2016, we found that the provider's pre-employment checks were not robust. One member of staff had one reference and two members of staff had gaps in their employment history, which had not been discussed. At this inspection, the provider had reviewed their recruitment processes and there were procedures in place to ensure that pre-employment checks were undertaken. The provider had not recruited any new staff for the service. However, the provider had asked all existing staff to provide a list of their previous employment and had asked for gaps in employment to be explained. We reviewed four employee files, which all contained records of employment checklists.
- At the last inspection in September 2016, there were low completion rates of mandatory training. In addition, the provider did not provide mandatory training in medicines management. Not all staff had the core skills and knowledge necessary for their role. The provider had not identified some areas of core knowledge that should be part of the mandatory training programme offered to staff. During this inspection, we found that the provider had identified a range of training that would provide staff with the core knowledge necessary for their role. The completion rate of mandatory training had improved in most areas. We found that 100% of both permanent and relief staff had undertaken training in health and safety. The training rate for fire safety had improved and was 70% and the training completion rate for equality and diversity was 100%.
- Medicines management training had been identified as mandatory as a result of the inspection in September 2016. When the service was inspected in May 2017 we found that 80% of the staff had completed medicines management training.

Assessing and managing risk to clients and staff

- At the last inspection in September 2016, we identified that the service needed to make improvements to client risk assessments as some clients did not have risk assessments and other risk assessments lacked detail. When we re-inspected the service in May 2017, we found that the service had made some improvements. Staff had received training on risk assessments. However, the quality of risk assessments was inconsistent and further improvements were still required. The service manager had undertaken an audit of risk assessments in April 2017 and had also identified that the quality of risk assessments was variable. The service manager had provided staff with feedback and identified what needed to be improved. We reviewed six client risk assessments. Three clients had physical health needs. One client had a history of seizures, and the risk assessment and risk management plan did not identify this clearly. The management plan did not contain information as to how to support the client, for example, advising the client not to have a bath. Another client had an eating disorder and the risk management plan did not outline how to support and monitor the client. Another client, who had diabetes, did not have a care plan addressing this. There was a risk that staff might not understand these clients' specific risks and needs.
- When Trelawn House was inspected in September 2016, it was noted that the provider's lone working policy had last been reviewed in February 2013. The policy did not provide guidance for staff that were lone working in the service. Since that inspection, we found that the provider had reviewed their lone working policy. It now contained specific guidance for staff that were lone working in the service. The provider had implemented

an on call manager's rota. This meant that staff who were lone working could contact a manager out of hours. All the staff we spoke with were aware of the lone working policies and procedures. Those staff who had used it said that they had received support from the on call manager.

- The September 2016 inspection identified that 45% of staff had not undertaken safeguarding adult and children training. Three staff members could not describe how they would make a safeguarding adults referral to the local authority. Staff had not identified that the repeated medicines errors and omissions that had taken place in the service should have prompted a referral to adults safeguarding. When the service was inspected in May 2017, we found that the service had made improvements. The provider had trained all staff in safeguarding adults and in safeguarding children and young people. All the staff and the volunteer we spoke with were able to describe what might constitute a safeguarding concern. The staff knew how to make a safeguarding referral. The service was reporting medicines errors to the local authority as safeguarding concerns. The service had arranged to meet with the local authority's safeguarding team in June 2017 to discuss how to improve communication. The staff discussed safeguarding concerns during their daily handover meetings and during governance meetings.
- When the service was last inspected in September 2016, we found that staff were not managing medicines safely. Multiple medicine errors had occurred. During that inspection, we noted that over 50 errors or omissions had occurred in a period of 19 days. Staff were not giving clients their medications as frequently as prescribed or were giving incorrect doses. The provider had not assessed staff as competent to dispense medicines. Medicines management training was not mandatory training for staff. During this recent inspection, we found that the provider had improved their medicines management. However, the provider was still working to fully embed some of the new processes. After the last inspection in September 2016, the provider has moved the medicines storage cupboard to a more appropriate location. This meant that clients could sit in a private space to take their medicines. Staff remained with clients whilst they took their medicines and recorded on a medicine administration record (MAR) when clients had taken them.
- Staff undertook medicines reconciliation when clients were admitted into the service. This meant that staff were aware of the client's prescribed medicines and could monitor whether clients were taking them as prescribed. Clients were responsible for reordering their own repeat medicines from their GP. Staff now prompted clients to do this, which meant there was a significant reduction in the number of missed doses of medicines since the last inspection. However, we saw one client had not had their medication for six days and there was no record for another client who self-administered insulin. Staff had not recorded what action they had taken to support the client who had not taken their medication. Staff had not reported these errors as incidents. Staff stated that if clients consistently refused to take their medication, staff would review whether they could support the client appropriately and if Trelawn House was a suitable placement.
- The manager told us there were no routine medicines audits, but staff reviewed any issues at the daily handover meeting. We reviewed the daily handover notes, which staff completed at every shift. There was evidence that staff discussed clients' medication. Staff recorded the actions they would take to support clients regarding them taking their medication.
- Staff used an electronic system to report all medicines incidents. The service planned to complete a review of medicine incidents at the service in June 2017.

Reporting incidents and learning from when things go wrong

- When the service was inspected in September 2016, we found that staff were not reporting incidents that had occurred in the service. When we re-inspected the service in May 2017, we found that the service had made improvements. The service had introduced a new system in February 2017 to record incidents. Staff had reported 34 incidents since February 2017. None of these had been serious incidents. Staff knew what constituted an incident and were aware of the system in place to record them. Staff discussed incidents during

their handover meeting. The incident reporting process required the registered manager to review all incidents that had taken place. However, at the time of this most recent inspection, the registered manager had not reviewed 26 of these incidents. The registered manager was aware that these incidents were awaiting a management review. Seventeen of these incidents were medicines errors. However, at the point of this most recent inspection, the provider had not undertaken an in-depth review of the medicines errors that had occurred in the service. The provider stated that they were planning to undertake an in-depth review of medicines errors in June 2017.

- The provider's incident review team monitored all serious incidents and investigations. Learning from all incidents was shared with the managers of the provider's services on a regular basis.
- The quality performance manager reviewed all incidents in the service. If the incident was serious, the provider convened a serious incident review group. The manager shared the learning from all incidents with staff during the team's governance meeting.

Are substance misuse/detoxification 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)

- When we inspected the service in September 2016, we found that clients' care plans were not specific or measurable. Some clients' care plans were incomplete. During this inspection, we found that the provider had recently changed their care planning process and documents. This had helped to improve the quality of care plans but the new care planning processes and documentation were not fully embedded. The service was using a mixture of new and old care planning documents. The new care planning document looked at a range of needs, which included physical health, community, emotional health, accommodation, and family and relationships. Staff completed the new care planning document with clients. The new care planning documents allowed staff and clients to identify clear measurable goals. The staff and clients reviewed the goals regularly during key working sessions. We reviewed six care planning documents during this inspection. We found three clients with complex physical health needs did not have care plans that addressed this. The staff had not discussed with the clients how best to support them around their physical health. There was a risk that staff may not respond appropriately to clients if their physical health deteriorated. The use of both types of care plan had led to variable quality with regards to care planning. The service manager was aware that care plans required improvement and was intending to address this in supervision.

Skilled staff to deliver care

- When we inspected this service in September 2016, we found that the manager had not recorded staff supervision in the previous year. This meant there was no record of when supervision had taken place and what the manager and supervisee had discussed. During this inspection, we found that supervision was not being documented consistently. We reviewed the supervision files for three permanent members of staff. Two members of staff had not had documented supervision since January 2017 and another had not had documented supervision since November 2016. These members of staff had supervision contracts in their files, which stated that they would have supervision every four weeks. Formal supervision ensures that staff work within professional codes of conduct and boundaries and that their training needs are identified. Supervision can help ensure that clients receive high quality care at all times from staff that are able to manage the personal and emotional impact of their practice. Since the inspection in September 2016, the service had undergone a restructure. A new service manager had taken over the supervision of all staff in April 2017. They had identified that formal supervision was not happening on a regular basis and were taking steps to implement a programme of regular supervision. Despite not having formal documented supervision, all the staff we spoke with said that they felt supported in their work.

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

Substance misuse/detoxification

- When we inspected the service in September 2016, we noted that staff had a poor understanding of the Mental Capacity Act. Seventy seven per cent of staff had not undertaken training in the MCA and staff had difficulty in understanding how it could relate to clients in the service. During this inspection, the provider had organised for staff to undertake further MCA training and we found that 100% of permanent and relief staff had undertaken MCA training. All the staff we spoke with had an understanding of the basic principles of the MCA and understood how it could relate to the clients in the service.

Are substance misuse/detoxification services caring?

Kindness, dignity, respect and support

- Staff spoke respectfully about clients and we saw positive interactions between staff and patients. Staff were aware of individual client preferences.

The involvement of clients in the care they receive

- When we inspected the service in September 2016, we found that it was not always clear from the files whether staff had given clients a copy of their care plan. During this inspection, we reviewed six care plans. The service was in the process of changing the format of the clients' care plans to one that ensured that the client's involvement was clearly evident. For the clients who had the new care plans, the care plans were signed and indicated that the client agreed with the contents. However, it was not clear from the records we reviewed whether staff had offered the client a copy of their care plan. The service manager was aware that the new care planning process was still being embedded. As part of that process, the service manager stated that staff would offer clients a copy of their care plan and staff should record this on the client file.

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

Access and discharge

- The service was not routinely formulating early unplanned exit plans with clients. It was not always clear what guidance staff gave to clients should they leave treatment early. Clients who have recently undergone detoxification are at high risk of overdose. The service intended to introduce early unplanned exit plans, which included harm minimisation advice, to hand out to clients if they wished to leave the service early.

The facilities promote recovery, comfort, dignity and confidentiality

- At the last inspection in September 2016, we found that staff dispensed medicines in the staff office which was not a suitable environment. When the service was inspected in May 2017, we found that the service now had an identified room for clients to take their medicines in private.

Listening to and learning from concerns and complaints

- When we inspected the service in September 2016, we found that the provider's complaints policy did not include information regarding organisations that clients could appeal to if they were unhappy with the outcome of their complaint. At this inspection, the updated complaints policy clearly identified the external organisations clients could appeal to if they remained unhappy with the outcome of their complaint.

Are substance misuse/detoxification services well-led?

Good governance

- When the service was inspected in September 2016, we identified that the provider's governance framework was out of date. There was no integrated governance system to underpin the quality and safety of the service. There were no regular audits and no service risk assessment. The provider was not monitoring incidents at the service. Mandatory training rates were low and staff were not having regular documented supervision. The service did not have clinical governance meetings.
- When the service was inspected in May 2017, we found that the provider had made some improvements but were still in the process of embedding these

improvements. The service had employed an external consultant to assist them in making improvements. The completion rates of mandatory and specialist training had improved. The provider had systems to prompt when staff had to renew their training. The service had improved their incident reporting and had clear processes to review incidents. The service had processes to monitor the type of incidents that were being reported in the service. The manager had arranged to meet with the local authority's safeguarding team to discuss whether these should be reported as safeguarding concerns. The staff and quality manager attended the monthly governance meetings. The service had monthly governance meetings, which had started in January 2017. These meetings had a set agenda, which reviewed a number of quality issues. For example, the meeting reviewed the safety of the service, staffing, and the quality and management of the service. The provider reviewed serious incidents on a monthly basis as part of the Cranstoun Incident Review Group.

- After the last inspection, the provider had updated a number of their policies to ensure that they reflected best practice. For example, the provider had updated the lone working policy. The provider had also updated the visitor's policy and it was now clear that children were not allowed on the premises. The provider had updated the Control of Substances Hazardous to Health (COSHH) risk assessment, as previously it was not accurate.
- The service had a service risk assessment, but this had not been updated since December 2016. The provider stated that they would review the service risk assessment on an annual basis as part of the service's periodic service review, which was due to take place in June 2017. The lack of regular ongoing review meant that the provider could not be assured that they were identifying and managing risks in a consistent and timely manner.
- The provider was in the process of implementing a timetable of audits to be undertaken. For example, they intended to audit client files on a quarterly basis.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to meet the regulations:

- The provider must ensure that staff have regular documented supervision
- The provider must ensure that clients have unplanned exit plans
- The provider must ensure that the service's risk assessment is reviewed on a regular basis
- The service must ensure that fire safety and emergency equipment is checked on a regular basis
- The provider must ensure that all clients' risk assessments and care plans include detailed information regarding the client's physical health. When physical health risks are identified, clients must have a risk management and care plan to address these risks.
- The provider must ensure that audits are completed regularly at the service to ensure the premises are safe and any identified risks are managed appropriately.
- The provider must ensure that they keep accurate medicines administration records for clients and take prompt action when clients do not take their medicines. The provider must ensure that all medicines incidents occurring in the service are identified and reported.

Action the provider SHOULD take to improve

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- The service should ensure that the fridge and medicine room temperatures are monitored regularly in accordance with the provider's policies.
- The provider should ensure that there are mechanisms to record whether a client has been offered a copy of their care plan.
- The provider should ensure that training information is accurate and up to date.
- The provider should continue embedding the newly implemented governance processes. The provider should ensure they have mechanisms to ensure that they monitor the quality and safety of the service.
- The provider should continue embedding their newly implemented care planning processes.

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 18 HSCA (RA) Regulations 2014 Staffing Staff did not have regular formal supervision sessions. This was a breach of Regulation 18 (2) (a)

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not ensured that all clients had an early unplanned exit plan. Clients' risk assessments did not always include plans to mitigate identified physical health risks. Medicines management was not safe. Multiple medicine errors had occurred. Medicine administration records were incomplete This was a breach of Regulation 12 (1) (2) (a) (b) (d) (g)

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 17 HSCA (RA) Regulations 2014 Good governance The systems and processes in place to operate the service and assess and improve quality and safety were

This section is primarily information for the provider

Requirement notices

not fully embedded. The service's risk assessment was not up to date. Regular audits, to monitor and improve the quality and safety of the service, were not taking place.

Fire and emergency procedures and checks were not robust

This was a breach of Regulation 17(1)(2)(a)(b)(f)