Aspinden Wood Centre

Quality Report

Aspinden Wood Centre
1 Aspinden Road
London SE16 2 DR
Tel: 020 7231 4303
Website: www.equinoxcare.org.uk

Date of inspection visit: 26, 27 October and 1 November 2017
Date of publication: 24/01/2018

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.

This was an unnounced, focused inspection, where we looked at whether the provider had made the required improvements that we said it must at our previous inspection in June 2017.

Following the June 2017 inspection the provider voluntarily agreed to stop new admissions. In addition, two warning notices were served relating to Regulations 12 safe care and treatment and 17 good governance.

At this inspection, October 2017, we found that some improvements had been made , but that further improvements were needed, including the embedding of new systems introduced since the last inspection.

We served a warning notice relating to Regulation 15 premises and told the provider if must ensure premises were clean and safe. In addition, we asked the provider to continue not to admit new patients until further improvements had been made. The provider agreed to do so until February 2018.

We found the following areas that require improvement;

- Systems to ensure the cleanliness, hygiene and maintenance of client bedrooms and bathrooms were not effective. Some areas of the service smelt of urine and bathrooms were in need of refurbishment.
- CCTV had been introduced in the entrance of the building.However, systems to monitor who entered and left the building were not robust and did not

Summary of findings

ensure the safety and well-being of clients and staff. In addition, staff could not see into the 'wet room', which was the communal living area where clients were able to smoke and drink.

- Staff were not taking appropriate action when fridge temperatures fell out of range and the majority of staff had not had their competence to administer medicines assessed.
- Further improvements were needed to ensure that risk assessments were updated following changes in client presentation, for example following a hospital admission.
- Further improvement was needed in how client's physical health care needs were managed.Communication with the visiting commuity nursing team needed improvements to ensure clients needs were met.
- Systems to share learning from incidents with staff were not in place.
- There were a number of fire safety actions that still needed to be addrerssed. Personal evacuation plans for clients with mobility issues did not meet their needs. A fire door within the premises had been locked, which meant that the safety of clients and staff had been compromised.
- Improvements were needed to ensure that observation were carried out in the 'wet room' when they were due according to smoking risk assessments.
- Whilst monitoring of mandatory training had improved, staff take up of the majority of mandatory training was below 75%. Not all staff received supervision regularly.
- We found that there were no capacity assessments in place for clients where there were areas of concern regarding capacity other than DoLs authorisations. Records showed that only half of the staff team had completed mental capacity training.
- The provider had not implemented changes required to ensure it was delivering care in accordance with guidance on same sex accomadation although had considered how it might implement this.
- Staff needed to ensure that all incidents were reported, including incidents of verbal abuse towards staff.

However, we found the following improvements had been made since our last inspection in June 2017:

- Medicines management and administration had improved, but the revised systems needed further embedding. The service now had risk assessments for client's self- administering medication and were completing medication audits. The majority of staff had completed medicines training
- Processes for identifying, assessing and managing risk had improved. All clients had a risk assessment in place, including moving and transferring.
- There had been improvements in communication with community psychiatric nurses. A revised GP contract was about to be introduced, with the aim of improving physical health support to clients and improving communication with staff.
- A fire safety assessment had been completed; regular fire alarm tests and evacuation drills were being carried out.
- Observation of clients at risk had improved. The service had fitted CCTV into all communal areas. Clients were now regularly observed at a minimum of hourly.
- New systems to identify who was supervising which staff had been introduced, along with a standardised supervision template.
- A permanent manager had been appointed and arrangements were in place for them to receive a handover from the acting manager.
- The service had developed a detailed referral form. They had introduced drug and alcohol stars. These were used to document discussions with clients regarding how they wanted to be supported with managing their alcohol intake. These were detailed and person centred. Staff had identified and managed clients nutritional and hydration needs.
- Staff had completed safeguarding training, were able to tell us how to make a safeguarding referral and safeguarding information was clearly displayed for

Summary of findings

both clients and staff to see. All safeguarding concerns had been appropriately considered with alerts made to the necessary stakeholder organisations.

- An audit programme had been introduced.
- Staff were committed to the clients and to the service. Staff felt that managers were open and approachable. Staff were positive about the changes they had seen taking place since the last inspection.

Summary of findings

Our judgements about each of the main services

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

Summary of findings

Contents

Aspinden Wood Centre

Services we looked at
Substance misuse services

Summary of this inspection

Background to Aspinden Wood Centre

Aspinden Wood Centre provides accommodation and 24 hour care and support for up to 26 men and women who have long term issues with alcohol and complex needs including mental ill health, physical health issues or homelessness. The service operates a harm minimisation approach that allows clients to drink agreed amounts of alcohol. The aim is for the service to promote stabilisation and harm reduction.

At the time of the inspection there were 19 clients using the service. One client was in hospital. Thirteen clients had complex needs, this included clients requiring support with activities of daily living, personal care, mobility issues or disability and risk of falls.

Clients were placed at Aspinden Wood by local authorities and clinical commissioning groups from all over the country.

Aspinden Wood is registered to carry out the regulated activity:

Accommodation for persons who require treatment for substance misuse.

The inspection in October 2017 was a focused inspection to follow up on the concerns identified during the previous inspection in June 2017. At the time of inspection a new registered manager had started and the acting manager was still at Aspinden Wood for a period of handover.

Our inspection team

The team that inspected the service comprised of a lead CQC inspector, one other CQC inspector and a CQC pharmacy specialist. There were two specialist advisors, one was a psychiatrist specialising in substance misuse, the other was a nurse specialising in substance misuse.

There was also 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 to check whether the provider had taken actions to improve following the inspection in June 2017. At this unannounced inspection, we reviewed aspects of the safe, effective and well-led key questions to identify whether breaches had been remedied.

The unannounced, focused inspection carried out in June 2017 identified concerns regarding omissions of care and treatment which put clients at risk of harm. We took enforcement action against the provider and issued a warning notice in relation to Regulation 12 - Safe Care and treatment and Regulation 17 – Good Governance. We required the provider to become compliant by 28 August 2017.

We told the provider it must take the following actions to improve its services:

- The provider must have a clear service model in place that clearly states how they will support the clients to manage their substance misuse issues.
- The provider must ensure that governance processes are in place to provide assurance that all aspects of the service are operating well.
- The provider must ensure that they have clear admission criteria in place. They must ensure that comprehensive assessments are carried out prior to admission to ensure that they can meet the needs of the clients; they must outline how they will meet the client's needs within the assessment.

Summary of this inspection

- The provider must ensure that there is sufficient staff on duty to meet the client's needs. They must ensure that there is a system in place to be able to accurately measure the staffing requirements needed to safely meet the needs of the clients.
- The provider must ensure that all clients have comprehensive care plans and risk assessments that are updated when their needs change and address their holistic needs, including assistance with personal care and moving and transferring.
- The provider must ensure that physical health needs of clients are met. The provider must ensure that risk assessments and care plans are updated to include information regarding physical health care when clients' needs change. The provider must ensure that visits from health care professionals are clearly documented with the agreed actions and outcomes of these visits.
- The provider must respond appropriately when clients' needs change and the service may no longer be able to meet their needs.
- The provider must ensure that there are systems in place for the proper and safe administration and management of medicines. Staff who administers medicines must be competent to do so. The provider must ensure that where clients administer their own medicines the associated risks are assessed and appropriately mitigated or managed.
- The provider must ensure that serious incidents are recorded and reported. The provider must ensure that there are clear actions in place following incidents. The provider must ensure that learning from incidents occurs and outcomes are discussed both with staff and clients.
- The provider must ensure that the manager is appropriately supported to maintain the safety and quality of services.
- The provider must ensure there is an effective system in place to record and monitor staff compliance with mandatory training. The provider must ensure that staff receive regular supervision.
- The provider must ensure that clients are supported to clean their rooms on a regular basis.
- The service must ensure that clients are safe when they are using the 'wet room'.
- The provider must ensure that fire regulations are adhered to. They must ensure that the fire action plan is implemented and that regular fire checks are carried out.
- The provider must ensure that robust safeguarding processes are in place. The provider must ensure that all staff have completed safeguarding training and understand their responsibilities to keep clients safe.
- The provider must ensure that feedback from safeguarding concerns are reviewed, lessons learnt and where appropriate changes to policy and practise made.
- The provider must ensure that the Mental Capacity Act is used appropriately. They must ensure that all staff have completed Mental Capacity Act training.
- We also told the provider that it should consider taking the following action:
- The service should ensure the appropriate security is in place to ensure that they know who is in the building. The provider should ensure that communal areas can be observed appropriately.
- The provider should ensure that there is a policy in pace regarding same sex accommodation. The provider should ensure that consideration is given to where bedrooms and bathrooms used by female residents are located.
- The provider should consider if safety of staff and clients would be enhanced if staff had access to personal alarms.

Summary of this inspection

How we carried out this inspection

This was a focused inspection with questions asked within the safe, effective and well-led domains.

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

During the inspection visit, the inspection team:

- visited the unit
- spoke with four clients
- spoke with the acting manager
- spoke with the clinical lead , the care quality compliance lead and the head of quality and compliance
- spoke with four other staff members employed by the service provider, including an agency nurse, deputy manager, recovery assistant and substance misuse worker.
- attended and observed one handover meeting
- attended one house meeting for clients
- looked at nine care plans and risk assessments
- we checked medicines storage, medicines administration record (MAR) charts, and medicines supplies
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke to four clients about their care and treatment. They all informed us we that they liked living at Aspinden Wood and that they wanted to stay there. Three clients told us that they felt safe within the service. One client told us that they had stopped smoking and had been able to reduce their alcohol intake to four cans a day whilst being at the service. One client told us that they felt that staff did not understand alcohol withdrawal symptoms.

We spoke with four clients about how staff supported them with their medication; they told us that they always received their medicines on time.

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 provider had made improvements; however there were the following issues that needed further improvement:

- Systems to ensure the cleanliness, hygiene and maintenance of client bedrooms and bathrooms were not effective. Some areas of the service smelt of urine and bathrooms were in need of refurbishment.
- Whilst CCTV had been introduced in the entrance of the building, systems to monitor who entered and left the building were not robust and did not ensure the safety and well-being of clients and staff.
- Staff were not taking appropriate action when fridge temperatures fell out of range and the majority of staff had not had their competence to administer medicines assessed.
- There were some shifts where staffing levels had been under the agreed establishment levels.
- Improvements were needed to ensure that risk assessments were updated following changes in client presentation, for example following a hospital admission.
- Staff knew what incidents to report and how to report them. However staff were not reporting all incidents of verbal aggression. Systems were in place for managers to share learning from incidents across services. However, systems to share learning from incidents with staff were not in place.
- Personal fire evacuation plans for clients with mobility issues did not meet their needs. A fire door within the premises had been locked, which meant that the safety of clients and staff had been compromised.
- Staff could not see into the 'wet room', which was the communal living area where clients were able to smoke and drink.Further improvements were needed to ensure that observation levels of the wet room were carried out when they were due.
- Whilst monitoring of mandatory training had improved, staff take up of the majority of mandatory training was below 75% and needed further improvement.
- The provider had started to consider how to implement same sex accommodation and separation of bathroom and bedrooms facilities but had not yet been able to implement changes.

Summary of this inspection

However:

- The service had made improvements in how safeguarding was managed and information was shared within the service. However this needed to be embedded within the staff team and discussed regularly.
- Medicines management had improved. The service now had risk assessments for client's self- administering medication and were completing medication audits.The majority of staff had completed medicines training
- The service had increased it's staffing numbers with a higher ration in place.
- Staff had access to radio systems to maintain contact with each other whilst working in different parts of the building and call assistance if required.
- Staff had ensured that all clients with moving and transferring needs had these assessed and were appropriately supported with these.
- Processes for identifying, assessing and managing risk had improved. All clients had a risk assessment in place, including moving and transferring.

Are services effective?

We do not currently rate standalone substance misuse services.

We found the provider had made improvements; however there were the following issues that needed further improvement:

- Systems to ensure the effective handover and communication between the service and visiting healthcare professionals needed to be consistent.
- The service had adopted a 'psychologically informed environment' (PIE) model of recovery and used harm minimisation approaches to address clients alcohol misuse. However, the PIE approach had a long lead in associated with its introduction that was not timely. The service was not clear how harm minimisation approaches would be monitored for their efficacy, or clients were clear what it was that they were agreeing to.
- Revised systems to deliver regular, good quality supervision needed further embedding. Further improvements were needed to ensure that specialist training to meet the needs of clients was identified and provided in a timely fashion.

Summary of this inspection

- Since the last inspection the provider had introduced systems to ensure that clients personal care needs were met, but care plans did not detail how clients preferred to have their personal care needs met.
- Staff take up of MCA training needed improvement. Some clients now had DoLS authorisations in place however some clients who may not have had capacity to manage their finances did not have capacity assessments in place to assess this.

However:

- Clients had their needs assessed and individualised care plans were put in place to address these. Clients had comprehensive recovery stars in place to address their alcohol misuse.
- Staff identified and appropriately managed clients nutritional and hydration needs.
- The service had revised its admission criteria and referral processes in anticipation of new clients in the future.
- The service was developing induction packs; we saw that there was an induction pack in place for the nurse that was due to start.
- There were improvements in contact with Community Psychiatric Nurses. A new GP contract was about to come into effect. Further improvements were needed to ensure contact with District Nurse teams was consistent and effective.

Are services caring?

We did not inspect this domain at this inspection.

Are services responsive?

We did not inspect this domain at this inspection.

Are services well-led?

We do not currently rate standalone substance misuse services.

We found the provider had made improvements; however there were the following issues that needed further improvement:

- The provider had not ensured that systems to ensure the cleanliness, hygiene and maintenance of client bedrooms and bathrooms were not effective and had not been reviewed or updated since the last inspection.
- Since the last inspection in June 2017, the provider had reviewed and made changes to many of it's governance systems. These needed further embedding to ensure they were consistent, effective and robust.

However;

Summary of this inspection

- Staff were committed to the clients and to the service. Staff felt that managers were open and approachable. Staff were positive about the changes they had seen taking place since the last inspection.
- Since the last inspection, a permanent manager had been appointed.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

At the previous inspection in June 2017 we found that staff had not undertaken Mental Capacity Act training. At this inspection we found that Mental Capacity Act training had been provided. Half of the staff team had attended this training, however there was no date set for the remaining staff to attend.

At the previous inspection in June 2017, we found that staff did not assess client's capacity to consent to specific decisions where there were concerns. During this inspection we saw improvements; some clients had their capacity to consent to specific decisions assessed. Some clients now had Deprivation of Liberty Safeguards (DoLS) authorisations were in place.

At this inspection we saw in nine care plans that staff supported clients with managing their finances. Staff told us that not all of these clients had capacity to manage their finances; however where there were concerns regarding their capacity, this was not documented.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

During this inspection we saw that further improvements were needed to ensure the safety and security of clients and staff.

- At the previous inspection in June 2017, we found that the entrance was unlocked and people could enter and leave the building without monitoring. During this inspection we found that whilst there had been some improvements, further work was needed as a robust system to monitor who was entering and leaving the premises was not in place. The entrance remained unlocked and people could enter and leave the building without monitoring. The service had installed closed circuit television (CCTV) in communal areas, including the entrance, but staff were not always available in the office to monitor this. This compromised the safety and security of clients and staff.
- The service had a communal living area called the 'wet lounge' as clients were allowed to drink in this lounge. At the previous inspection in June 2017 we found staff were not observing this room regularly. During this inspection, we saw that whilst some improvements had been made, further work was needed. Staff were now carrying out general observations of all clients at hourly intervals. CCTV had been installed since our last inspection and was displayed in the staff office, but staff were not always available to monitor this.
- The service accommodated female and male clients. At the previous inspection in June 2017 we found that the service did not have a policy in place to manage the gender mix and client's bedrooms and shared bathrooms, were not separated according to gender. At this inspection this had not improved. The service did not have a same sex accommodation policy in place, clients bedrooms were not separated according to sex and clients were sharing bathrooms. Staff told us that they were beginning to consider how to develop a policy and a separate female lounge, but no clear plan was in place.
- During this inspection, we saw that improvements were needed to ensure that a safe, clean environment was maintained.
- At the previous inspection in June 2017, we found that staff did not always support clients to clean their rooms. At this inspection we found this had not improved. During the inspection we found that two bedrooms smelled strongly of urine which included one that was empty and had not been cleaned. We also saw that in some bedrooms the bed linen was dirty. One bathroom was dirty and had a bath seat which was made of fabric. This seat was used by multiple residents if they needed to bath. This was an infection control risk. It was difficult to maintain cleanliness in all of the communal toilets and bathrooms due to the flooring being worn out and old facilities. The provider had escalated this to the landlord, but there were no clear timescales in place to address maintenance issues in the bathrooms.
- Since the last inspection, staff recorded on client records and within handovers if clients had been offered support to clean their rooms or if they refused. Where clients had care plans in place that identified they needed support to maintain their bedroom, these did not detail the nature of the support required, or next steps if the clients declined to clean their bedroom.
- At the previous inspection in June 2017, we found that the service was not carrying out regular health and

safety checks. At this inspection, improvements had been made. We saw that these checks were being carried out and that health and safety audits were now also being completed.

- At the previous inspection in June 2017 staff did not carry personal alarms. At this inspection this had improved. Staff now had access to two way radios that they could carry with them to be able to communicate with colleagues in other parts of the building.
- At the previous inspection in June 2017, we found that the service needed to make improvements regarding fire safety. At this inspection we saw improvements, but further work was needed.
- At the previous inspection in June 2017, the services fire risk assessment had not been reviewed or updated and fire alarm tests were not being carried out. This had improved during this inspection. The fire risk assessment had been reviewed and updated. Weekly fire alarm tests were being carried out. Monthly fire drills had also been introduced.
- At the previous inspection in June 2017, the service had not implemented an action plan following a visit to the service from the London Fire Brigade (LFB) in March 2017, where improvements were recommended. During this inspection we saw this had improved, but further work was needed. Since the last inspection, the service had developed personal evacuation plans, but for some clients with mobility issues these lacked sufficient detail. These evacuation plans had not been practised, as was required on the fire action plan. One client who was hearing impaired did not have arrangements to alert them to a fire should they be asleep in their bedroom.
- At the previous inspection in June 2017 we found that clients who smoked in their bedrooms and in the communal 'wet lounge' did not have these risks assessed. During this inspection we saw improvement; all clients that smoked had a separate risk assessment regarding their smoking. However, these were not robust, as the measures to mitigate clients smoking in their rooms were not identified. In addition, the measures to mitigate smoking in the 'wet lounge', which included half hourly observations had not been consistently and robustly implemented.
- During this inspection, we saw that one fire exit had been locked, which posed a health and safety risk. We also saw that the LFB recommendation regarding a minimum of two fire marshals being on shift on all times had not been fully implemented. We saw that on nine occasions in October 2017, two fire marshals were not identified on each shift.

Safe staffing

- During this inspection we saw that safe staffing levels were maintained. At the previous inspection in June 2017 we found that there was not sufficient staff to provide safe care and support to clients. At this inspection we found improvements. Staffing levels had been increased since our last inspection. The manager was able to increase staffing levels according to client need. Regular bank and agency staff were used which meant clients received continuity of care. However, further improvements were needed to ensure staff completed mandatory training and had the appropriate knowledge and skills to meet the needs of clients
- At the time of inspection the service had 12 permanent staff members, including the deputy manager and was recruiting further staff. The service also had an interim manager and a full time nurse who started during our inspection. The service was able to increase its staffing levels according to client need, for example we saw this had happened when two clients had hospital appointments on the same day and another client had a scheduled activity. The service used regular bank and agency staff who knew the service well. However we found that eight shifts during August and September had been below the established staffing requirement, this would impact on the delivery of care to clients.
- The service was developing induction packs for new staff. We saw there was an induction pack in place for a new nurse who was due to start.
- During this inspection, we saw that sufficient staff were on duty to facilitate regular one to one sessions with clients, but that there was a lack of consistency in how and where these sessions were recorded in clients care and treatment records.
- At the previous inspection in June 2017 we found that there was not an effective system in place to record and monitor staff compliance with mandatory training. At

this inspection we found that the service had improved its systems to monitor take up of mandatory training, but the majority of mandatory training had less than 75% staff take up.

- The provider had identified 30 mandatory training courses. Since the last inspection the provider had implemented a training matrix to monitor compliance. This showed that staff take up of the majority of mandatory training was below 75% for 24 of the 30 mandatory training courses. Overall take up of mandatory training across the staff group remained low at 23%. Plans were in place to run additional courses to improve staff compliance with mandatory training.
- During this inspection we saw that the service had not provided training for staff regarding alcohol withdrawal symptoms or epilepsy and seizure awareness. Staff could not describe the symptoms of alcohol withdrawal or seizures, or what they would need to do. Following the inspection the service organised epilepsy training for all staff and added this to the services mandatory training requirements.

Assessing and managing risk to clients and staff

- Improvements had been made to the way risk was assessed and managed, but further work was required to embed recent changes. All clients had a risk assessment and risk management plans in place, but these were not always updated following incidents.
- At the previous inspection in June 2017 we found that staff had not completed comprehensive risk assessments for clients and did not update risk assessments after a change to risk. At this inspection we looked at nine client care and treatment records and found that each had a risk assessment that was person centred and included risk management plans. However, we saw that three client risk assessments had not been updated following changes in risk. For example, one client had had a recent hospital admission and following discharge required ongoing medical input but their risk assessment and management plan had not been updated with this information.
- The provider had made improvement to ensure that clients were safely supported when moving and transferring.
- At the previous inspection in June 2017 we found that some clients were wheelchair users or experienced other mobility issues and required support with moving and transferring, in some cases using a hoist. We found that none of the clients whose records we looked at had moving and transferring risk assessments or management plans. At this inspection we looked at the records of seven clients who had mobility issues and required support with moving and transferring. We found that all of these clients had a moving and handling risk assessment and management plan in place.
- Since the last inspection, safeguarding arrangements within the service had improved.
- At the previous inspection in June 2017 not all staff had been able to tell us the procedure to escalate safeguarding concerns. At this inspection, staff were able to tell us how they would make a safeguarding referral and when they would do this. The service had safeguarding information on display for service users and staff so that they could see how to make a safeguarding referral. Since the last inspection, the service had introduced a spreadsheet to record safeguarding alerts and track their progress.
- Overall, arrangements for the safe management and administration had improved, but further embedding was required.
- At this inspection we saw improvement in staff take up of medicines management training. At the previous inspection in June 2017, evidence that staff had completed this training and been assessed as competent was not available. During this inspection we saw 92% of staff had completed this training. However, further embedding was needed as competency assessments for staff regarding medicines administration had been completed by only 33%.
- At the previous inspection in June 2017, we found that the service did not carry out risk assessments for clients self-administering medicines.At this inspection, we looked at 15 peoples' risk assessments for self-administering medicines such as inhalers and creams.We found each client had been appropriately

assessed for any risks associated with their self-administering medicines and that where needed measures to mitigate any identified risks had been put in place.

- At the previous inspection in June 2017, the provider did not have systems in place to reconcile medicines and identify medicines errors. Medicines audits were not being carried out. At this inspection we saw the provider had reviewed and updated its medicines management policy and procedure. The service was regularly reconciling medicines. In addition, regular medicines audits were being carried out to ensure that clients received their medicines on time and as prescribed. Any discrepancies found in the recording of medicines administration were discussed at each handover shift. Whilst all stocks of medicines seen during the inspection were in date, the provider did not have a system in place to monitor this.
- During this inspection, we checked medicines storage, medicines administration record (MAR) charts, and medicines supplies. All prescribed medicines were available at the service and these were stored securely in medicines cupboards within people's rooms. This assured us that medicines were available at the point of need. However, we saw that staff had not recorded client
- During this inspection we saw that fridge temperatures were recorded each day. On some occasions, the recorded fridge temperature exceeded the acceptable range. This meant that medicines requiring refrigeration were not stored at appropriate temperatures, and their safety and efficacy could be affected. Staff were not able to describe the steps they should take if the fridge temperature fell out of range.
- During this inspection we looked at the provider's arrangements for managing and dispensing controlled drugs (CDs). We saw that CDs were appropriately and securely stored. Appropriate records were completed when staff administered CDs and checked stocks. However, we found that the provider did not keep a CD denaturing kit for the appropriate destruction of CDs. A denaturing kit will render controlled medicines irretrievable and unfit for further use until they are fully destroyed by incineration.

Track record on safety

- At the previous inspection in June 2017 we found that the service had not raised serious incidents following safeguarding concerns raised by local hospitals. At this inspection we did not find any concerns that should have been raised as serious incidents.

Reporting incidents and learning from when things go wrong

- Overall, the provider had made improvements in how incidents were reported, but further improvement was required to identify and share learning from incidents. All staff knew what incidents to report and how to report them. However we found that not all incidents of verbal aggression were being reported.
- At the previous inspection in June 2017 we found that the service graded incidents as either low, medium or high but did not have clear guidelines in place regarding the grading of incidents. At this inspection we saw improvements. We found that incidents were graded by the service manager with clear guidelines in place as to how to do this and the appropriate action to take.
- At the previous inspection in June 2017 we found that the service was not reporting all incidents appropriately to the local authority as safeguarding alerts or to the CQC as notifications. At this inspection we saw that all incidents had been reported appropriately to the CQC and one safeguarding referral had been made by the service to the local authority.
- At the previous inspection in June 2017, we saw that the provider held a fortnightly managers meeting to discuss incidents, accidents and near misses across all services. However, the minutes of these meetings showed no clear actions as to how incidents had been responded to or how lessons could be learnt from incidents. At this inspection we looked at the minutes from three of these meetings and saw improvement. The minutes showed that incidents were discussed and any updates, actions that needed to be taken and lessons learnt were documented.
- At the previous inspection in June 2017 we found that staff at the service did not receive regular feedback regarding incidents and that learning from incidents was not discussed within team meetings. At this inspection we found that learning from incidents was not discussed within team meetings and so staff did not receive regular feedback regarding incidents.

Substance misuse services

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

Assessment of needs and planning of care (including assessment of physical and mental health needs and existence of referral pathways)

- The provider had improved systems to assess client's needs. All clients had individual care plans in place that addressed their range of needs. Revised systems to address client's physical health had been developed and were being introduced. Overall, processes to assess and meet the range of client need needed further embedding to ensure they were consistent and robust.
- At the previous inspection in June 2017 we found that clients had not had a comprehensive assessment undertaken by the service before admission. Since the previous inspection the provider had agreed not to admit any new clients.However, the service had revised their admission criteria and process. This would include the GP in the pre-admission assessment.
- At the previous inspection in June 2017 we found that the service did not have systems in place to identify and meet client's personal care needs. At this inspection we saw improvements. Staff were recording in client records when personal care had been offered and if it had been refused or given. Staff also discussed and recorded this information at handover, ensuring that it was passed on to the next shift if someone had refused their personal care. However, further improvements were needed. We saw that care plans did not detail how clients preferred to be supported with their personal care.
- During this inspection we saw that staff had introduced drug and alcohol recovery stars. These reflected the person's alcohol use and how they wanted to be supported with harm minimisation. They also included information about their physical and emotional health, accommodation, finances, meaningful activities and relationships. These were holistic and personalised. However not all the information was always transferred into the clients care plans.
- At the previous inspection in June 2017 we found that client's nutrition and hydration needs were not always clearly documented. At this inspection we saw improvements. We found that client's nutritional intake was recorded and monitored through regular staff handovers. Staff also documented it in the daily notes. We checked the care and treatment records of one client where staff had flagged concerns regarding weight loss and referred the client to the GP. We were able to locate records that demonstrated how this had been addressed by the GP and feedback given to the client and staff.
- Systems to ensure the effective handover and communication between the service and visiting healthcare professionals needed further embedding. At the previous inspection in June 2017, we found that there was no system in place to ensure that effective communication took place after a community nurse or community mental health team visit, or when a client was reviewed by the GP.
- At this inspection, we saw that two clients were receiving support from community nursing teams. Staff told us that information regarding the community nurses support was kept in the client's bedrooms. We found that one client had a folder which contained information regarding the community nurses visit and a written record of each visit. The second client did not have a folder in place or anyway of communicating the community nurses visits which meant staff would not know the details of the nurse's visit.The provider informed us after the inspection that the community nurse had taken the folder away to update it following their visit. However, this had not been communicated to the staff team.
- At the previous inspection in June 2017 we found that some clients were receiving regular depot injections for mental health conditions from community psychiatric nurses. However we could not find details of their visits or when depot injections had been given or were due. At this inspection we saw improvement in communication. We looked at the MAR sheet for two clients who were receiving depot injections; both clients MAR sheets clearly indicated when their last injection had taken place and when the next one was due.
- At the previous inspection in June 2017 we found that whilst the GP visited once a week, there was no robust system to record client outcomes and follow up actions when seen by the GP. At this inspection, we were told that a revised GP contract had been developed and was

about to be introduced. We saw that the recording of GP visits was still not being recorded consistently within the same place on care records and that there was not a system in place to ensure that any actions from previous visits were followed through. We were told by the provider, that this would be addressed through the introduction of the new contract.

Best practice in treatment and care

- At the previous inspection in June 2017 we found that the service did not have a clear model of care or criteria for admission. The service stated that they were following a harm reduction model of care. However, there was no service model in place which included what the aims and objectives were of the service and how harm reduction was going to be achieved.
- At this inspection we found some improvement, but further work and embedding was needed. The service was developing and beginning to implement a model of 'psychological informed environment'. The purpose of a psychologically informed environment was to enable clients to make changes to their lives. This would be through the service developing a psychological framework, through the physical environment and social space, staff training and support, managing relationships and evaluation of their outcomes. The service had ensured that staff had received training in this process and had started to participate in reflective practice sessions. However, this process was seen by the service as developing over the next five years and did not include an implementation plan of how harm reduction would be achieved.
- At the previous inspection in 2017 we found that there was not a clear criteria for admission or clear procedures which stated how the harm reduction approach would work in practice. At this inspection, we found that there was a criteria for admission in place; however this did not include details on the harm reduction approaches in use at the service. This meant that new clients would not know what they were entering into before they were admitted. The service had included on their new admission criteria that they would not accept clients buying alcohol for other clients; however there was no clear plan in place as to how they would manage this for existing clients, or those admitted in the future.
- At the previous inspection in June 2017 the service did not have systems in place to effectively monitor and reduce harm caused by alcohol consumption. At this inspection we saw improvements. Clients had drug and alcohol stars in place where discussions with staff were recorded about how clients wanted staff to support them with their alcohol consumption. We saw nine drug and alcohol stars, these were comprehensive and in the clients voice. They showed that conversations and agreements were in place as to how staff should support clients with their alcohol consumption. We also saw that this was addressed within clients risk management plans. Since the last inspection, drinking diaries had been introduced. However, these revised systems needed further embedding to ensure their efficacy: some clients drinking diaries had not been fully completed and systems to monitor additional alcohol consumption on top of agreed amounts were not in place.
- During this inspection we saw that the service was not using any evidence based, National Institute for Health and Care Excellence (NICE) recommended screening tools to measure or assess

Skilled staff to deliver care

- Revised systems to deliver regular, good quality supervision needed further embedding. Further improvements were needed to ensure that specialist training to meet the needs of clients was identified and provided in a timely fashion.
- At the previous inspection in June 2017 staff were not receiving regular supervision. At this inspection we found that a revised template for supervision was in place, this template was structured and detailed. We saw that some staff had received recent supervision using this new template; this supervision was well structured with detailed notes. The service had developed a new supervision structure which clearly detailed who would be delivering supervision to whom and when this should be carried out. Staff we spoke to was positive about the new supervision process. Bank and agency staff were included within the service's supervision structure. However, these new processes required further embedding to ensure that all staff received supervision in line with the providers recommended frequency.

Substance misuse services

- At the previous inspection in June 2017 staff were not receiving any specialist training for their roles. At this inspection we saw that staff had received some specialist training such as moving and handling and an introduction to the new psychologically informed environment process. We saw that the service had identified specialist training that different staff grades would need to undertake. However, staff had not yet attended this.

Multidisciplinary and inter-agency team work

- The service had monthly team meetings; however, these were not always being held regularly, the frequency of the meetings needed improving.
- Staff shared information about patients at effective handover meetings within the team. Handover meetings took place three times a day when staffing changed at the beginning of a new shift.
- During this inspection, we saw that the provider had introduced monthly reflective practice sessions for staff, which were externally facilitated.

Good practice in applying the MCA

- At the previous inspection in June 2017 we found that staff had not undertaken Mental Capacity Act training.At this inspection we found that Mental Capacity Act training had been provided. Half of the staff team had attended this training, however there was no date set for the remaining staff to attend.
- At the previous inspection in June 2017, we found that staff did not assess client's capacity to consent to specific decisions where there were concerns. During this inspection we saw improvements; some clients had their capacity to consent to specific decisions assessed. Some clients now had Deprivation of Liberty Safeguards (DoLS) authorisations in place.
- At this inspection we saw in nine care plans that staff supported clients with managing their finances. Staff told us that not all of these clients had capacity to manage their finances; however where there were concerns regarding their capacity, this was not documented.

Are substance misuse services caring?

We did not inspect this domain at this inspection.

Are substance misuse services responsive to people's needs?

(for example, to feedback?)

We did not inspect this domain at this inspection.

Are substance misuse services well-led?

Leadership

- At the previous inspection in June 2017 the Registered Manager of the service was on sabbatical. The provider had not applied for the acting manager to become registered manager. During this inspection, the provider told us that the registered manager would not be returning to the service and that a new manager had been appointed and would apply to become the registered manager. A handover period between the newly appointed manager and acting manager was in place.
- Leaders (both the organisation and the local leaders) were visible in the service and approachable for patients and staff. This was an improvement since the previous inspection.

Governance

- Since the last inspection in June 2017, the provider had reviewed and made changes to many of its governance systems. These needed further embedding to ensure they were consistent, effective and robust. However, systems to ensure the cleanliness, hygiene and maintenance of client bedrooms and bathrooms were not effective and had not been reviewed or updated since the last inspection.
- Since the last inspection the provider had reviewed and made changes to its recovery model and harm reduction approach, but further work was needed to ensure that the recovery model and harm reduction approaches were consistently and effectively implemented within a reasonable timescale.

Substance misuse services

- At the previous inspection in June 2017 we found that the provider had failed to make sure that systems and processes were established and operated effectively to ensure the quality and safety of the service. At this inspection we found that the provider had taken steps to ensure that there were systems and processes in place to ensure the quality and safety of the service. These included increased staffing levels, safeguarding procedures had been developed and there was a new contract with the GP being put in place. However, further work was needed to ensure that these systems were consistent, effective, robust and embedded.
- At the previous inspection in June 2017 there were no records of any audits since March 2017. At this inspection we found that audits were now taking place within medication management, health and safety, recovery stars and risk assessments. The provider had a new quality assurance team who were to ensure that regular auditing took place. Audits of care plans and client notes were taking place by the service managers.

Culture

- Staff we spoke to were very committed to the clients and to the service. Staff informed us that the team worked well together and that they felt comfortable to put forward new ideas and suggestions. Staff felt that managers were open and approachable. Staff were positive about the changes they had seen taking place since the last inspection.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that a clean, hygienic, well maintained environment is provided for clients.
- The provider must have a clear service model in place that clearly identifies the recovery and harm reduction models in use at the service. The provider must ensure that staff are implemented as quickly as possible.
- The provider must ensure that effective, consistent and robust governance systems are embedded within the service.
- The provider must ensure there are effective systems in place for the proper and safe administration and management of medication. Staff who administer medicines must be competent to do so.
- The provider must ensure that appropriate measures are in place to ensure the safety and security of clients and staff within the premises.
- The provider must ensure that there is sufficient staff on duty to meet client's needs.
- The provider must ensure that staff receive mandatory and specialist training so that they can safely meet the needs of clients. The provider must also ensure that staff receive regular supervision.
- The provider must ensure that the physical health care needs of clients are met and that this is documented.
- The provider must ensure that risk assessments are updated when clients' needs change.
- The provider must ensure that all actions to minimise the risk of fire and to promote clients and staff safety in the event of a fire, are completed.
- The provider must ensure that learning from incidents is shared with staff and that all incidents are reported.
- The provider must ensure that all clients have comprehensive care plans in place that address all their needs.
- The provider must ensure that the Mental Capacity Act is used appropriately. They must ensure that all staff have completed Mental Capacity Act training.
- The provider must ensure that the new manager is appropriately supported to maintain safety and quality of the service. They must ensure that the manager is registered with the CQC.
- The provider must ensure that there is a policy in place regarding same sex accommodation. The provider should ensure that consideration is given to where bedrooms and bathrooms used by female residents are located.

Action the provider SHOULD take to improve

- The service should ensure that staff record clearly when one to one sessions with clients have occurred.

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 **Care and treatment must be provided in a safe way for service users.** The provider had not ensured that risk assessments were updated following changes in client's needs The provider had not ensured that an effective system was in place for assessing the risks to the health and safety of clients. The provider had not ensured that there was safe management of medicines. The provider had not ensured that staff had received training in the management of epilepsy and seizures including the risk of alcohol related seizures. The provider had not ensured that adequate systems were in place to ensure communication took place between different professionals The provider had not ensured that fire safety measures were sufficient to meet the needs of all clients. The provider had not ensured that all incidents were reported and that learning and outcome of incidents were discussed with both staff and clients. **This was a breach of Regulation 12 (1)(2)(a)(b)(c)(g)(i)**

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

Systems or processes must be established and operated effectively to ensure compliance with the requirements of the Act.

The service was not operating a clearly defined model of substance misuse treatment

The provider had not ensured that it maintained accurate, complete and contemporaneous records in respect to each service user including the monitoring of clients alcohol intake.

The provider had not ensured that there were effective systems in place to assess, monitor and improve the quality and safety of the service.

The provider had not ensured that there was a clear plan in place for regarding achieving same sex accommodation guidance.

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

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Sufficient numbers of suitably qualified, competent skilled and experienced persons must be deployed. They must receive such appropriate support, training, professional development, supervision and appraisal as necessary to enable them to carry out the duties they are employed to perform.** The provider had not ensured that staff had completed mandatory training. The provider had not ensured that all staff had received appropriate specialist training required for their role. The provider had not ensured that staff received regular supervision. The provider had not ensured that there was a system in place to ensure that adequate staffing was in place. **This was a breach of Regulation 18(1)(2)(a)**

This section is primarily information for the provider

Enforcement actions

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 15 HSCA (RA) Regulations 2014 Premises and equipment **All premises and equipment used by the service provider must be clean, secure, and suitable for the purpose for which they are being used.** The service had not ensured that client bedrooms and communal bathrooms were clean and well maintained. The service had not ensured that all the equipment used in the communal bathrooms was suitable and could be cleaned to ensure that infection control measures were met. The service had not ensured the safety and security of the premises to protect staff and clients **This was a breach of Regulation 15 (1)(a)(b) (c) (2)**