

Compass - Enfield

Quality Report

Forest Primary Care Centre
2nd Floor
308a Hertford Road
Edmonton
London
N9 7HD

Tel: 0208 379 6010

Website: <http://www.compass-uk.org/>

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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

The service was actively engaging with patients from the wider communities and had created good links with the local hospital. The service provided flexible appointments and was accessible during the week.

However, staff had identified risks to patients undergoing alcohol and opiate detoxification but risk management plans did not demonstrate how staff were managing or mitigating the risks. There was an inconsistent approach to risk assessments as staff were using two separate risk

assessment tools. Care plans were not meeting the national treatment agency (NTA) care planning guidance and staff were not using the care planning tool consistently.

Staff did not routinely conduct medical reviews of patients during the detoxification programme, which went against the provider's policy and The Drug Misuse and dependence: UK Clinical Guidelines on clinical management (Orange book), 2007.

During medical reviews, staff did not assess patients' withdrawal symptoms with an additional validated

Summary of findings

alcohol or opiate assessment tool. This meant that they were not able to assess the full extent of the patient's dependency. The service carried out various audits within the past 12 months which demonstrated similar findings. The provider did not have systems in place in order to improve on the areas of concern. Overall, the service was providing inadequate, unsafe care and treatment to patients.

As a result of the safety concerns identified, we issued the provider and registered manager with a warning notice under Section 29 of the Health and Social Care Act 2008. We took this action as we believed people using this service may have been exposed to a serious risk of harm.

Summary of findings

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Compass- Enfield

Services we looked at

Substance misuse/detoxification

Summary of this inspection

Background to Compass - Enfield

Compass-Enfield is provided by Compass - Services To Tackle Problem Drug Use and is registered to provide the following regulated activities:

- Treatment of disease, disorder or injury
- Diagnostic and screening procedures

The service has a registered manager in place.

Compass-Enfield provides a drug and alcohol treatment service for adults in the London Borough of Enfield. The service provides advice and information, substitute prescribing, psychosocial groups and detoxification.

Compass - Services To Tackle Problem Drug Use has two services within the London Borough of Enfield, which work together. Compass-Enfield provides a fully integrated drug and alcohol treatment service for adults, including maintenance care and treatment for patients

that are nearing the end of treatment. Patients that attend a similar Compass service called The Claverings transfer to Compass-Enfield when they are near to the end of treatment.

The service had 129 patients on their caseload at the time of the inspection. Patients were seen on a weekly and monthly basis depending on the stage of recovery or treatment. Compass-Enfield provides a range of services to patients, including a patient involvement group and a structured day programme four days a week, which patients attend as part of their recovery programme. Staff managed a needle-exchange service from the site, which operated throughout the week.

We inspected Compass-Enfield twice in 2013 and reports were published in 2013 and 2014. At the time of the last inspection, Compass-Enfield met essential standards. The service were recently inspected against the new regulations called fundamental standards.

Our inspection team

The team that inspected the service consisted of two CQC inspectors, one assistant inspector, two CQC pharmacy specialists, two specialist advisors and an expert by

experience - which is a person who has had experience of using similar services. The specialist advisors were a consultant psychiatrist and a social worker, both of whom had a background in substance misuse services.

Why we carried out this inspection

We inspected this service as part of our comprehensive mental health inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

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

- Is it well-led?

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

During the inspection visit, the inspection team:

Summary of this inspection

- looked at the quality of the service environment including the needle exchange service
- spoke with four patients who were using the service
- spoke with the registered manager, assistant director and team leader
- spoke with seven other staff members; including doctors, keyworkers and a lead nurse
- received feedback about the service from commissioners and external stakeholders
- attended and observed a patient feedback session with eight patients
- attended and observed two structured day programme groups
- looked at 19 patient care and treatment records
- carried out a specific check of the medication management at the service
- looked at a range of policies, procedures and other documents relating to the running of the service
- collected feedback from three patients using comment cards we had left in the service.

What people who use the service say

We spoke with four patients and most were positive about the service. They said that the service was good and had a nice atmosphere. Staff were described as being 'helpful, brilliant, and caring'. Patients were less positive about the resources in the service, the appointment times and the attitude of some staff.

Patients felt there was a lack of opportunity to feedback about how the service was run. Patients felt that the day

programme only had one learning style, which was based around reading from a flipchart, and that the allocation of keyworkers was not made clear to patients. This was highlighted when staff members left the service and there was a change in keyworker. Other patients told us that they felt their recovery was progressing well and that they enjoyed the day programme structure.

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?

- Medical reviews of patients were not being completed every three months, in line with the provider's policy. Patients were beginning opiate detoxification treatment without an initial physical health check. This was contrary to national guidance outlined in The Drug Misuse and dependence: UK Clinical Guidelines on clinical management (Orange book), 2007.
- Following a patient's initial assessment, staff identified the risks affecting patients. However, staff did not document how the risks were managed and mitigated. Risk assessments were not updated with new information or record any action taken. A new risk assessment tool had recently been adopted which led to two different tools being present in client records. This led to an inconsistent approach to assessing risk and posed a risk to patient safety.
- The service doctor did not use an additional validated alcohol or opiate severity assessment tool during clinical assessment. This was not in accordance with national guidance.
- There was no record of how often the panic alarm in the reception area was tested to make sure that it functioned effectively. This did not ensure the safety of staff.
- However, the environment was clean and tidy. The service had two clinical rooms which included a room that was dedicated for the needle-exchange service. The rooms were safe and well stocked. First aid signs were clearly visible on the walls. The clinical room doors were unlocked which was raised with the service manager. It was highlighted that these doors must be kept locked at all times. The service manager told us that doors were normally locked but were kept open to accommodate the inspection.

Are services effective?

- The service used a care planning tool called the outcome star. The tool was used to help identify patients' needs across several domains, for example, physical health and social needs. Staff used the care planning tool inconsistently and the quality of care plans was poor as a result. Some patients were not involved in developing their care plans. A care plan audit showed that the service was underperforming in all areas of the care planning process. Recovery goals did not have set dates for review and were not in accordance with national guidance

Summary of this inspection

- Staff received an annual appraisal and regular supervision. The supervision records predominantly focused on a caseload review and not structured clinical supervision as described in the Compass Supervision Policy. There was no focus on a staff members' professional development and no specific agenda items to discuss.

Are services caring?

- Patients felt they were not given the opportunity to feedback about the service, in particular about the structure and content of the day programme.
- However, staff were caring and friendly towards patients. Patients commented that their overall experience at Compass-Enfield had been positive.

Are services responsive?

- The service found it difficult to book interpreters at short notice. The leaflets provided by the service were only available in the English language. This did not reflect the needs of the local multi-cultural population.
- However, the service provided a duty system for urgent calls and staff alternated to manage this. The service was accessible during the working week and the other site provided appointments in the evening.
- Staff took an active approach to engage patients from different cultures and communities. Staff were identified to lead in different areas in order to target specific groups of people. For example, the women's lead had built strong links with a local midwifery department in order to share knowledge and work with pregnant women who misused substances.

Are services well-led?

- The systems in place did not ensure that patients were being treated and cared for in a safe way. The provider had failed to ensure that risk assessments, physical health assessments, care planning and regular medical reviews were taking place.
- Results from recent audits were not followed up appropriately and promptly. The service did not have systems in place for staff to provide regular feedback about their experiences in the service.
- However, the provider had created a new learning and development framework in order to support staff within their role.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

Seventy-seven percent of staff were trained in the Mental Capacity Act. Staff understood that all patients were assumed to have capacity. Patients voluntarily entered treatment and were presumed to have the capacity to

consent to treatment. Staff were aware of how to escalate concerns around capacity to consent. However, not all staff could describe the five areas associated with testing capacity.

Substance misuse/detoxification

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse/detoxification services safe?

Safe and clean environment

- The service was located within a primary care centre. Closed circuit television was operating internally and externally to ensure peoples' safety. There was a panic alarm in reception for staff to use in an emergency. However, staff were unaware when this was last tested.
- The environment was visibly clean, free from clutter and had furniture that was well-maintained. The service had a good-sized waiting area with a dedicated reception. The door that led to the reception was not locked, as the keypad entry system was faulty. This left the member of staff based at reception quite vulnerable. We raised this matter with the service manager who said that they would ensure it was fixed.
- Patients could not proceed past a specific point in the waiting area unless supervised by a member of staff. This was because the corridor led to offices and meeting rooms. The corridor was monitored by the administrative staff as the area was visible from reception, which was manned throughout the day. However, we were told that rooms were usually locked when not in use.
- Fire exit signs were clearly marked and the service had an identified fire warden. The staff member had appropriate training to undertake this role. A recent fire risk assessment was completed and no risks were identified. The building had regular, weekly fire drills and monthly fire extinguisher checks, which had all been completed for the past six months.
- The service had two separate, fully equipped clinic rooms. The rooms were very clean and tidy. One clinic room had a locked fridge, which contained vaccinations.

The temperature of the medicines fridge was checked daily to make sure it was at the correct temperature and vaccines remained effective. First aid information was clearly displayed and there was a stocked first aid box.

- The cleaning records from the past six months were completed and demonstrated that the environment was cleaned regularly. Hand washing posters were visible in the corridors and hand washing facilities were present in each individual meeting room, including both clinical rooms.
- Both clinic rooms were unlocked at the time of inspection. Staff recognised that the inspection team would require access to these rooms and confirmed the rooms would normally be locked. One clinic room had an examination bed and equipment to check blood pressure. There was no other physical health check equipment. The blood pressure machine had no indication of when it was last serviced. We were told that the machine was new and equipment checks would be started. .
- Records showed that 55% of staff had received training in basic life support and anaphylaxis management earlier in the year. The training included cardiopulmonary resuscitation (CPR). The senior manager told us that a member of staff who had completed the training was always available to attend to a medical emergency. Fifty five per cent of staff had completed training to administer a medicine called naloxone. This could be administered in cases of opiate overdose. The provider had appropriate resuscitation and anaphylaxis guidelines in place. This assured us that a member of staff was always available to provide emergency life support.
- The needle exchange clinical room was located within the service. Patients had access to this service without an appointment. An identified member of staff led on the needle exchange service. Data was received from local pharmacies on a monthly basis about the drugs

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that were used by the people that returned used needles. The information was sent to the service, which they found useful in identifying drug trends in the borough. The room had a hatch opening, which was not currently in use, as patients were asked to come into the clinic room instead.

- The needle exchange service provided safe, dark, non-transparent boxes where needles were stored and could be locked once used. All patients were provided with the boxes during the needle exchange process. There was a large stock of the smaller disposal boxes. The waste bins for used needles were appropriate and not over-filled. The larger bins could also be locked and were removed by an external company.

Safe staffing

- The service predominantly operated between 9am to 5pm Monday to Friday. On a Wednesday afternoon the service would close due to a weekly team meeting. The multidisciplinary team (MDT) included a service manager who also managed another local service, a team leader, a clinical lead and two agency nurses. They were supported by three permanent recovery workers and an administrator.
- Previously, the service was operating with a high turnover of doctors and locum doctors were employed for short periods. The service had recently employed a locum specialty doctor who worked every Friday morning.
- The service employed four permanent recovery workers. An agency recovery worker was due to join the team shortly on an interim basis. The qualified nursing establishment was two. However, Compass-Enfield was having difficulty recruiting permanent qualified nursing staff that had a substance misuse background. As an interim measure the service had recruited agency staff with a view to employing them full-time. One of the service commissioners also told us about this. The service did not have any non-medical prescribers employed.
- The staffing establishment was based on how many patients the service had on their caseload. Keyworkers had a caseload of approximately 35 patients each. Staff told us that the service was short-staffed and it was difficult at times to manage a caseload of 35 due to the high amount of administrative work.

- Employment records for all staff showed that appropriate pre-employment checks had been carried out. The provider had a recruitment and Disclosure and Barring Service (DBS) policy. This ensured that staff had criminal record checks every three years.
- There was a rota system in place for staff members from Compass-Enfield to work until 7pm during the week. This service was available to patients who are unable to get to appointments during core working hours.
- Staff sickness records for the past 12 months showed that sickness was relatively low. One member of staff had left Compass-Enfield in the past 12 months.
- The service had a doctor present every Friday morning when medical reviews take place. Due to the nature of the service, out of hours help was unavailable. Patients were advised to attend their local accident and emergency department outside of working times if they were in crisis. Patients were signposted to local support groups.
- Staff mandatory training included information governance, infection control, and safeguarding adults and children. Records showed that seven out of nine staff members had up to date safeguarding of vulnerable adults and children training. All nine staff had completed an information governance course and infection control training.

Assessing and managing risk to patients and staff

- The initial triage and assessment of patients prior to commencement of treatment was completed at the providers' other local service called The Claverings. Patients' care and treatment was then transferred to the service. Patients that were treated at Compass-Enfield were more stable in treatment and were seen as part of a maintenance programme. This was to separate patients who were at the start of treatment and those who were at the end of treatment or in recovery.
- The service manager told us that there were plans to have a clear treatment pathway, which would formalise the current practice of moving from one site to another. Senior management explained that, on occasions, the service saw patients who were at the start of detoxification but this was normally for a specific reason and was discussed with both teams.

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- Risk assessments and risk management plans were not clear and robust. A new risk assessment tool had recently been adopted which led to two different tools being present in care records. The approach to assessing risk was inconsistent. In 13 risk assessments, staff had identified potential risks, but there was no further information about how the risk was being managed. For example, the service used a specific form called a treatment outcome profile (TOP). The form measured a patient's progress and highlighted areas of change and areas of further work. The TOP form highlighted risk information about the patient. However, the information was not reflected in the risk management plan and did not show how the risks were being managed or mitigated. Two records demonstrated good practice, letters had been sent to the patients' GPs explaining risks that had been identified. The risk assessments in these two records were robust and one record identified risks to children, explaining how the risk would be managed.
- The provider had carried out a recent audit of 30 risk assessments and a number of concerns were identified. The audit recorded responses to the question, 'Are there any safeguarding risks and have they been addressed?' Fifty per cent of risk assessments provided a response to the question and 50% did not. However, following the audit, there was no action plan in place to address the concerns.
- Eighty per cent of staff were trained in safeguarding vulnerable adults and children at risk. Staff were able to explain how to raise a safeguarding alert or discuss concerns. There was a specific early help safeguarding form, which was completed and sent to senior managers as well as the hidden harm team. The hidden harm team provided support and advice to the team for cases that involved children. Issues related to safeguarding children were included in the initial patient assessment.
- The service had made one safeguarding referral in the past 12 months to the local authority and provided us with information about this. The concern was fully investigated by the provider and options were explored by the safeguarding team.
- The hidden harm team was based within Compass-Enfield's service. It provided a play therapy room with a play therapist as part of the adults aftercare programme. This was a recent addition to the service and was working well. Children could be supervised by therapists from the hidden harm team while their parent or carer was being seen by key workers at Compass-Enfield.
- The provider had a lone working policy, which covered all aspects of staff working alone in the community. An electronic diary was updated in relation to staff whereabouts and staff were asked to make contact with the service regularly. The service manager told us that the staff member acting as duty worker for the day, was responsible for answering the phone during working hours and monitoring that staff were 'checking in'. Staff members rarely worked on their own offsite.
- The management of medicines in the service was safe. All prescribers followed the Royal College of General Practitioners guidance on community detoxification. They followed a template, comprising of an initial assessment, titration, re-titration and stabilisation. A clinical nurse specialist provided specialist advice and support for all patients undergoing alcohol detoxification. The service did not keep control drugs on the premises. They were stored at the provider's other location.
- The provider had an appropriate prescription distribution system. Each prescription pad was logged into the computer system on receipt, with the corresponding identification number. The prescriptions were logged with specific numbers and signed by the manager and keyworker. This system worked effectively and ensured safety.
- The service had a pharmacist that was part of the clinical working group who provided an advisory role to the team. A patient group directive policy was in place for the use of naloxone and Hepatitis B vaccines. This was appropriately signed. The patient group directive meant that staff were permitted to supply prescription-only medicines to groups of patients without individual prescriptions. The service did not store controlled medicines on site. However, fridge temperatures were being monitored daily to ensure the correct temperature and remained fit for use. The inspection team highlighted to the service manager that clinical room doors must be locked at all times.
- There was a lack of physical health monitoring recorded in medical notes. A patient was seen on 25 February

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2015 for an initiation of a specific opiate medicine regime. Prior to beginning this regime, no physical examination was documented in the records. Another patient had an appointment on 3 March 2015 and no physical health examination had been documented in the records. A third patient began a course of Buprenorphine re-titration on 13 April 2014 and no record of any physical examination was available in the medical notes. The Compass Prescribing policy 2014 did not specify that physical health monitoring should take place at the initiation of a medicine regime and be reviewed thereafter. However, this is contrary to The Drug Misuse and dependence: UK Clinical Guidelines on clinical management (Orange book), 2007, which states 'a standard physical health assessment and physical examination should be carried out on all patients entering methadone maintenance treatment.' The Compass policy was not in accordance with national guidance. This was highlighted to senior management who told us that physical health checks were taking place. However, there were no records to show it was taking place. This meant that patients were at risk of serious complications to their physical health because physical health assessments were not completed prior to treatment.

Track record on safety

- There had been one serious case review in the past 12 months which was in relation to a death in the community. The serious case review report included recommendations and actions for Compass-Enfield and other authorities involved.
- There has been one serious incident in the last year. This incident was investigated by the provider. A full investigation report including findings and recommendations for improvements was produced. Team meeting minutes showed that incidents were discussed and were a standing agenda item at such meetings

Reporting incidents and learning from when things go wrong

- Staff were aware of how to report an incident and felt confident to discuss this with peers. All incidents were reviewed by the service manager.

- Learning from local incidents and sharing took place within weekly team meetings and clinical review meetings. Incidents and safeguarding referrals were fixed items on the agenda for meetings and new ways of working were implemented in response to learning.
- Following an incident, the provider undertook an investigation. Staff told us they felt supported to report an incident and were able to discuss these with their colleagues and seniors. The service did not have a system in place to share learning with members of staff who were unable to attend the clinical review meetings.
- An internal review took place as a result of concerns that were raised about the lack of training, prescription pads not being securely kept, staffing issues, lack of regular supervision and the management of an incident involving a member of staff. The issues were fully investigated by the provider. Behaviour and conduct of staff was found to be an issue and the management team worked with staff on improving communication and staff conduct. Recommendations and findings were disseminated to staff.

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

Assessment of needs and planning of care

- We reviewed the care records of 15 patients. Four separate records were reviewed which specifically looked at the medical notes. Care records included care plans, medical reviews, risk assessment and management plans, and physical health examinations. Patients were initially assessed and triaged at a different registered service, then transferred to Compass-Enfield.
- Seven of the 15 care plans did not demonstrate that care plans were personalised, holistic and recovery-orientated. The goals did not specify a review or completion date. The National Treatment Agency (NTA) Care Planning guide 2006 states, "All goals should have a time limit set, within which the keyworker and client expect the agreed changes to have taken place. Goals without time limits may be postponed to some unspecified future time and never be addressed." A care plan for one service user was unavailable and could not be located in the electronic or paper files. The NTA

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guidance says, 'Care planning is a core requirement of structured drug treatment. Models of Care: Update 2006 identifies care planning as a key component of Tier 3 and Tier 4 structured specialist drug treatment interventions. This meant that care planning for patients that were attending this type of community drug and alcohol service was a key requirement.

- The service used a specific tool for care planning which had recently been adopted. The tool was used to support a more comprehensive understanding of patients' needs. However, staff used the tool inconsistently, and the quality of the care plans was poor. Five care plans were not signed by the patients and it was unclear whether a copy had been given to them, if the individual had been involved in the care planning process and whether they agreed with the goals set. The NTA guidance states that 'only by including clients can achievable goals be set, linked specifically to clients' needs'.
- For one patient, a re-engagement plan was available in their records. This type of plan informed staff of how to contact the patient if they stop attending appointments or the patient is uncontactable. However, this plan was dated 2013 and had not been reviewed or updated since. This meant that the existing details could have been out of date and there was a risk of not being able to contact the patient or relevant persons if required.
- The provider carried out a care plan audit in January 2015, which was repeated in May 2015. The January audit highlighted that the service was below the 100% target rate in all areas of care planning. This included regularly reviewing the care plans, quality of the planning and lack of evidence of patient involvement. Reviewing care plans scored 78% in January and had improved to 85% in the May audit. However, the areas of development had not been addressed within the timescale that was outlined in the action plan. This meant the provider was aware of the areas that required improvement but was not actively addressing them.
- Records were held on an electronic records system as well as on paper. It was not clear what information was held in the paper record and what was held on the electronic system. This was inconsistent in the records we reviewed. The electronic records did not allow staff to find information easily and quickly. The electronic

records did not have a specific area where information about a patient's physical health was recorded. The senior manager told us that the type of electronic care record system had not been chosen by the provider.

- There was a specific information form for staff to complete with patients, which included asking for the type of drugs that were used, contact details, whether the patient had contact with children and if they were pregnant. The members of staff explained that patients rarely wanted to provide personal details and usually the details given were brief.
- We reviewed the medical records of four patients and found that staff were not documenting that they had informed patients of side effects, discussed treatment options and made sure patients understood their treatment programme. This meant patients may have not have given their consent to treatment based on a clear understanding of the risks and benefits. However, one medical record did contain a treatment programme, which was signed and dated by the patient.

Best practice in treatment and care

- The service was not following current national guidance regarding the prescribing and administration of medicines. Three care records showed that patients were undergoing a specific medicine regime of re-titrating. Physical examinations had not been completed prior to the medicine being prescribed. The way medicine was being prescribed and administered was unsafe. For example, a patient was seen once prior to starting a regime and once during. No physical examination was documented in the records.
- The service offered patients routine Blood Borne Virus (BBV) screening and vaccination. However, the service was not performing as well as expected. The commissioners were monitoring this closely as the service were below set target rates.
- The Compass Prescribing policy 2014 did not specify that physical health monitoring should take place at the initiation of a medicine regime and be reviewed thereafter. The Drug Misuse and dependence: UK Clinical Guidelines on clinical management (Orange book), 2007 says 'a standard physical health assessment and physical examination should be carried out on all patients entering methadone maintenance treatment.' The Compass policy was not in line with this guidance.

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- The service did not offer psychological therapies to patients. Staff signposted patients to other local services for this.
- The doctor told us that all new initial patient assessments patients would be referred to their GP for an electrocardiogram (a test on their heart). Communication with GPs was documented in patient files. However, one care record did not clearly demonstrate that a health condition had been reported to the patients GP. This meant that the GP was unaware and the patient was at risk. This was raised with the senior manager who rectified this immediately.
- The provider collated National Treatment Outcome Profile (TOPS) information every 12 weeks which covered several domains. This tool was used to measure progress and/or improve patients' recovery and inform any changes to a patient's life.
- The lead nurse for the service had undertaken audits concerning medicine administration records, medical reviews and care planning. Key workers did not get involved in completing audits but the findings of audits were discussed in the team meetings.
- A prescription audit had been carried out ten months prior to the inspection and the outcome was positive. An action plan and recommendations were made from this audit in order to provide a more systematic way of record-keeping, which was used in one-to-one meetings with staff to highlight good practice and areas that required improvement.
- Fifteen care records were reviewed and four separate records were reviewed which specifically looked at the medical notes. The four records did not demonstrate that an additional validated alcohol or opiate assessment tool had been used. National guidance recommends part of a comprehensive assessment should be the use of 'relevant and validated clinical tools'. The severity of the person's alcohol dependence should be assessed using the Severity of Alcohol Dependence Questionnaire (SADQ) or the Leeds Dependence Questionnaire (LDQ) (Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence, 2011). This meant that tools to assist clinical assessment were not being used.
- A medical review audit from September 2015 demonstrated that patients were not receiving medical

reviews every three months as stated within the Compass prescribing policy 2014. The providers' prescribing policy 2014 stated 'during the initial commencement period it is important that patients are reviewed regularly to observe for signs of withdrawal or over sedation.' The medical review audit assessed patients who were on reducing opiate substitute prescribing regimes and patients who had received treatment for alcohol dependency. This audit showed the provider was aware that this was an area of concern. However, systems were not in place to ensure all patients had regular medical reviews. For example, one patient's medical record showed that a review had not taken place for 10 months. The last documented review was on 2 December 2014. Two other patient records showed that a review had not taken place for six months. Another patient's medical record showed they had been reviewed appropriately. The policy stated that any patients that were prescribed medication should have this reviewed at least every three months as part of their planned medical reviews. This had not happened for three of the four patients whose records we reviewed.

Skilled staff to deliver care

- The doctor and nurses were responsible for completing patient physical health checks. The doctor was responsible for prescribing medicines. The service did not have any non-medical prescribers.
- Staff received training in counselling, management, stimulants and overdose prevention. The providers training package was being redesigned following a training needs analysis so that it was fit to meet staff needs.
- Records showed that staff members were not receiving regular supervision on a monthly basis and there were gaps on average of up to four months. During supervision, the emphasis was placed upon discussion of the individual staff members' active caseload. There was little emphasis on staff members' performance, development and wellbeing. One hundred per cent of non-medical staff had received an annual appraisal in the last 12 months.
- Five supervision records showed that caseloads were reviewed during the meetings for all staff. There were no specific agenda items, for example, safeguarding of

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vulnerable adults or children, risk or diversity. The notes were brief in all records. Only one supervision record we saw focussed on a staff member's request for further development within their role.

Multidisciplinary and inter-agency team work

- There was a daily multi-disciplinary meeting involving key workers, qualified nurse and managers.
- The provider liaises with the relevant community mental health teams (CMHTs) to ensure that clients are supported appropriately. The service manager told us that liaison is good when the patient already has a community psychiatric nurse, otherwise organising an assessment can be difficult. The pathway for patients that were experiencing mental health problems as well as misusing substances was not clear.
- Joint meetings with provider's other service took place when patients were transferred to Compass-Enfield.
- The women's lead from Compass-Enfield had built up a strong link with a local midwifery department, which involved working with pregnant women who misused drugs and alcohol.

Good practice in applying the MCA

- Seventy-seven per cent of staff had received Mental Capacity Act training in the previous year.
- Staff members told us that all patients were voluntarily approaching the service for treatment and they were presumed to have the capacity to consent. Staff were aware of how to escalate concerns around capacity to consent. However, not all staff could describe the five areas associated with testing capacity.

Are substance misuse/detoxification services caring?

Kindness, dignity, respect and support

- Staff were friendly and caring towards patients. Patients were positive about the service. There was a mixed opinion of the staff's approach, but overall they were described as excellent and helpful. At the start of the daily, structured programme, the facilitator would read out the rules of the group, which would highlight 'to be

kind and maintain confidentiality'. Advice about complementary therapies was made available. For example, information on guided meditation was available.

- Patients were asked to sign a form for consent to sharing information, which was not always documented within the electronic care records.

The involvement of people in the care they receive

- Care plans did not always show that patients were actively involved within the care planning process. The plans were not regularly signed by the patient to show they had read and agreed with the plan. Some patients told us that they had a care plan and had seen it; others said they were not aware of it.
- Feedback from the structured day programme was that patients were unhappy that the group mainly focused on looking at the notes on the board. The group feedback was that they would like to interact with each other more but the service did not offer an opportunity for patients to be involved within the planning of the programme content. Staff acknowledged that the service did not always provide opportunities for patients to regularly feedback about the group.
- At the reception of the service, there was a comment cards box. An electronic feedback board was in the waiting area. The board was provided by an external team. It was difficult for the service to obtain feedback from the external team. The comments from this board were unavailable to us. The service manager told us that this was a longstanding issue .
- The provider had a peer mentor programme for patients who were coming to the end of their treatment. The patient could become an advisor and advocate for other patients. The programme was designed to empower patients and build confidence.
- The service asked patients to sign a treatment contract. The contract outlined what the service expected and what the patient should expect from the service. The contract stated that if the patient felt that the service was not meeting their part of the agreement then they could speak with a manager and formally complain. The

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contract also highlighted that the service could provide lockable storage boxes for medicines if patients had children. This was in order to prevent children from being in contact with medication.

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

Access and discharge

- Patients entering the service were nearing the end of treatment and would be transferred over from the The Claverings. This service was part of the Compass provider which helped to ensure a smooth and safe transition. Patients would be assessed again in relation to their current drug use and social circumstances. Patients were regularly discussed within the team clinical meetings.
- The service provided maintenance programmes and continuing engagement. The structured day programme, provided psychosocial support facilitated by trained recovery workers. Staff told us that patients were transferred once stable in a treatment programme and they were able to offer an appointment a week post-assessment.
- A telephone duty system was in place for urgent calls. Staff alternated in answering the 'duty phone'. Patients contacted the team if they needed to be seen or needed advice.
- The service had a doctor on site on a Friday morning. However, there was a doctor available throughout the week at the other site which could be reached easily.
- The service commissioner we spoke with was positive about the service and said communication with staff had been very good and that they were very professional in their approach. The service had responded promptly to all requests for information.
- Staff members took an active approach in engaging patients who did not attend appointments by texting, making telephone calls and writing letters. A patient was asked during the assessment to complete a re-engagement plan, which included professional contact details, and friends and family details. If the patient missed three appointments and had not

contacted the service, they were discharged from the service. The discharge process was followed if patients had left the service or a discharge had been planned. This highlighted risks that would require follow up.

- The provider was taking active steps to engage and build links with London Friend, an organisation who specialised in supporting lesbian, gay, bisexual and transgender communities. The provider had purchased new needle exchange packs to target groups of people who misuse drugs in a specific way. The packs were intended to be used as an engagement tool in North Middlesex Hospital and provided harm reduction, support and encouraged people to begin treatment for substance misuse.
- The service was open from 9am to 5pm. However, the other site was open longer, until 7pm. This meant patients had the flexibility to attend an appointment there if required. Wednesday afternoon was by appointment only due to the team holding a weekly team meeting. Other services would see patients requiring appointments at that time. Keyworkers also saw people at short notice.

The facilities promote recovery, comfort, dignity and confidentiality

- There were clearly labelled rooms, which were suitable to provide individual or group therapy. The rooms were adequately sound proofed.

Meeting the needs of all people who use the service

- The waiting area had a large amount of leaflets. These included information regarding how to complain and the complaints procedure, service-user rights and responsibilities, and a local lesbian, gay, bisexual and transgender mental health service-user group. The information that was available was only in English. Compass-Enfield served a multi-cultural population and patients who did not speak English would not be able to access this information. The needle exchange clinic did not provide leaflets in other languages. Staff told us that they had access to interpreters but this would need to be pre-booked. There was a variety of languages spoken within the team, which helped communication.

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- The service recognised that black and minority ethnic communities (BME) found it difficult to access services. In response, the team actively helped to find support groups for patients.
- The service was located on one floor and had a working lift, which made it easy for people with physical disabilities to access the building.
- Specific staff took the lead in different areas in order to target specific groups of people that needed to access treatment. For example, there was a sexual health lead, a BME lead, and a women's lead.
- The women's lead had built up a strong link with a local midwifery department, which involved working with pregnant women who misused drugs and alcohol. This was joint working with specialist midwives and offered the opportunity for shared learning between services. The service had developed an information pack for sex workers, which contained harm reduction information.
- The service was keen to engage people and provide harm reduction information to individuals to highlight safety. Within the clinical room there were many posters clearly displayed showing different types of needles and safer injection sites. Lists of local pharmacies that provided needle exchange services were visible on the wall. Leaflets were not available in languages other than English.

Listening to and learning from concerns and complaints

- Information on how to make a complaint about the service was on display in the waiting area.
- The provider had a clear complaints procedure and policy which staff were aware of. Staff told us that they would support patients to make a complaint if required. The service manager told us that there had been informal complaints raised and these were not escalated but were resolved locally. There had been no formal complaints raised in the last six months.
- A staff member told us that they met with patients to discuss any problems they had. Concerns were often resolved in this way. For example, recently a patient had requested a specific type of substitute prescribing and the service user had a meeting with key workers to discuss treatment options. This allowed an opportunity to promote engagement.

- There was a suggestions box for patients but it did not appear that many suggestions or comments were made. This meant that the service is unable to improve and learn from people using the service. The information sent to us by the provider explained that the service was reviewing the feedback process and intended to appoint a service-user representative to collate feedback from patients and directly feed this back to the service manager.

Are substance misuse/detoxification services well-led?

Vision and values

- Staff understood the overarching principles of the service and the main objectives of the work the service carried out.

Good governance

- The provider had systems and processes in place to assess, monitor and improve the quality and safety of the service, but these were not always effective in ensuring safe care and treatment was provided to patients. Patients were put at risk as a result.
- There was no clear system in place to ensure all patients were being medically reviewed regularly. Patients were not receiving a physical health check prior to administration of medicine and there were no systems in place to ensure that checks were being completed. There was no system in place to ensure risk assessments and care plans were reviewed to make sure identified risks were being appropriately mitigated. A warning notice was served on the provider and registered manager because of the seriousness of the risks this caused to patients.
- During 2015, the service had carried out various clinical audits, which covered medicine administration records, medical reviews, care plans, and risk assessments. In particular, an audit was carried out which analysed patients' electronic care records. The audit had highlighted inconsistent documentation and recording of information. Outcomes from this audit provided the service with areas for improvement and areas that required further embedding of current systems. However, this did not lead to an improvement in recording.

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- The provider did not always have oversight of the service as systems had failed to ensure that safe care and treatment was being appropriately delivered. For example, risk assessments, care plans and physical health assessments were not completed appropriately in accordance with national guidance. Results from recent audits carried out in 2015 were not actioned and managed as a matter of urgency. This meant the areas of concern had not significantly changed and were not being actively addressed.
- The provider used key performance indicators to monitor performance which were monitored by the drug and alcohol commissioners (DAAT) for this service. Information was collated into weekly reports so that the service could understand how they were performing. The successful completion target for alcohol users was 41.8%. The service scored 43.7%. The target for treating those using non-opiates was 40.4% and the service scored 42.6%. The successful completion target for opiate users was 6.4% and the service scored 5%. The provider was not performing as well as other substance misuse providers in relation to successful completions of treatment for opiate users. The lowered number of successful completions was due to the service treating many patients with high alcohol dependency and misuse of opiates. The provider faced challenges as treatment was more complex and patients had greater health needs. There was a clear management and clinical governance structure in place and a clinical governance policy. The provider had a risk register which highlighted risks and risk management strategies to ensure the quality of the service. The clinical governance framework was monitored by the clinical governance committee, audit and risk committee and the board of directors. Monthly reports had been produced in order to show how the service was progressing in relation to national and local targets.
- The provider sent us information, which related to the type of information the service was collecting. This included the National Treatment Outcome Profile (TOPs) which looked at several care domains. The service used this information to quantify progress and

to make improvements in service delivery. The provider routinely collected information on Blood Borne Viruses (BBV) screening and vaccination. Reports were sent to the service manager so that they were fully informed and could make improvements when they were falling behind the target rates.

- The service risk register was managed at the provider's head office and the director was able to add items. The manager told us that the risk register was not on the agenda for team meetings and was unsure of to what degree the staff were aware of the risk register.

Leadership, morale and staff engagement

- An internal review of the service had taken place in the past year following concerns that were raised in relation to the day-to-day running of the service. The provider investigated this. The senior manager told us that the culture of the team had been reviewed as a part of the investigation. Morale had improved since the service review.
- The service manager had a background in leadership over many years and had completed a leadership development programme. The leadership of the service required substantial improvements in order to ensure safe care and treatment was being provided.
- Compass-Enfield previously did not provide a formal leadership pathway for staff and was discussed during supervision and annual appraisals. However, a new learning and development framework had been created to support staff members to develop within their role. The framework clearly demonstrated where individuals should be at a set time within their career journey. For example, from initial recruitment to six months into the role. Mandatory and specialist training available to staff of different grades was clearly documented at induction, probation, continuing professional development (CPD), leadership, and management. This meant staff had a clear professional development pathway to follow.
- The service manager stated that no staff surveys had been carried out to find out the views of staff about the service and/or their role.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **MUST** take to improve

- Patients undergoing detoxification from alcohol or opiates must have an individual care plan in place detailing the care and treatment that staff must provide to ensure risks to their health and safety are managed appropriately.
- Patients undergoing detoxification must have a comprehensive risk assessment completed and a risk management plan showing how risks will be mitigated.
- The provider must ensure that patients undergoing detoxification have regular physical health checks.
- The provider must ensure that patients are reviewed by a doctor every three months as per the provider's policy.
- The provider must ensure that effective systems to assess and monitor the quality and safety of the service are in place.
- The provider should ensure that all staff are adequately supported and supervised in accordance with the provider's supervision policy.
- The provider should ensure that patients are aware of their treatment options and possible side effects from medication are explained to them. This should be documented accordingly within the care record.
- The provider should ensure that all staff are adequately supported and trained in Mental Capacity Act 2005 and have a clear understanding of the five main principles of assessing capacity.
- The provider should ensure that there is a system in place for information to be shared to all members of the team. This includes alerting of incidents and complaints.
- The provider should ensure that GPs are regularly updated with patient related information.

Action the provider **SHOULD** take to improve

- The provider should ensure that panic alarms and clinical equipment is regularly checked and properly maintained, displaying the date of the previous maintenance check.

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
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes to assess, monitor and mitigate risks relating to health, safety and welfare to patients were not operated effectively. The provider's systems had not identified serious risks to patients from shortfalls in the care and treatment provided. The service did not have effective systems and processes in place to ensure that areas for development were being actively addressed and improved upon. This was a breach of regulation 17(1)(2)(a)(b)(c)(e)(f).

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
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way: The risks to patients undergoing alcohol and opiate detoxification were not being assessed and monitored appropriately through the period of treatment and withdrawal. The provider had not done all that was reasonably practicable to mitigate the risks to the health and safety of patients undergoing alcohol or opiate detoxification. This was a breach of regulation 12(1)(2)(a)(b).