Sanctury Lodge

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

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

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

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

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

Overall summary

We ask the same five questions of all the services we inspect: are they safe, effective, caring, responsive to people's needs, and well led? We normally rate each aspect of a service then give an overall rating. However, we do not yet rate substance misuse services.

- The service did not have robust systems in place to ensure the safe provision of treatment. Staff training and supervision was inadequate, and staff had been employed to work at the service before the provider had received information relating to past criminal convictions. When these had been identified, the provider had not completed an action to mitigate potential risks.
- The service did not ensure the competency of staff administrating medications. Medication errors recorded were not reported through the provider's incident reporting process. The manager recorded errors in staff supervision notes but did not identify ways in which staff competency would be monitored and supervision did not take place regularly. The provider did not have robust processes for investigating and there was no evidence of lessons learnt from incidents.
- The provider did not have a robust system in place to monitor the quality of care offered to service users. Meeting minutes at staff, board, and community level were not routinely recorded. Service user satisfaction surveys were carried out, but action plans to address any concerns not completed. The service did not audit how many early exits from treatments they had and they did not follow up service users completing

Summary of findings

treatment. Complaints from service users were not followed up quickly, with most being from those who had exited the treatment unexpectedly. The provider did not have a whistleblowing policy in place and staff could not describe the reporting process if they had concerns about the service.

However

- Doctors prescribed detoxification regimes for people that met guidelines from Drug Misuse and Dependence: UK Guidelines on Clinical Management 2007, and 24 hour on call medical advice was available. Staff monitored withdrawal symptoms using the Clinical Institute Withdrawal Assessment of Alcohol Scale (CIWA-AR) and the Clinical Opiate Withdrawal Scale (COWS).
- Service users told us that they found the interventions and therapy to be effective and The service had developed effective working relationships with the local GP team. Service users registered with the GP surgery on admission and were seen quickly when there was a need.Therapists who provided group therapy and 1:1 time had regular supervision with the therapist lead.
- We observed caring interactions between all staff and service users. Staff respected service user's rights to privacy and dignity by providing quiet areas to make phone calls to relatives, or to have 1:1 time with support staff.
- The service actively supported people to maintain relationships with family and friends and provided family support groups every Friday. Support and therapy staff treated service users as partners in their care and treatment. The service ensured active involvement and participation in care planning, evidenced by service user's participation in care plan reviews.
- The registered manager and chief executive immediately responded to inspectors concerns that staffing at night was inadequate and increased night staffing immediately. We found the management team at Sanctuary Lodge responsive to concerns raised by inspectors, who developed an action plan and schedule to address these following the first inspection.
- Following this inspection we identified that the provider was not meeting Regulation 13; safeguarding service users from abuse and improper treatment, Regulation 17; good governance, Regulation 19; fit and proper persons employed, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Regulation We carried out enforcement action with the provider and told them to take action to ensure compliance by January 20th 2016. The provider will send us their action plan to meet the regulation and we will check on this at our next inspection.

Summary of findings

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Services we looked at
Substance misuse/detoxification.

Summary of this inspection

Background to Sanctury Lodge

Sanctuary Lodge is a detoxification and rehabilitation facility in Halstead, Essex. The facility has 23 double bedrooms with en-suite bathrooms and a five-bedded independent house as a step down unit called Fenton House. Those staying at Fenton House have all treatment provided at Sanctuary Lodge. Sanctuary Lodge provides service users with a full medical detoxification and rehabilitation programme, and has been registered with the CQC since 15 May 2014.

A registered manager was in place, but the service did not have an accountable officer for controlled drugs as required under the Controlled Drugs (Supervision of Management and Use) Regulations (2006; 2013).

Sanctuary Lodge is registered to provide accommodation for persons who require treatment for substance misuse, and treatment of disease, disorder, or injury.

Sanctuary Lodge admits self-funding individuals and this is the first comprehensive inspection to take place at Sanctuary Lodge.

Our inspection team

Team leader: Victoria Green

The team that inspected the service comprised four CQC inspectors, including one with a specialist background in substance misuse services, and an expert by experience, who had previously had experience of substance misuse services.

Following the announced inspection on the 4 November 2015, the team returned to the service to carry out an unannounced inspection on 11 November 2015, following concerns raised on 4 November 2015. The returning team comprised three CQC inspectors.

Why we carried out this inspection

We inspected this service as part of our ongoing 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 these services and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- Visited Sanctuary Lodge and Fenton House.
- Spoke with 14 service users and two people who had completed their treatment.
- Spoke with the chief executive and the registered manager.
- Spoke with nine staff members including a consultant psychiatrist, the admissions manager, therapists, support workers, support staff, and the chef.

Summary of this inspection

- Attended one therapy session. Looked at 12 care records of service users.
- Carried out a specific check of the medication management of seven patients.
- Looked at policies, procedures and other documents relating to the running of the service.
- Collected feedback from 13 service users using comment cards.
- Checked 15 staff records.

What people who use the service say

People who used the service told us they felt well cared for by the management of the hospital and all the support and therapy staff. They said staff were kind and compassionate in responses to them.

Service users reported a good range of activities, which they enjoyed. They said the therapy sessions supported them to achieve their goals.

There were spaces to take private calls with loved ones and staff respected their privacy and dignity.

Service users said the environment was clean and well equipped for what they needed. There was a good choice of food and healthy snacks available.

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?

- Staff did not manage controlled drugs in a safe way. We found discrepancies in amounts of methadone recorded. Staff failed to reconcile medication correctly after dispensing to service users, receiving deliveries of medication and when disposing of medication.
- Staff did not record full detoxification regimes onto one record. A person received an initial dose and staff archived the record. The remaining detoxification regime continued on a new record. This meant that it was not clear what day of the regime a person was on and what dose they were due to receive.
- Staff amended medication prescription charts without initialling or signing, as required by the service policy. Staff had not documented medication errors as incidents. Staff did not report incidents appropriately. We found examples of incidents that staff should have recorded in service user notes, one-to-one interviews, and staff personnel files. Staff had not reported in line with the service policy.
- Managers obtained disclosure and barring information after staff had started working for the service. This meant the service was not aware if the staff had any convictions that could have affected the safety of people using the service.
- The service had not properly identified mandatory training needs following recruitment.
- The safeguarding lead, identified in the service policy was the registered manager but they had not received safeguarding vulnerable adults training and did not know when to make a referral to the local safeguarding authority. We identified safeguarding incidents that should have been reported. This had potential to place service users at risk.
- The service had not trained staff in safeguarding children and vulnerable adults from abuse until October 2015, and there was no service policy in place to safeguard children visiting the unit. We interviewed eight staff and four did not know their responsibilities to report safeguarding concerns.
- Reported incidents only described what had occurred and did not explore the consequences of the event. There was no recording of investigation and lessons learnt from incidents. This meant that the provider did not learn, plan, and respond to mistakes identified. Staff interviewed did not understand responsibilities to raise concerns, record safety incidents and near misses, both externally and internally.

Summary of this inspection

- The staff did not complete thorough individual risk assessments that reflected the level of risk identified in the notes and initial admission assessment. The service did not provide training in risk assessment and care planning. Risks identified from the weekly reviews, were not updated into individual risk assessments and care plans. This meant that risk assessments were not accessible to new staff, staff not included in review meetings and agency staff.
- The service had not completed a thorough environmental risk assessment. Staff had not identified ligature points (places where someone intent on self-harm might tie something to strangle themselves) or taken action to mitigate potential risks. We observed ligature points in all bedroom and communal areas. We found no evidence of thorough individual risk assessments of clients' potential for suicide or self-harm, even when historical risk was documented in the admission assessment.
- The provider had not provided a fire blanket or extinguisher in the kitchen at Fenton House step down unit. However, the registered manager made plans to rectify this immediately we drew it to their attention.
- The service did not assess required staffing levels. Staffing was unsafe during the night, with one member of staff for 24 service users

However:

- The service had responded to one fire and safety report that had identified safety concerns. We saw evidence that the provider had addressed all the areas of concerns within the report.
- The service had a clear on call system in place for the consultant psychiatrist, who provided 24 hour on call cover. In event of medical emergency, staff contacted the GP or ambulance service via 111 or 999.

Are services effective?

- The service actively recruited people in recovery, as supported by the recovery agenda. Managers did not risk assess information received from the disclosure and barring service which helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. Support staff did not have a thorough induction. Induction and learning was completed through observation of others and reading the provider's policies, which meant that training and induction was not quality assured. The manager had asked that support staff sign when policies had been read,

but we found only one signiture which dated back to July 2015. The service had not identified training needsThe provider admitted that there was no formal supervision structure in place for support staff.

- Support staff had not received an annual appraisal of their work performance and did not receive regular managerial supervision. Records showed some staff had not received supervision in the previous 12 months. Those that had taken place for support workers, was inconsistant and did not allow for action points from individual supervisions to be followed up. There was some evidence that support workers learning needs were considered within the supervision notes. However, supervision was infrequent and did not allow for staff to revisit learning needed in a timely way.
- The provider had given thought to introduction of the national care certifcate for staff and we found evidence of this in four staff files. The care certifcate sets out explicitly the learning outcomes, competences and standards of behaviour that must be expected unqualified staff in the health and social care sector. The provider did not have policy or procedures in place to demonstrate a time frame for completion of the care certficate or how care cetficate modules would be validated and passed. Support staff were not trained in the use of National Institute for Health and Care Excellence (NICE) guidelines relevant to care and treatment of substance misuse issues.
- Senior management and support staff did not have a clear understanding around issues of individual capacity and consent. We did not see any evidence that assessment of capacity took place.
- The service did not begin discharge planning from admission to include service users' unexpected exit from treatment. Service user care plans did not address the potential risks to people who had left the programme early. The service did not monitor outcomes of people's care and treatment or collate information on the number of early exits. Processes were not in place to follow up people who use services on exit from service based treatment. The service did not complete audits to show outcomes were being achieved which meant that we could not measure how effective the service was compared to similar services.
- The provider requested service users paid the cost of the rehabilitation up front. Staff told us that service users paid on admission to the premises even if intoxicated and lacking capacity. Admission assessments would take place the

following morning when the service user was sober. There was no record of assessment of capacity to consent to pay for treatment. There were no formal methods of assessing individual's capacity to consent prior and during treatment.
- The provider's policy stated that each service user would have an individualised recovery plan. However we could not find evidence of these in 12 service users files. Care plans were available, but these were not individualised and did not reflect individual need and risk.
- The manager reported that staff had regular team meetings, however the provider did not keep records of these meetings. This meant that staff not on duty would have to rely on second hand information from colleagues. It would also be difficult to follow actions raised through to completion.

However

- Doctors prescribed detoxification regimes for people that met guidelines from Drug Misuse and Dependence: UK Guidelines on Clinical Management 2007. This meant that the reduction of medication prevented people from experiencing uncomfortable and unmanageable symptoms. Doctors provided prescriptions for medication to support people with withdrawal symptoms during the first three nights of detoxification.
- Doctors prescribed Vitamin B and Thiamine alongside detoxification medications to support people with symptoms associated with their alcohol misuse. The doctor reviewed people who were suffering significant withdrawal symptoms and would review the medication appropriately.
- The service had developed effective working relationships with the local GP team. Service users registered with the GP surgery on admission and were seen quickly when there was a need.
- Staff monitored withdrawal symptoms using the Clinical Institute Withdrawal Assessment of Alcohol Scale (CIWA-AR) and the Clinical Opiate Withdrawal Scale (COWS).
- The service provided a 12 step recovery based programme, a recognised treatment for substance misuse services. Service users told us that they found the interventions and therapy to be effective. Therapists who provided group therapy and 1:1 time had regular supervision with the therapist lead.
- Service users told us they received regular weekly 1:1 with named therapists to discuss care plans and progress.

Are services caring?

- Service users told us that staff were caring and compassionate in responses to them.

Summary of this inspection

- Service users reported that in addition to their weekly 1:1 with their named therapist, they knew they could seek support from any member of staff at any time.
- We observed caring interactions between all staff and service users.
- Staff respected service users' rights to privacy and dignity by providing quiet areas to make phone calls to relatives, or to have 1:1 time with support staff.
- The provider had a therapy programme in place that focused on the 12 steps of detox and group work. We saw supportive interactions in groups between staff and service user's.
- The service actively supported people to maintain relationships with family and friends and provided a well-attended family support group every Friday within the premises.
- Support and therapy staff treated service users as partners in their care and treatment. The service ensured active involvement and participation in care planning, evidenced by service user's participation in care plan reviews.

However

- We found one written example where a male service user was told to strip down to his underwear whilst two female staff searched his clothes for contraband items. Staff had not documented whether the service user had consented and understood his rights prior to the search being carried out. The search policy did not refer to searching individuals, only to the searching of service user's belongings.

Are services responsive?

- The provider had recently opened Fenton House as a residential placement for service users requiring a step down programme to encourage independence. Service users could opt to pay for an additional four-week programme by renting a room at Fenton House and attending therapy at Sanctuary lodge during the day. They received an allowance each week to buy food, which they prepared independently.
- Those who had successfully completed the detox programme were able to return for therapy sessions every Friday for 12 months after the end of treatment. This service was included in the price of the treatment. However, the service did not collate service user numbers so we could not see whether this opportunity had been used.
- Service users filled in consent to treatment forms and behaviour forms on admission. They also received a comprehensive handbook that explained their rights and Sanctuary Lodge rules of behaviour.

Summary of this inspection

- The provider acknowledged the importance of family and social networks in service user recovery. The service provided a well-attended family support group once a week in addition to treatment.
- The service had a full range of rooms and equipment available to support treatment and care. We observed service users using these areas for group therapy sessions, exercise, and relaxation. The provider ensured that there were quiet spaces for service users to meet visitors and make phone calls, once they had completed the first 7-day part of the programme.
- Service users were able to personalise their bedrooms with photos of family and friends. The bedroom areas were spacious and all but one bedroom had an ensuite bath/ shower area.
- The provider ensured that a choice of cooked food and fresh snacks were available throughout the day. Service users told us that this was of a good standard. Service users had access to a kitchen area to make hot drinks and snacks throughout the day. The provider ensured that food could be adapted to meet the dietary requirements of religious and ethnic groups.
- The provider ensured that activities were available for service users seven days a week.

However

- The provider had not gathered data on admissions and discharges since the service opened, and could not tell inspectors how many admissions had ended early and why. This meant that the provider did not thoroughly review any potential issues with the service that might have contributed in early exits from treatment.
- The provider did not have clear policy and procedures for dealing with complaints. The provider had not carried out an audit of complaints, and did not demonstrate that complaints had been investigated. The registered manager told us that complaints and concerns were discussed at team meetings, but they did not keep a record of the minutes to demonstrate discussions and actions. The provider did not demonstrate that they learned from mistakes. We case tracked a complaint around early discharge and found the provider had not made efforts to protect confidentiality of a service user, copying a previous discharge form and crossing out a previous service user's name.
- The bedrooms were all located on the first floor and the service did not have a lift, although had advertised having one on its website. This made it inaccessible for people with mobility problems that prevented them from climbing the stairs. However, the provider did demonstrate that they had been

adaptable previously and made a bedroom area on the ground floor, for someone with mobility issues. The provider was eventually able to support the individual's recovery to safety mobilise to the first floor.

Are services well-led?

- The service did not risk assess staff employed by the service to ensure they were safe and appropriate to work with people using the service.
- The service did not have a clear induction policy or mandatory training pathway for support staff. We found evidence in staff files that staff had received training in some areas prior to commencement of employment but not during employment. This meant we could not be confident that support staff had been appropriately trained to carry out their duties safely. The service had not properly identified mandatory training needs following recruitment. The provider had no robust induction process to identified training needs. However, in 11 of the 15 staff files there was evidence of a performance review after three months. The service had not trained staff in safeguarding children and vulnerable adults until October 2015.
- The provider admitted that there was no formal supervision structure in place. Staff supervision was inconsistent and did not allow for action points from individual supervisions to be reviewed. This meant the service could not be confident that staff had the skills and knowledge to carry out their role.
- The registered manager had not received safeguarding vulnerable adults training and did not know when to make a referral to the local safeguarding authority.
- The registered manager had identified medication errors in staff supervisions and medication audits. However, these were not reported in the incident-reporting book, and there was no evidence of checking competency following errors. Instead, staff were asked to revisit the provider's medication policy. There was no evidence of following up whether they had done so. We did not see evidence that staff had spoken to service users about medication errors when they had occurred.
- Staff reported incidents using an internal incident reporting. However, inspectors found evidence in staff files, and clinical notes that not all incidents had been reported appropriately through the internal reporting processes. The service had also failed to report one incident of fire to the CQC as required by the registration regulations as it affected the running of the service.
- The service did not have a whistleblowing policy in place

Summary of this inspection

- The registered manager told us that the service had regular board meetings to discuss complaints, service delivery, and service planning. The provider had no minuted meetings to document discussions and lessons learnt. It was also unclear how often these board meetings took place.
- The service did not risk assess staffing levels. Staffing was unsafe during the night hours. We found incidents reported that had occurred during the night hours, including an injury to a support member of staff by a service user, and two fires. There had been no learning demonstrated from these incidents within the investigation process.
- There was no administration support to the registered manager. This meant that the registered manager was supporting staff with day-to-day activities, carrying out managerial tasks, the everyday running of the unit and all administration work.
- The service did not monitor outcomes of people's care and treatment or collate information on amount of early exits. Processes were not in place to follow up people who use services on exit from service-based treatment.
- The service did not carry out audits to demonstrate service outcomes had been achieved. This meant that we could not measure how effective the service was, compared to similar services.
- The service did not have clear policy and procedure on assessing mental capacity and consent. Interviews with support and therapy staff and management demonstrated that staff had little knowledge in this area. The registered manager acknowledged that staff had not been trained in the Mental Capacity Act.

However

- The service had a value-based approach to interviewing and employing potential new staff. We saw evidence of this within staff files.
- The service actively recruited people in recovery as supported by the recovery agenda.
- We saw evidence in two staff files that management had supported staff to undertake outside training related to their work. This included adjusting contracts to take unpaid leave to undertake counselling skill courses.
- Support staff and therapists told inspectors that they were happy in their roles and enjoyed their work. The service had a no blame policy, and staff told inspectors that they felt able to speak to the registered manager if they had concerns or had made an error.

Summary of this inspection

- We found the management team at Sanctuary Lodge responsive to concerns raised by inspectors, and they developed an action plan and schedule to address these.
- The registered manager and chief executive immediately responded to inspectors concerns that staffing at night was inadequate and increased night staffing immediately.
- The registered manager had an informal open door policy, and we saw evidence that staff felt able to approach them about issues throughout the inspection.
- The registered manager and the chief executive were visible within the treatment areas. We observed that the registered manager and chief executive had positive relationships with staff and service users
- The registered manager sought views of service users and staff in developing new ideas and processes. We saw evidence on the follow up unannounced inspection that the registered manager gave staff the opportunity to give feedback on services and input into service development. The registered manager had begun to engage the therapy team, and service users in developing a new, more person centred recovery care plan for service users.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

- There was a lack of understanding from the provider and staff in regards to the requirements of the mental capacity act 2005. Issues regarding capacity were discussed with the registered manager, staff and director during interviews. They did not understand that individuals might lack capacity and capacity needed to be reviewed. No training had taken place in use of the Mental Capacity Act. This was particularly relevant when reviewing the admission process and service users ability to consent to treatment and to pay the upfront, non-returnable fee.
- The service did not have clear policy and procedure on assessing mental capacity and consent. 1:1 interviews with support and therapy staff and management demonstrated that staff had little knowledge in this area. The registered manager acknowledged that staff had not been trained in the Mental Capacity Act (2005), although training had been scheduled for March 2016

Substance misuse/detoxification

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse/detoxification services safe?

Safe and Clean Environment.

- Inspectors and an expert by experience toured the premises and found that it was generally clean and in good condition. Some paintwork and furniture needed refreshing and updating. The registered manager told inspectors that the service was due to begin updating bedrooms.
- The registered manager told inspectors that an external contractor under took the cleaning of the premises five days a week. The registered manager stated he had, had difficulty with the company and raised concerns with them that the cleaning was not to the required standard. Support staff on night duty would have a list of cleaning chores 4 days a week. We saw evidence that chores were completed. However, the provider did not formally audit the quality of the cleaning by staff and the external company, consequently, we could not be confident the provider had taken appropriate infection control measures to ensure the safety of service users and staff. Most service users felt the environment was clean, however two services users told us the cleanliness could be better.

Safe staffing

- The service did not assess required staffing levels. The service had recorded incidents during the night hours, which included a fire at the service, when a service user had initially been unable to leave their bedroom due to chairs blocking the exit, and another incident where a member of staff was injured by a service user. The manager and director told us they had previously had two members of staff on duty at night in the main centre but had recently trialled moving one of them to Fenton House, which is located nearby. However, we concluded that one member of staff for 24 service users was unsafe and the provider

immediately addressed concerns raised and increased the number of staff on duty to two members of staff at night."

- Managers obtained disclosure and barring information (DBS) after staff had started working for the service in 14 out of 15 cases. This meant that safety checks of staff employed had not been carried out to ensure they were safe and appropriate to work with people using the service. This meant that the service was not aware if there was any conviction history of the staff that could have affected the safety of people using the service.

Assessing and managing risk to patients and staff

- We reviewed ten service users care plans and risk assessments. On some occasion's information highlighted in care plan reviews, notes and initial admission assessment had not been added to the risk assessment. The registered manager stated that staff had not been trained to identify and put in place risk management plans/ contingency plans to mitigate risks. This meant that the provider was not assessing the risks to the health and safety of service users of receiving the care or treatment.
- The service had not completed a thorough environmental risk assessment. Staff had not identified ligature points, (places where someone intent on self-harm might tie something to strangle themselves) or taken action to mitigate potential risks. We observed ligature points in all bedroom and communal areas. We found no evidence of individual risk assessments of clients' potential for suicide or self-harm, even when historical risk was documented in the admission assessment.

Substance misuse/detoxification

- Children were able to visit loved ones receiving treatment. However, the service did not have a policy in place for children visiting the premises This meant the service had not considered any potential risks to children and how they could mitigate these.

Track record on safety

- We reviewed the incident-reporting folder and the 14 incidents recorded. Whilst we could see evidence of reporting, we did not find that incidents had been investigated, and action plans were not available.

Reporting incidents and learning from when things go wrong

- We reviewed the medication error-reporting book where 35 medication errors had been recorded since June 2015. Errors included incorrect documentation on medication charts, incorrect stock recording of controlled drugs, missing medication, and service users receiving incorrect medication. The action points were to talk to staff and for staff to read the medication policy, but no investigation or learning points were identified. Where an error in administration to a service user was identified, including not receiving detox medication or medication for physical and mental health need, the action points did not include informing the service user. Consequently, systems or processes were not in place to assess, monitor, and improve quality and safety of the services. This meant the provider had not taken measures to mitigate risks relating to health, safety, and welfare of service users.
- We interviewed the consultant psychiatrist. During the interview, they stated that staff made between two to three medication errors a month. We could not find any documentation of errors recorded. They stated that on one occasion diabetic medication had been administered twice in error to a service user with diabetes, but could not remember the service users name and therefore we could not find information as to whether physical health checks had been carried out following the error, or whether the service user had been informed of the error. We could not find this error in the incident-reporting book.
- Whilst the registered manager did carry out initial medication competency assessments on staff at the start of employment we found that these were not revisited following medication errors. Staff were not documenting medication errors as incidents so the provider did not demonstrate learning from incidents. We found examples of medication errors, including recording of a controlled drug, administration of a drug that was out of date to a service user, and an inappropriately altered medication record that was brought to the registered manager's attention. Staff files showed five medication errors in the supervision records which were not documented within the incident-reporting book. We did not see records of competency checks in staff's training files.
- Staff reported incidents using an internal incident reporting system and there were two examples of fires occurring at the service. There had not been a review of staffing numbers at night.
- We reviewed the policy and procedures in place for the provider. The registered manager had been identified as the safeguarding link in the providers safeguarding policy but did not have training in safeguarding vulnerable adults. Staff had been trained in safeguarding children and vulnerable adults in October 2015. We interviewed six members of staff who did not understand their roles and responsibilities in reporting safeguarding incidents internally or to outside agencies.
- We interviewed six out of nine members of staff who did not understand their roles and responsibilities in reporting safeguarding incidents internally or to outside agencies. We found evidence of medication errors in staff files that had not been reported in the reporting log.
- We identified a safeguarding concern during the interview with the registered manager. A male service user had been sexually inappropriate towards female service users. This had not been reported as a safeguarding to the local authority. CQC had not received a statutory notification. We requested that this be done on three occasions, 5th November, 11th November, and 16th November 2015. The registered manager did not seem to understand the importance of notifications to CQC. We spoke with the manager and sent an email to the registered manager on the 16th of November 2015 to request that he immediately refer to his responsibility as registered manager under regulation 18. The concern was eventually reported on the 16th. Consequently, safeguarding incidents that should have been reported were not. This had potential to place service users at risk.

Substance misuse/detoxification

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

Assessment of needs and planning of care

- The care plans were not person centred. Policy stated that every service user would have a recovery plan, but these were not evident. The registered manager stated that the care plans were the recovery plans but they were not updated to include new information from the 1:1 weekly care plan/ treatment review with therapy staff.
- Processes were not in place to follow up people who use services on exit from service-based treatment, which meant that we could not measure how effective the service was, compared to similar services.

Best practice in treatment and care

- The service did not begin discharge planning from admission to include service users' unexpected exit from treatment. Service user care plans did not address the potential risks to people who had left the programme early. The service did not monitor outcomes of people's care and treatment or collate information on the number of early exits. Processes were not in place to follow up people who use services on exit from service based treatment. The service did not complete audits to show outcomes were being achieved which meant that we could not measure how effective the service was compared to similar services. However, we saw evidence that when people were discharged from the service, either on completion of treatment or on early exit, the provide made efforts to identify support links in the community and inform family, friends and GP's, providing individual's consented to this.
- Service users told us that they found the interventions and therapy to be effective. The service providered a 12 step recovery based programme, based on the principles of Narcotics Anonymous (NA) and Alcoholicas Anonymous which is a recognised treatment for substance misuse services. The recovery programme was predominatenly group led. The service actively recruited people in recovery, as supported by the recovery agenda Service users told us that this was important to them.
- Service users who had successfully completed the detox programme could return for therapy sessions every Friday for 12 months after the end of treatment. This service was included in the price of the treatment. However, the service did not collate service user numbers so we could not see that this opportunity had been used.
- Doctors prescribed detoxification regimes for people that met guidelines from Drug Misuse and Dependence: UK Guidelines on Clinical Management 2007. This meant that the reduction of medication prevented people from experiencing uncomfortable and unmanageable symptoms. Doctors provided prescriptions for medication to support people with withdrawal symptoms during the first three nights of detoxification.
- Doctors prescribed Vitamin B and Thiamine alongside detoxification medications to support people with symptoms associated with their alcohol misuse, in line with NICE clinical guidance (2011). The doctor reviewed people who were suffering significant withdrawal symptoms and would review the medication appropriately.

Skilled staff to deliver care

- We reviewed 15 staff files. Managers obtained disclosure and barring information after staff had started working for the service in 14 of 15 cases. This meant the service was not aware if the staff had any convictions that could have affected the safety of people using the service**.**
- Formal induction processes were not in place for staff on commencement of employment. Three-month probation interviews were completed, but not followed up with regular supervision and appraisals. This meant that the provider had not ensured that persons providing care or treatment to service users had the qualifications, competence, skills, and experience to do so safely.
- We found that training had not been carried out. Training certificates found in staff files were copies from previous employers. The registered manager confirmed that the providers were looking at training and that staff had not received any formal mandatory training other than safeguarding training. The service did not have a system in place to check the competence of staff to administer medicines safely or carry out physical health checks on patients going through assisted withdrawal from alcohol or opiates. In two service user files physical

observations records had not been recorded. The registered manager stated that support staff had personal experience of substance misuse and recovery, but we could not find evidence that support staff had received specific training on detoxification and recovery. The service did not have a system in place to check the competence of staff to administer medicines safely or carry out physical health checks on patients going through assisted withdrawal from alcohol or opiates. In two service user files physical observations records had not been recorded.

- The service had introduced the national care certificate for new starters, but there was no time frame or process to ensure competency and validity of modules completed. The manager had not understood the care certificate processes. The registered manager confirmed during an interview with us that staff had received copies of the care certificate modules. There was no system in place for auditing who was undertaking the care certificate and the quality of the work completed by staff.
- The registered manager told us that he had requested that staff read and sign an audit sheet to say they had read the providers policies and procedures. Only one signature was seen for June 2015. We spoke to staff and they did not have a clear idea of the provider's policies and procedures. Consequently, we were not confident that staff had understood the provider's policy and procedures.

Multi-disciplinary and inter-agency team work

- The service had developed effective working relationships with the local GP team. Service users registered with the GP surgery on admission and were seen quickly when there was a need
- The provider had a clear on call system in place for the consultant psychiatrist, who provided 24 hour on call cover. In event of medical emergency staff, contact the GP or ambulance service via 111 or 999.

Good practice in applying the MCA

- The service did not have clear policy and procedure on assessing mental capacity and consent. Interviews with support and therapy staff and management demonstrated that staff had little knowledge in this area. The registered manager acknowledged that staff had not been trained in the Mental Capacity Act (2005), although training had been scheduled for March 2016.
- There was a lack of understanding from the provider and staff in regards to the requirements of the Mental Capacity Act 2005. Issues regarding capacity were discussed with the registered manager, staff and director during interviews. They did not understand that individuals might lack capacity and this should be reviewed. No training had taken place in use of the Mental Capacity Act. This was particularly relevant when reviewing the admission process and service users ability to consent to treatment and to pay the upfront, non-returnable fee.

Are substance misuse/detoxification services caring?

Kindness, dignity, respect and support

- We observed caring interactions between all staff and service users.
- Staff respected service users' rights to privacy and dignity by providing quiet areas to make phone calls to relatives, or to have 1:1 time with support staff.
- The service had a therapy programme in place that focused on the 12 steps of detox and group work, which supported people's recovery journey. We saw supportive interactions in groups between staff and service users.

The involvement of people in the care they receive

- Service users told us that staff was caring and compassionate towards them.
- The service undertook weekly community meetings with service users. However, meeting minutes did not always show whether concerns and requests raised by service users had been responded to and who by. The provider gave service users a satisfaction survey on discharge but did not collate this information to look for themes for improvement to their service.
- The named therapist ensured that weekly 1:1 sessions could take place and service users told us they could seek support from any member of staff at any time.
- The provider acknowledged the importance of family and social networks in service user recovery. The service provided a well-attended family support group once a week in addition to treatment. The service offered two mediation opportunities for service users and their families as part of the treatment, recognising the importance of family relationships in recovery.

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- Service users had copies of their care plans, which were updated during 1:1 time with therapists. However, these were not comprehensive and did not always focus on individual needs and risk. They were not always updated to include information from the care plan reviews meetings. This meant that service users did not always have a robust, individualised care plan.

The service protected service users' confidentiality by having a password system in place for information requests over the phone. However, this password did not change and due to the turnover of those using the service, had potential to be misused.

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

Access and discharge

- The service had not gathered data on admissions and discharges since the service opened in May 2014, and could not tell inspectors how many admissions had ended early and why. The service gave service users a satisfaction survey on discharge but did not collate this information to look for themes for improvement to their service. The service did not collate information about admissions and discharges, so we could not observe this. However, service users told us that they had not had to wait for long before admission.
- The service employed admission managers who carried out telephone assessments to gather information on the service users' needs, risks, and willingness to engage with the service. The admission manager was clinically trained in integrative psychotherapy, and accredited by the BACP, would prioritise based on need.

The facilities promote recovery, comfort, dignity and confidentiality

- The provider recently opened Fenton House as a residential placement for service users requiring a step down programme to encourage independence. Service users could opt to pay for an additional four-week programme by renting a room at Fenton House and attending therapy at Sanctuary Lodge during the day. They received an allowance each week to buy food, which they prepared independently.
- The service had a full range of rooms and equipment available to support treatment and care. We observed service users using these areas for group therapy sessions, exercise, and relaxation. The service ensured that activities were available for service users seven days a week. There were quiet spaces for service users to meet visitors and make phone calls, once they had completed the first seven-day part of the programme. This meant that the service provided facilities that promoted recovery and confidentiality.
- The service promoted comfort and dignity. A relaxing outdoor area and smoking shelter was available for service users that backed onto fields. We observed this in regular use and service users told us they enjoyed this space. Service users had access to a kitchen area to make hot drinks and snacks throughout the day, and were able to personalise their bedrooms with photos of family and friends. The bedroom areas were spacious and all but one bedroom had an ensuite bath/ shower area.

Meeting the needs of all people who use the service

- Service users filled in consent to treatment forms and behaviour forms on admission. They also received a comprehensive handbook that explained their rights and Sanctuary Lodge rules of behaviour. However, the provider did not formally undertake capacity assessments on admission to ensure that people were fit to consent. Those who were intoxicated on admission would be presumed to have capacity following the initial telephone assessment, and consequently would pay the treatment fee on admission.
- The provider acknowledged the importance of family and social networks in service user recovery. The service provided a well-attended family support group once a week in addition to treatment. The service offered two mediation opportunities for service users and their families as part of the treatment, recognising the importance of family relationships in recovery.
- The provider ensured that a choice of cooked food and fresh snacks were available throughout the day. Service users told us that this was of a good standard and could be adapted to meet religious and cultural needs.
- The bedrooms were all located on the ground floor and first floor. and the building did have had a lift, but this was not working at the time of the inspection. The provider told us that this had since been rectified.

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Listening to and learning from concerns and complaints

- The service did have clear procedures for recording and investigating complaints. A complaints policy was given to people in an admission pack. Brief information on how to make a complaint was also included in the service's terms and conditions admission document. However, the service had not kept within the 28-day response period, as stipulated in the provider's policy. The provider felt that complaints came from those who had left treatment early and wanted a refund of their fees. However, the complaints had highlighted concerns around treatment, and capacity to consent to treatment which had not been fully responded too."
- The registered manager told us that staff learnt from concerns and complaints during team meetings. These had taken place once a week, but had been reduced to once a fortnight due to staffing and service activity-taking priority. Meeting minutes were not documented; therefore, we could not verify that they had taken place. This meant that actions were difficult to follow through to conclusion. Not all staff would be present for team meetings and there was no auditing of actions discussed and whether they had been carried through.

Are substance misuse/detoxification services well-led?

Vision and values

- The provider provided staff with a handbook that set out expected behaviour. This was also available in the service user's handbook that service users received on admission. Service users received a statement of purpose within the treatment handbook. However, inspectors could not find a visions and values statement and staff did not know of one.
- The provider's interview processes were values based, and how the provider scored potential applicants was evident in all staff files. The provider also ensured that potential staff had personal experience of recovery, supporting the recovery agenda.
- The registered manager and the chief executive were visible within the treatment areas. We observed that the registered manager and chief executive had positive relationships with staff and service users. Service users told us that the registered manager and chief executive were always accessible and friendly in their approach. The registered manager told us that they had used disciplinary procedures with two members of staff who had been found to be behaving inappropriately. The registered manager was able to demonstrate understanding of policies and procedures to address performance. However errors had been documented in staff supervision notes available, they had not been revisited and action plans to address competency had not been developed. Staff told us that senior staff were approachable and supportive. Staff told us that they felt confident to report concerns. However, we could not find a whistle blowing procedure for staff.

Good governance

- The service did not carry out cleaning or environmental audits. This meant that the service did not have systems in place that enabled them to identify and assess risks to the health, safety, and welfare of people who used the service.
- Medication audits did not highlight errors that we had found throughout staff supervision notes and medication administration records (MARS). This did not ensure the quality of the audits taking place and did not mitigate the risks relating to the health and safety of people using the service. The provider was unable to identify risks using the audits, where quality and/ or safety had been compromised. This meant that risks were not identified or monitored and that appropriate action could not be demonstrated.
- The service had decided to introduced the national care certificate for new starters, but there was no time scale and process to ensure competency and validity of the modules completed. It was unclear if the manager had understood the care certificate processes. The registered manager told us staff had received copies of the care certificate modules. There was no system in place for auditing who was undertaking the care certificate, and the quality of the work completed by staff. The registered manager was not aware of the period for completion for new staff as recommended by Skills for Health who had introduced the certificate as a potential tool for employers to ensure competency of staff. The service was unable to assess, monitor, and

improve the quality and safety of the services provided to service users and mitigate risks to health, safety, and welfare, which was intended by introducing the national care certificate.

- Staff carried out a regular audit of service user notes, but the registered manager did not review the quality of these audits. Service users and therapists met each week to discuss each person's care plan and update it. People then received a copy of their updated care plan each week.
- We looked at two complaints reported to us, following an early discharge of a service user. The discharge form was incorrect as it stated the service user was being discharged against advice, although the complaint and service users written clinical notes stated they had been told to leave. The form also contained another service user's name, which had been crossed through, but remained legible. This meant that processes had failed to protect the confidentiality of people using the service and did not accurately reflect the nature of the early exit.

Leadership, morale and staff engagement

- We found the management team at Sanctuary Lodge responsive to concerns raised by inspectors, and developed an action plan and schedule to address these.
- The registered manager sought views of service users and staff in developing new ideas and processes. We saw evidence on the follow up unannounced inspection that the registered manager encouraged engagement with staff to give feedback on services and input into service development. The registered manager had begun to engage the therapy team in developing a new, more person centred recovery care plan for service users.
- The service had a value-based approach to interviewing and employing potential new staff. We saw evidence of this within staff files within interview questions and scoring. The service also recruited staff with individual experience of substance misuse and recovery, supporting the recovery agenda.
- Support staff and therapists told inspectors that they were happy in their roles and enjoyed their work. The service had a no blame policy and staff told inspectors that they felt able to speak to the registered manager if they had concerns or had made an error. This was evidenced in the supervision notes that were available, on discussion of medication errors and staff concerns.
- The registered manager had an informal open door policy and we saw evidence that staff felt able to approach them about issues throughout the inspection. Consequently, we were confident that staff felt able to raise issues of concern.
- There was evidence in staff files that staff were enabled to enhance their own development through external courses and that the registered manager and chief executive supported this. The registered manager had adapted a contract to allow a member of staff to have time off for study.
- Staff had not completed a series of mandatory training as part of an induction programme. Supervisions were infrequent, with eight records of supervision seen for an 18 months period. The registered manager confirmed that appraisals had not taken place.
- The registered manager had asked staff to read and sign the policy folder so they understood the processes of Sanctuary Lodge; however, inspectors saw one signature, which had been signed in July 2015.

Commitment to quality improvement and innovation

- The arrangements for governance and performance management did not operate effectively. The registered manager told us that regular board meetings were held, but minutes were not recorded. Governance arrangements, service strategy, and plans or how the service used information to monitor performance and plan for improvement were not in place.
- People, who had raised complaints following early discharge, felt that they were not taken seriously and felt ignored. Complaints were not resolved within the timeframe of the service policy. The provider did not use information provided in the complaints to make improvements in the quality of care.
- The service did not audit service user feedback upon discharge, or complaints received. This meant that the service did not have systems in place to help quality assure the service they provide.

The registered manager was receptive to inspectors concerns over care plans. The registered manager provided inspectors with an action plan to revise care plans to

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ensure that they addressed individual needs and risk in line with best practice for substance misuse services. We saw evidence that the registered manager was involving staff and service users in this process of reviewing care plans.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- The provider must ensure that the safeguarding lead is trained in safeguarding vulnerable adults, and ensure that all staff are clear about their individual responsibilities to report safeguarding concerns.
- The provider must strengthen procedures to ensure that staff report incidents and errors in line with their service policy. The provider must establish processes for investigating and acting upon these, to demonstrate that learning had taken place to reduce future risks and ensure that staff are competent to carry out tasks.
- The provider must strengthen systems and processes to share information and escalate risks to health, safety, and/ or welfare of people to relevant individuals and bodies. Including safeguarding boards and regulatory bodies and that, these are done without delay. The provider must establish processes for investigating and acting upon these, allegations of abuse.
- The provider must have policy and processes to protect children visiting the service.
- The provider must have systems to assess and monitor the quality and safety of the environment. The provider must ensure where actions are implemented to reduce risks these are monitored and sustained.
- The provider must strengthen the systems in place to regularly assess and monitor the quality of care provided to patients. The provider must ensure that clinical audits are carried out and recorded in order to enable staff to learn from the results and make improvements to the service and learning should be clearly evidenced.
- The provider must ensure that effective communication systems are in place so that those who need to know within the service have the information they need to carry out their role safely.
- The provider must ensure that patient care plans address the potential risks to patients of early exit from the programme in line with best practice.
- The provider must strengthen systems in place to protect confidentiality of service users past and present is maintained and do not contravene the Data Protection Act 1998.
- The provider must demonstrate that organisation feedback is sort from relevant persons and that it is record, evaluated, and acted upon to improve service delivery, and that appropriate audit or governance systems are in place and are able to demonstrate their effectiveness.
- The provider must strengthen their recruitment process to ensure that all people employed have completed the necessary safety checks prior to working with service users. The provider must ensure that where risks are identified from the Disclosure and Barring Service that they undertake appropriate risk assessments.
- The provider must strengthen mandatory training compliance for all new starters and existing staff to ensure that persons employed have the qualifications and competence necessary to carry out their work safely.
- The provider must strengthen their medication management procedures to demonstrate staff competency in carrying out medication administration, and investigate and act upon learning points when errors occur. Where training needs of staff are identified, the provider must ensure that they have the governance systems in place to access, monitor, and revisit competency of staff to carry out responsibilities.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The safeguarding lead was not trained in safeguarding vulnerable adults. Staff were not clear about their individual responsibilities to report safeguarding concerns. Safeguarding concerns were not alerted to the appropriate external agencies. The was no policy and process in place to protect children visiting loved ones at the service. There was no clear process for investigating and acting upon allegations of abuse. Service users were not protected from abuse and improper treatment in accordance with this regulation. Systems and processes were not established and did not operate effectively to prevent abuse of service users. Systems and processes were not established to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse. This was a breach of Regulation 13 (1)(2)(3).

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 17 HSCA (RA) Regulations 2014 Good governance There were no systems or processes in place to assess and monitor the quality and safety of the environment.

This section is primarily information for the provider

Enforcement actions

The systems in place to regularly assess and monitor the quality of care provided to patients were ineffective.

Staff training needs were not identified, and competency to carry out responsibilities was not assessed. Medication management, training procedures were not in place to demonstrate staff competency, and investigate and act upon learning needs when errors occur.

Robust communication systems were not in place to ensure that those who needed to know within the service had the information they needed to carry out their role safely.

Concerns about risks to health, safety, and welfare of people within the organisation, were not escalated to relevant external bodies. This Included safeguarding boards and regulatory bodies. Where risks had been identified, and actions implemented these were not monitored and sustained.

Service users' capacity and consent were not clearly assessed, evaluated, and documented.

Systems to protect confidentiality of service users were not robust.

Organisation feedback was not recorded, evaluated, and acted upon, to improve service delivery.

Clear governance systems were not in place to demonstrate the effectiveness of the service.

This was a breach of Regulation 17(1)(2)(a)(b)(c)(d)(e)(f).

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Accommodation for persons who require treatment for substance misuse

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

The recruitment process did not ensure that all people employed had completed the necessary safety checks prior to working with service users.

Where risks had been identified from the Disclosure and Barring Service, appropriate risk assessments had not been completed.

Staff had not received and mandatory training to ensure that persons employed had the qualifications and competence necessary to carry out their work safely. Where mandatory training had been identified for the service, this had not been carried through.

This was a breach of Regulation 19 (1)(2)(a).