Phoenix Futures National Specialist Family Service

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

Ratings

Overall rating for this location

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

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.

Summary of findings

Overall summary

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

- There areas of concerns identified at the service were regarding the detoxification treatment provision that it offered to clients dependent on drugs or alcohol. Whilst there were some safeguards in place, for example admission criteria for clients admitted for a detoxification, and the medicines administration training and procedures completed by staff at the service, there remained some issues that had the potential to make the care and treatment unsafe. In addition, some of the governance arrangements to support these detoxifications had not been agreed and ratified between the service and the doctor overseeing these detoxifications. For example, the contract between the doctor and the service and the detoxification protocols were still in draft format, and the medicines administration policy was in the process of being reviewed.
- There were some concerns with managing medicines and risk. Staff did not always store medication appropriately and records of controlled drugs were not always completed in accordance with legislation. Risk assessments had not been completed with regard to a number of clinical requirements.
- The systems in place did not fully ensure that managers could access accurate training information for permanent and sessional staff when required. It was difficult for the service to provide us with consistent information, for example, it was also not clear which training was mandatory and when this needed to be repeated. The service did not have sufficient training in place to enable the staff working there to support the children and the clients in the service, or to complete the clinical tools that staff used. In addition, staff had not received training to manage challenging behaviour, aggression or violence.
- Systems were not in place to ensure that client information was recorded consistently and that all information was in held centrally so that information was accessible to all staff at all times. Records, including risk assessments were not always accurate, and had not been reviewed or updated, for example following incidents. The service did not have a risk assessment in place to manage aggression or violence. There were concerns regarding the service's infection control procedures.
- The governance systems established to assess, monitor, and improve the quality and safety of the service, and manage risk effectively, did not operate effectively and were not embedded in the service.

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

- There were many areas of good practice identified in the service. Of note was the service's strong recovery ethos and the evidence based therapeutic programme that was designed to address the clients' substance misuse, their parenting and child development, which incorporated best practice tools and interventions. The service was committed to innovation and developing its service to meet the families' needs in conjunction with the clients, relatives and carers, and staff. The service worked in partnership with other agencies from pre-admission, and throughout treatment up to discharge, to support the families. They had good working relationships with these services and professionals, including children's social care, the local primary care GP, health visitors, specialist midwifery service, as well as local schools and nursery provision. The service achieved positive outcomes and all clients, relatives and carers, and other services spoke highly of the service and staff, and told us they felt involved in their care and treatment.
- There were areas of good practice identified in the service with regard to managing risk in the service. For example, there were sufficient staff to cover the service, the service had clear admission criteria, and a lone working policy and procedure. Child safeguarding training to level three was completed by all staff, with the managers completing level four safeguarding training, and the service had good working knowledge of child safeguarding procedures. A detailed service guide and a

Summary of findings

detoxification handbook was available for clients prior to admission or on admission. This gave them a clear understanding of what to expect from the service and what how to complain to the service.

- The environment at the service was clean, tidy and well maintained. The family areas were comfortable and the furniture, fixtures and fittings were generally in good condition.There was provision in the service environment for both adults and children. This included outside sitting and play areas, sensory rooms for the children that could also be used as a quiet space, a lounge with a TV and DVD and family board games, and a complimentary therapy room for clients. Activities were facilitated for both clients and families during the week and at weekends by the service. The service facilitated access for clients to religious and spiritual support in the community.

Summary of findings

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Background to Phoenix Futures National Specialist Family Service

Phoenix Futures National Specialist Family Service offers residential treatment for clients with drug and alcohol issues whilst they remain the primary carers for their children. The service's aim is to support families to stay together.

The service provides treatment to single clients and couples. Children up to the age of 10 are able to live with their clients on site. The service can accommodate up to 30 people, including both adults and children and has 12 family bedrooms available.

The residential treatment includes a therapeutic rehabilitation programme of either 12 or 26 weeks. The programme offers clients the opportunity to work on both their substance misuse and parenting skills. It includes three main elements: therapeutic, parenting and child development.

Where clients are still dependent on drugs or alcohol, the service also supports them to detoxify from these substances through a medically assisted withdrawal at the beginning of their residential treatment.

An Office for Standards in Education (OFSTED) registered crèche is available for children up to the age of 8 to attend whilst their clients are participating in the therapeutic programme. Office for Standards in Education rated the crèche as 'good' for the standard of its early years' childcare provision at the most recent inspection in March 2015. Where appropriate, children were enrolled in external childcare provision and/or school.

The service accepts referrals from community services across the country, including children's social care, family law companies, the family drug courts, and substance misuse teams.

The service is not fully accessible for families with a disability.

The National Specialist Family Service is one of four residential substance misuse services registered with the Care Quality Commission by the provider, Phoenix Futures. It registered with the Care Quality Commission on 20 January 2011 to provide accommodation for persons who require treatment for substance misuse as its regulated activity. It has a registered manager appointed to manage the regulated activity on behalf of the service. It also has a nominated individual who is a senior person in Phoenix Futures who has overall authority over the regulated activity.

The Care Quality Commission have inspected the National Specialist Family Service twice since it was first registered. These inspections took place on 1 October 2012 and 12 February 2014. The service was inspected against the previous regulations, the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. In 2012, the service was found to be meeting all the standards inspected. However, in 2014, the service was found to be in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, for cleanliness and infection control. The service sent us an action plan following that inspection which set out actions they would take in order to meet the requirements of this regulation. We checked these at this inspection and found that these specific actions in the plan were met.

This is the first inspection of Phoenix Futures National Specialist Family Service under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our inspection team

The team leader of the inspection was Kate Gorse-Brightmore.

The inspection team consisted of two inspection managers, two inspectors, a pharmacist inspector, and a specialist advisor with experience of substance misuse.

Summary of this inspection

Why we carried out this inspection

We inspected this service as part of our on-going substance misuse 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, asked a range of other organisations for information and sought feedback from clients at a focus group.

During the inspection visit, the inspection team:

- looked at the quality of the environment and observed how staff were caring for clients
- spoke with three clients during the inspection and collected feedback from six clients using comment cards
- spoke with six clients at the focus group prior to the inspection
- spoke with two relatives or carers
- spoke with the registered manager
- spoke with seven other staff members, including therapeutic workers, child care workers, the programme manager, the head of quality and performance, and the service user involvement manager
- attended and observed one handover meeting
- looked at eight care and treatment records for clients, including six current clients and two discharged clients
- reviewed eight staff personnel files
- carried out a specific check of the medication management
- looked at a range of policies, procedures and other documents relating to the running of the service
- received feedback about the service from two care co-ordinators or commissioners.

What people who use the service say

- Feedback we received was extremely positive. People (clients) felt the service was safe and clean. They told us that staff were helpful and supportive of them and their children, and they were easy to approach. Clients felt that staff listened to them, and said they were caring and respectful towards them, as well as their children. This was reflected in the service user survey in September 2015, 89% of service users rated highest their relationship with their worker and satisfaction with the environment. All the clients discussed the therapeutic group programme, and how the structure and the sessions and helped them to change their behaviour.
- The relatives and carers we contacted spoke highly of the service. They praised the clean, tidy and calm environment, and stated that the staff were always available to answer their questions. One of the family members told us how their family member had learnt parenting techniques that they continued to

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implement even though they have left the service. The other relative we spoke to gave an example of how the staff in the service had gone that extra mile during a time of crisis.

- The feedback we received from people who commissioned the service, and those who made referrals into the service, confirmed further examples of staff going that extra mile for clients and children, including in times of crisis. Both confirmed that the clients and the children were always the service's prime concern. They told us that the staff were knowledgeable and worked well with clients who had complex supports needs, offering aservice provided a high standard of support to both clients and children, maintaining professional standards throughout, and achieving positive outcomes for families.

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The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

- Drug testing clients using urine testing kits and breathalyser tests for alcohol were completed at the service. There were concerns around infection control and prevention during these carrying out these tests.
- The service did not consider the risk of mixed sex couples sharing bathroom facilities.
- The service had not risk assessed the requirement for physical health examinations and observations to be completed during detoxification, or the use of a recognised withdrawal scale.
- The service had not risk assessed the requirement of emergency medications and equipment (like a defibrillator) for adults and children, or the emergency doctor's provision outside the contracted on-call hours. The contract with the doctor was still in draft format.
- There was inconsistent recording of the information gathered during house checks. Information was inputted into the log-book, the handover sheet, or the client's care records. Clients' notes and information were not kept in their care records but in other places in the service. Doctor's notes were not kept in the client's care records at the service. This meant that notes were not accessible to all staff. This could impact on the safety of staff and the families at the service.
- The service found it difficult to provide us with consistent training information for permanent and sessional staff, and it was not clear what training was mandatory. Mandatory training is training identified by the service as required to fulfil their role.
- Staff had not completed paediatric first aid training, except for two staff who worked in the on-site day crèche who held current certificates for paediatric first aid. Also the therapeutic staff had not had any basic childcare training.
- Less than a quarter of permanent staff had completed mental health awareness training.
- No staff had completed training in the clinical institute of alcohol withdrawal scale, despite the service using it with clients who were dependent on alcohol.

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- There was no mandatory training for the managing of aggression and violence, or working with challenging behaviour, and we did not see a risk assessment regarding the management of aggression or violence.
- Staff did not always store medication appropriately and records of controlled drugs at the family service were not always completed in accordance with legislation.
- Risk assessments and management plans did not always follow the contemporaneous records, and were not reviewed and updated following incidents. This meant that staff could be unaware of any client risk and not manage them appropriately.
- Incidents were not always reported using the incident procedures and learning from incidents was not always shared despite the mechanisms in place for incident reporting and sharing learning.
- The service was in the process of updating its serious incident policy to include the duty of candour.

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

- The environment was clean, tidy and well maintained. The family areas were comfortable, and the furniture, fixtures and fittings were generally in good condition.
- There were sufficient staff to cover the service. Regular bank staff were employed where there was a need to increase staff due to the case mix, last minute sickness, long-term sickness or annual leave.
- Prescriptions and administration records were completed accurately and staff reconciled (checked) people's medicines on admission to the service by contacting their GP to ensure the family received the right treatment.
- Child safeguarding training to level three was completed by all staff, with the managers trained to level four. The service had good working knowledge of child safeguarding procedures and child protection.
- The service had a clear admission criteria, and completed a detailed admission assessment, which included obtaining additional information from other services, like social care and criminal justice agencies.
- There was a lone working policy in place, which included a 24 hour on-call management rota.

Are services effective?

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

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- The service's protocols for detoxification from opiates and alcohol were in draft format. There was no protocol for detoxification from benzodiazepines. Best practice with regard the use of recognised withdrawal scales and prescribing certain medications, were still to be risk assessed, discussed and agreed between the service and the doctor.
- Care plans were not always consistent with contemporaneous notes and observations, or had not been reviewed. Correctional fluid had been used to change the care plan dates and other information.
- Assessments were not completed on a client's ability to self-administer their own medication, or their children's medication. There was limited information around self-administering medication and the children's medication in the medication and detoxification policy. However, at the time of the inspection the service was reviewing this policy and told us that they were considering inputting additional information regarding self-administering medication and the children's medication .
- Staff supervision did not always fall within the eight week period outlined in the supervision policy, and the information in the personnel files was not consistent for each staff file.
- Staff training figures on mental capacity was low and the staff we spoke to were not clear about mental capacity and confused this with the Mental Health Act.

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

- The service had an evidence based therapeutic programme that was designed to address the clients' substance misuse, their parenting and child development. This included therapeutic substance misuse interventions in line with the National Institute of Health and Care Excellence and Public Health England.
- Clients completed the accredited Triple P Positive Parenting Programme to support them in managing their children's behaviour through promoting their children's development, social competence and self-control. The service also used the Department of Health Framework for the Assessment of Children in Need and their Families.
- The service worked in partnership with other agencies to support the families and had good working relationships with

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these services and professionals, including children's social care, the local primary care GP, health visitors, specialist midwifery service, as well as local schools and nursery provision.

Are services caring?

We found the following areas of good practice:

- Staff were caring and approachable, and treated families with kindness, dignity and respect.
- Clients had a named therapeutic worker from the start of their treatment and their children had a named child-care worker.
- Patients told us that they felt involved in their care and treatment and that they had a care plan.
- Clients were able to input into the service easily in a number of ways. We saw evidence that the staff and listened to their suggestions and made changes as a result of this feedback.

Are services responsive?

We found the following areas of good practice:

- There was no wait to access the service.
- In the last six months, all clients left the service in a planned way.
- There were provision in the service environment for both adults and children, These included outside sitting and play areas, sensory rooms for the children that could also be used as a quiet space, lounges with a TV and DVD and family board games, and a complimentary therapy room for clients.
- Activities were facilitated for both clients and families during the week and at weekends by the service.
- The service facilitated access to religious and spiritual support in the community, and could access interpreters as required.
- A detailed service guide and a detoxification handbook was available for clients prior to admission or on admission.
- Clients and staff had a clear understanding of the complaints procedure and there were mechanisms in place to support patients to make a complaint, and for staff in the service to learn from any complaints made.

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

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- Discharge plans were not in place or agreed at the start of treatment.
- The service was not fully accessible for families with a disability as there was no special equipment to support people to use the bathroom facilities.
- The complaints information for clients, relatives and carers did not include details of the local government ombudsman.

Are services well-led?

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

- Some policies and procedures were still in draft format or had recently been introduced. Some of the audit systems in place were not sufficiently established and actions from these audits had not been completed. Therefore, the governance systems had not operated effectively and were not embedded to assess, monitor, and improve the quality and safety of the service provided.
- The system the service used to manage training was not effective as the service found it difficult to provide us with consistent information and clearly define mandatory training and when this training needed to be repeated.
- The systems in place for recording the information gathered during the house checks were not clear resulted in information not being recorded or incidents being missed. Information was inputted into the log-book, the handover sheet, or the client's care records without any consistency.
- Local managers did not demonstrate a clear understanding of performance indicators and how the service performed against them.

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

- Staff at the service had a strong recovery ethos and the staff could explain a service culture that represented the service's values and beliefs.
- All staff told us that the senior managers, service manager and programme manager were approachable and supportive. They felt confident in being able to approach them with concerns without fear of victimisation.
- Staff, clients, relatives and carers were able to feedback into the planning, delivery and development of the service.
- The service was committed to innovation and developing its service to meet the families' needs.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

- One third of the staff at the service had received training in the Mental Capacity Act (2005) and the Deprivation of liberty safeguards. Staff did not have a clear understanding about the mental capacity.
- There was a standard operating procedure on the mental capacity, consent and the Deprivation of liberty safeguards in place for staff to refer to, which included all staff members' roles and responsibilities.
- There were no clients subject to Deprivation of liberty safeguards.
- Staff members could provide examples where they may wait to gain a client's consent regarding their treatment.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

- The environment was clean, tidy, and well maintained. Family areas were comfortable and the furniture, fixtures and fittings were generally in good condition. The service was in the process of refurbishing some areas, for example, one client told us their room had new laminate flooring. The service manager told us of refurbishment plans for the bedrooms, outside play area for the children and a new medication room.
- Environmental risk assessments and operation risk assessments were in place, as well as a health and safety policy. The family service manager told us that health and safety training was mandatory. This was not clear from the training information submitted as it was not included on the provider's list of mandatory training.
- There were health and safety structures in place, including daily, monthly, quarterly and annual checks. These checks included fire alarm tests and fire drills, emergency light tests, first aid checks, legionella and water temperature checks. The service was subject to external regulatory inspections with the fire service and with environmental health for the child nursery kitchenette for food preparation, hygiene and practice. Maintenance and health and safety issues were discussed at team meetings. The service had a "hat system" in place. The "gold hat" was responsible for the weekly and monthly checks. The daily checks were the responsibility of the staff on the cleaning rota for that day. Staff reported health and safety concerns to the service manager or maintenance worker dependent on their urgency. The maintenance worker kept a log of their work, which was overseen by the "gold hat." We observed health and safety as a standing agenda item on team meeting minutes. Issues discussed and actioned included the external door to the garden being propped open and rubbish bags being left in the corridor.
- Operational risk assessments and risk management plans included risks in the kitchen, laundry, garden and smoking shelter, and risks around electricity. These included risks to children and clients, and mitigation for these. There was also a risk assessment and management plan for the client and family activities. Risk had been assessed, managed and mitigated for children in bathroom areas and moving between the different floors of the house.
- The infection control policy included protocols for hand hygiene, disposal of sharps and clinical waste, the use of personal protective equipment, blood borne viruses and general housekeeping to prevent infection. The service manager had completed an infection control audit in May 2016. All cleaning schedules were adhered to and there were housekeeping rules on display. The service adhered to the control of substances hazardous to health regulations. Appropriate waste disposal bins were in place, and colour coded mops with disposable heads. There was also clinical waste collection in place. Drug testing of clients was undertaken in a small bathroom. The bathroom had a sink and a toilet. However, the sealed urine-testing unit was disposed of in a nappy bag in a yellow clinical waste bin in another bathroom. There was no clinical waste bin in the toilet where the drug testing was completed. Staff wore gloves but no other personal protective equipment like aprons or masks. Also, the service sterilised and re-used breathalyser tubes rather than disposing of them following single use. This was not in accordance with the manufacturers guidelines. The lack of robust infection control practices put people's health and welfare at risk.

- Families using the service could be single parent families, or two parent families of the same or different genders. Each family had their own bedroom but shared toilet and bathroom facilities. This meant that accommodation and bathroom facilities were mixed sex. The service did not risk assess any increased risk or potential issues around dignity and respect around mix-sex bathroom provision. All families could lock their bedroom doors at all times if they wished.
- The staff office was situated on the first floor. There were restricted lines of sight from this office to most client areas, which were spread over five floors. A suicide risk standard operating procedure was in place. This included the completion of a suicide risk assessment that incorporated the assessment of ligature risks. This had been completed for the family service in May 2016. It included detailed information and control measures, like staff presence, areas locked when not in use and ligature cutters. Staff also assessed suicide risk and suicide ideation as part of the comprehensive admission assessment.
- House checks, similar to observations, were completed every 30 minutes for all families. A member of staff would circulate the building and note down where clients and children were and what they were doing in the service log book. The service manager confirmed that these observations were completed to manage risk in line with child safeguarding or parenting concerns. Physical health observations for patients completing a detoxification from either alcohol or drugs were not completed. However, staff told us that they may be more vigilant with clients who were completing a detoxification from substances, and that these house checks could be increased if this was required. The service manager told us that if there was a concern identified, this information would be inputted into the client notes. Other staff informed us that they would put this information on the handover sheet. There was no single system used by staff to record concerns from the house checks. These duplicate systems meant that important risk information could be missed. We observed information missing from the client case notes: some was in a log book used by the service to document information in relation to families during the day in the service, and we were told that some would be on the handover sheet.
- Bedrooms did not have client call buttons. However, all the landings in the house had an internal dialling telephone for clients to use if they needed to contact a member of staff. In addition, there was strict admission criteria around current and historic violence. All clients carried a baby monitor for times when they were not with their children but they were expected to maintain responsibility for their children throughout their treatment. Clients were not allowed to lock the bedroom doors when children were sleeping. Clients signed to agree this in the client contract that was completed on admission.
- Staff did not use radio or panic alarms in the service. However, there had been no incidents in the service where an alarm system would have been helpful. Also, in line with the lone working policy, staff working alone in the service would carry a telephone to contact the emergency services or the on-call managers in the event of an incident or an emergency.
- There was a procedure for new admissions whereby two members of staff searched people's suitcases, bags and pockets. Later in treatment, the clients' belongings or rooms could be searched if there was a situation that search warranted this. In addition, clients were expected to open mail where staff were present. Staff and patients were clear about the rationale for this in keeping the community safe, for example for illegal could be drugs smuggled in. Clients were informed of this prior to admission and it was also detailed in the client agreement and The Guide given to clients either on admission, or prior to admission.
- There was no clinic room at the service. The doctor was allocated a quiet room in the service for their consultations. The doctor did not complete any physical health assessments that would require a clinic room or a couch. Their clinical assessment was based on self-reported information gathered from the client, information provided by the GP and assessments completed by the family service managers.
- The service had recently acquired defibrillators, but staff did not use these at the time of the inspection as they had not completed the training to use them. There were no emergency medicines or oxygen, We were told the service had reviewed the provision of naloxone in response to national guidance, although this had yet to be obtained and integrated into the medical emergency

policy. A risk assessment had not been completed around the need for a defibrillator or the use of Naloxone, or the requirement of other of emergency drugs and oxygen. A risk assessment had not been completed around the service's requirement of emergency medication or equipment for children.

Safe staffing

- There were14 permanent staff. There were also10 sessional workers that worked as relief workers on the staff rota. This gave the service permanent access to a bank of staff to fill vacancies due to leave, sickness or training. These sessional workers were recruited twice a year and inducted into the service the same as permanent staff. This meant that these workers were familiar with the service. The service had a regular agency that Phoenix Futures would use but this was rare due to the level of relief staff retained for cover. In the 3 months prior to 2 March 2016, 86 shifts were covered by sessional staff due to a staff vacancy. This vacancy had been filled at the time of the inspection. The service had used no agency staff to cover these shifts and all shifts had been covered.
- There was a service manager, who oversaw the operational running of the service and a programme manager oversaw the program. There was a senior administrator and maintenance worker, who all worked full time, 37.5 hours per week. Four therapeutic workers worked full time and on a rota basis. They were responsible for the delivery of therapeutic interventions like one to one key-work sessions, care planning and group delivery. Three night-care workers also worked on a rota basis, 25 hours per week, to offer support and guidance throughout the night and to ensure a safe environment for the families. They worked as lone waking night staff. The third night-care worker role had been a recent vacancy that the service had successfully recruited into prior to our inspection. The childcare team oversaw and delivered the parenting and child development activities of the programme, including the crèche provision. The team included three staff members: two full time and one part time. The service also had a volunteer supporting one of the group activities for one and a half hours per week, who was a volunteer from the Sheffield Residential Service.
- The staffing provision was identified as a result of an external residential service review in 2010 for Phoenix Futures, where the service was benchmarked against research evidence and other services. The service manager was able to increase the staff complement as required, according to the case mix and requirements of the families in the service. Any permanent staff increase required her to complete a business case in conjunction with the head of operations and would be discussed and agreed at the Phoenix Futures executive board. Caseloads averaged three families per worker. All staff and clients told us they felt that there were enough staff.
- The GP attended the service as required to assess clients who were new admissions to the service. The GP told us they would try to be flexible with their availability. This meant that clients could be admitted throughout the week due to pressures, for example, from the court system. There was weekly GP attendance at the service to review the clients in treatment if this was required. There was one regular GP to support the family service. However, there were three local substance misuse GPs available to support the service and cover for annual leave or sickness. However, whilst the partnership agreement was working well with regard to GP cover, the formal contract with the GP to agree this was still in draft format.
- There was twenty-four hour on call management provision, including a local manager and senior manager at operational level or equivalent. We observed the rota to confirm this. A GP was available daily between 8am and 8pm for on-call support. Out of hours, staff told us that they would call 111 for medical advice and support, or 999 for emergency medical help. However, we did not observe a risk assessment to confirm that this emergency provision was sufficient, considering the increased physical health risks for patients detoxifying from alcohol, or other potential risk and emergencies.
- Mandatory training is training identified by a service as required for staff to fulfil their role and to keep themselves and clients safe. The mandatory training that was required was unclear and training figures were difficult for staff to obtain. For example, manual handling, health and safety, fire safety, and equality and diversity were not identified on the training summary we received for the service. On the training matrices we received for permanent staff, the training rates for this training for permanent staff was above 75%. However,

from the information overall it seemed that this was below 50% if sessional staff were included.Also, the training information in the personnel files did not clarify this issue around mandatory training as evidence of complete training was not always present in the files. This meant that managers were unable to ensure that staff had completed this necessary training. It also meant that staff, particularly sessional workers, may be unable to fulfil their role and keep families safe, for example in the event of a fire. However, we were confident that the following training was above 75% at the time of inspection:

- First aid including basic life support
- Medication administration (in house and e learning)
- Infection control
- Risk assessment and care planning
- Child safeguarding up to level 3 for staff, and level 4 for managers
- Adult safeguarding
- All the parenting and childcare team who worked in the crèche had a diploma in childcare and education, or a diploma in childcare, learning and development. The programme manager who supervised this team also had a qualification in childcare and education above that of a diploma. This was mandatory for the staff to help ensure they could competently fulfil their role. Of these staff, two had completed a course in paediatric first aid and held current certificates. Paediatric first aid was not mandatory training for staff in any part of the service, including those in the childcare team. Though the first aid at work course syllabus we observed was thorough, it did not deliver anything specific to paediatric first aid. This meant that staff who worked in the service would not have any recent knowledge of paediatric first aid if there was an emergency with a child residing at the service.
- In addition, the staff who did not work in the parenting and childcare team did not have any mandatory basic childcare training. Clients were expected to care for their child or children at the service and they agreed to this as part of the client agreement. However, staff confirmed there were times that all staff had experienced supervising a child or a baby for a short time. There was an incident where a client's mental health deteriorated and the child was cared for by one of the therapeutic team whilst alternative arrangements were made for the child the following day. Also, the observations completed by staff half hourly throughout the day included specifically observing the children. We saw records where a therapeutic staff member had noticed nappy rash on a child. Without relevant training, we could not be confident that all staff had the necessary skills and ability to care for children in a consistent and safe way.
- The service used the clinical institute withdrawal assessment scale for clients who were dependent on, or misused alcohol. However, none of the staff that were completing this tool had received training in how to use it. Staff we spoke with were unclear on the timescales required for this tool to be completed. We observed a case record for a client where this tool was not used in the recommended timescales and was not completed correctly.
- Medication administration training was mandatory for all staff. It was difficult for managers to provide us with an overview of which staff had received what training in medication administration, and when this was due for renewal. This information was not in a clear format that was easy for managers be able to extract information. The final information we received demonstrated that 78% of staff had received medication administration training. All permanent workers that required this training had competed the in-house training and the level two medication administration e learning training. Whilst some of this training was outstanding for the sessional workers, staff did not administer medication in the service unless they had received the appropriate level of training.
- Client and child information was stored in paper note form. The child information was kept in the same file as the client. Where there were two clients in treatment, the child's information was kept with the mother's notes. The medication administration records were kept separately to the clients' records. These medication administration records all had a photograph of the client. All records were kept in a lockable filing cabinet in the staff or administration office. However, we found it difficult to find information on care planning and medical assessments because information was not always kept in one place. This meant that notes were

not accessible to all staff and could cause errors in the client's treatment. The head of quality told us they planned to introduce a new electronic system in the future where all people's records and their medical assessments would be stored centrally.

Assessing and managing risk to clients and staff

- The service had clear admission criteria. The admission and assessment processes were supported by the client assessment, admission, care planning, risk assessment and discharge process introduced in April 2015. This was the standard operating procedure for the service, which the service manager confirmed. The admission criteria included clients with severe mobility issues who were unable to care for themselves, severe physical health needs, and significant cognitive impairment or learning disabilities. The service manager told us that criminal offences which posed a risk to others would be risk assessed in terms of severity, frequency and timeframe to assess whether they were the basis for exclusion. However, the service would not accept clients with schedule one offences, recent arson or violent offending. Both the procedure and the service manager confirmed that where clients required a detoxification at the beginning of their residential rehabilitation, the exclusion criteria for this would be a history of fits and seizures during an alcohol detoxification and complex poly substance use. However, the final decision of suitability would be the doctors overseeing the detoxification. Due to the nature of the service, it also had admission criteria for the children who would be attending with their clients. Children would not be admitted to the service over the age of 11, children with behaviour problems that may be a danger to others or children who had a history of abuse towards others.
- All patients were risk assessed at the pre-admission assessment by the service, in addition to the information submitted by the referring agencies. The service manager or programme manager completed the pre-admission assessment to ensure there was sufficient overview of the risk in the service and authority to make the decision about the admission. The service manager gave clear examples of where they had requested further information from the client or referrer in order to make a decision as to whether the client was suitable for admission. For example, this may include information from criminal justice services about offences and additional blood work from the GP. The service manager said the decision would not be taken to admit a family unless they were sure that the service could manage any risk and keep all the clients safe.
- If a client required a detoxification from drugs or alcohol, or both, the doctor reviewed the information gathered from the client's community GP, as well as pre-admission information completed by the service managers in order to agree the client's suitability. On admission, the GP would attend the service to assess the clients and prescribe appropriate medication for their detoxification. The staff at the service completed the drug and alcohol testing to inform the doctor's assessment. The doctor attended the service weekly, reviewed clients, and would see them for an appointment if required. Those clients detoxing from lower levels of substances may not need to be seen again by the doctor. Staff told us that they would contact the doctor throughout a client's detoxification and rehabilitation if they had any concerns.
- There were four staff handovers each day. The staff discussed each family in turn, including any incidents and general concerns, as well as risk and safeguarding issues.We observed a handover and viewed handover minutes, which confirmed these discussions.

  Physical health observations were not completed for clients completing a detoxification. This meant staff would not know if a client was becoming physically unwell during an alcohol or opiate detoxification and where clients may be at increased risk, particularly those completing an alcohol withdrawal who may be at risk of seizures. Staff did use the clinical institute withdrawal assessment revised scale for alcohol for clients who had been dependent on alcohol. However, they did not include the physical observations it asked for like blood pressure and pulse. Staff we spoke with were unclear of how often this scale needed to be completed. There was evidence in one of the client files we reviewed that the assessment had not been completed in line with timescales in the policy or guidelines for the use of the tool. The service did not use any recognised national scales for opiates or benzodiazepines. However, the doctor we spoke with

felt that physical observations were not required at the family service for clients completing a detoxification because it was medically assisted rather than medically managed.

- We reviewed eight care records of clients receiving treatment at the service. We observed risk assessments and risk management plans in place for all families. However, these risk assessments were not always personalised to the individual or specific regarding the risk issues. Most of the risk assessments used a score format and there was the score with no additional clarifying comments, or the comments were vague, for example stating that a patient had a range of offences of varying severity. Also, some of the information on the handover sheets or completed on the house checks was not updated in the client's records, or in the risk assessment, for example a disagreement between clients. Risk assessments and management plans did not always follow the information that was in contemporaneous notes, and were not reviewed and updated following incidents. This meant that staff could be unaware of any client risks and not manage them appropriately.
- Client's mental and emotional health was risk assessed at pre-admission, and then on an on-going basis by the therapeutic staff. The service manager and the therapeutic staff gave evidence of how they responded promptly to a client's deterioration, including attending the local GP practice and the accident and emergency service. We saw detailed notes in the client's file of the action taken by staff at to support the client. However, less than a quarter of permanent staff had completed any training in mental health awareness. This training was not mandatory. This meant staff may not have the skills and understanding to recognise changes to a person's mental health.
- All families had a contingency plan agreed on admission if they were to leave the service as an unplanned discharge. An unplanned discharge is when a client wants to leave the service before finishing treatment. We observed contingency plans in all eight files that we reviewed. This included contacting the referring agency, social care and the police if necessary. Where there were ongoing child protection plans in place, staff asked the social care worker from the Local Authority for specific, detailed plans of the steps that were required to be taken in respect of the child if the client was to leave. However, staff told us that they would work with the client to try to get them to stay in the service, and where this was not possible, offer harm minimisation information around their substance use.
- We looked at the systems in place for medicines management. We checked three sets of records and spoke with care staff who were responsible for medicines.The medicines policy had recently been reviewed; we were told a new policy was being introduced which simplified many of the procedures for obtaining, recording and managing medicines in the service, but this had not yet been ratified.
- Medicines were not always stored securely with access restricted to authorised staff. The service held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and these were managed appropriately except in situations where the clients had left the service. During our inspection, we observed methadone, a controlled drug, stored in a normal locked cupboard, rather than the controlled drug cupboard to be discarded when clients left the service. Records of controlled drugs at the family service were not always completed in accordance with legislation. For example, some records did not contain the address of the supplier and there was crossing out in one register. This meant that staff did have robust practices in place to minimise the risks associated with controlled drugs.
- We checked medicines requiring cold storage and found fridge temperatures had not been recorded in accordance with national guidance because only the current temperature had been logged. The fridge at the family service was a domestic type, and the thermometer was incapable of recording maximum and minimum temperatures. This had been highlighted in an audit carried out by the pharmacy provider on 11 February 2016 and again in an external audit carried out on 21 March 2016, but no action had been taken at the time of our inspection. If medicines are not stored at correct temperatures, this can affect their efficacy.
- Prescriptions and administration records were completed accurately. Staff checked (reconciled) people's medicines on admission to the service by contacting their GP, and we saw examples of how this

worked to ensure patients received the right treatment. Medicines were stored and administered in the administration office at the service, and clients queued up outside at medicines times. This meant frequent interruptions from knocks on the door and the telephone ringing which increased the risk of administration errors. Medicines were administered at four fixed times through the day, which may not always meet people's needs, for example if people needed certain medicines at specific times. The service manager confirmed that building work was due to commence on a medication room and we observed the plans for this.

- Managing challenging behaviour was not mandatory for staff and the training figures we saw did not include this training. We did not see a risk assessment regarding managing the risk of aggression or violence. This was not contained in the operational risk assessment completed by the service manager in December 2015. However, there was a violence and aggression policy in place and client conduct was detailed in the client agreement that both clients and staff signed on the client's admission. Also, there was a strict admission criteria that excluded client's with a recent history of violence and aggression and background checks on clients with other external agencies were completed prior to families being admitted, as well as on visitors. All clients, staff, relatives and carers remarked on the calmness of the service and there had been no incidents of violence or aggression in the service in the last 12 months.
- There was a lone working policy in place for staff, which included staff in the service carrying the hand-held phone at all times and the on call management rota.
- All staff at the service had completed the mandatory child safeguarding training to level three, with the two managers having completed training to level four. There was a detailed child safeguarding policy in place and staff demonstrated a good understanding of their role with regard to safeguarding children. The children were a focus during handovers, with all the children discuss at the handover we observed during our inspection. The objective of the staff observations or house checks every 30 minutes were to check on the child welfare and to ensure that clients were managing to client their children during the families stay at the service. The checks were completed throughout the day and night. The night worker would not go into the room unless this was required, for example if a baby was crying. The night worker would knock on the door to ensure that the client was awake and responding to the child appropriately.
- One to one sessions also had a child and adult safeguarding focus due to the nature of the service. All but one of the permanent members of staff had completed the adult safeguarding training and half had completed training in domestic abuse. There was a safeguarding adults' policy which the service was in the process of reviewing. Safeguarding and the services responsibilities were outlined in The Guide given to clients.
- There were procedures in place for children and families to visit the service. There was a comprehensive visitors policy in place, including detailed risk assessments and checks on those visiting in order to safeguard the children and clients. Information about visits was included in The Guide that all clients received on admission.
- All permanent and sessional staff at the service had been checked by the disclosure and barring service. This helped to ensure they were suitable to work at the service.

Track record on safety

- The family service had one serious incident recorded in the last 12 months. This was a medication prescribing error on the 4 April 2016. A client was given too many iron tablets.

Reporting incidents and learning from when things go wrong

- All staff told us the types of incidents that should be reported. These included environmental concerns, accidents, medication errors, aggression and violence, and safeguarding. However, we saw that an incident documented on the handover sheet that was not reported as an incident via the reporting system. Staff confirmed that an accident book was in place to record accidents.
- All staff members could report incidents using the organisation's standard incident form. The incident form included the severity of the incident and any follow-up actions. Incident reports were sent to the head of quality

and relevant managers within 24 hours of the incident taking place. Serious incidents were investigated more fully, including by external managers as required and reported to relevant bodies as appropriate, including the Care Quality Commission. The appropriate action for the severity of incident was detailed on the incident reporting form and serious incident policy and reporting procedure. Incidents were discussed as part of the standard agenda for all staff handovers and we observed incidents recorded on the handover sheets and discussed in the meeting. We observed a full investigation into an incident, including actions and staff and client debriefs following the incident where a client's mental health had deteriorated. We observed learning from incidents cascaded in the team meetings to staff, for example increased vigilance for children around the office and an update in procedures around drug testing. Discussions around the incidents in team meetings also included areas of good practice.

- However, when we reviewed the recording and reporting of a serious incident involving medicines, we found that whilst descriptions of the incident and immediate actions taken were comprehensive and appropriate, a full investigation had not been carried out to identify the cause. We checked minutes of staff meetings and found learning had not been shared with staff to prevent reoccurrence. The staff we spoke with were unaware of the error which had taken place on 4 April 2016.
- Senior staff confirmed that they understood the duty of candour but stated that transparency and openness was the culture of the organisation for all incidents. The service was currently updating its policy to include the specific requirements around duty of candour. Staff stated that they were encouraged to report all incidents and felt supported to do so.

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

Assessment of needs and planning of care

- Care records we looked at had evidence of detailed pre-admission assessments, including evidence requested from other services, for example social care service. All pre-admission assessments were completed by the programme manager or service manager. This was due to the complexity of the family situations and the increased need to manage the risk in the residential setting for the children staying at the service with their clients. There was evidence that clients had consented to treatment and agreed to the client contract, which included their responsibility for their children whilst they were at the service.
- Clients attending the residential rehabilitation family service could choose to detoxify from the substances that they were dependent on at the beginning of their rehabilitation placement. They were also able to detoxify at another placement before attending for the residential rehabilitation placement. Clients would complete their detoxification whilst they were in the Welcome House period of treatment. This was the induction phase of treatment. Clients could be in this phase of treatment for up to eight weeks. They would complete work around their path to addiction, and their expectation of the placement.
- Protocols were written for these detoxifications but they were still in draft form with comments waiting to be agreed and finalised. At the beginning of the inspection the services managers told us that they would manage withdrawal from all substances, including benzodiazepines. However, there were only protocols in place for opiate reductions from methadone and buprenorphine and alcohol, but not from benzodiazepines.
- Where clients required a detoxification, they would have an assessment appointment with a doctor. Clients told us that in most cases this would be the same day. However, staff confirmed that this could be within four hours for clients who misused alcohol and within 72 hours for a client dependent on opiates. Clients would have alternative prescribing arranged with the community, substance misuse service up to the point the family service could assess them and take over this prescribing. This was in line with the draft policy.
- The doctor and the staff at the service did not undertake any physical health examination at this assessment. The doctor and the managers told us that they relied on the information provided by the GP, information from the referring service, and the family service assessment and risk assessment, to inform their assessment of a client entering for an alcohol or opiate detoxification, and their decision to prescribe detoxification medication.

The service also requested a liver function test for patients entering the service who required a medically assisted withdrawal from alcohol. On admission to the family service the therapeutic staff completed a breathaliser test for alcohol as well as a drug test for all substances. Both the liver function test and the results from the drug tests would inform the doctor's assessment. Clients entering the service only for residential rehabilitation would be tested for substances on admission so that the staff could protect the community from triggers that could cause them to relapse.

- The doctor prescribed a fixed alcohol detox regime for alcohol and opiate withdrawal. The therapeutic staff and the night staff oversaw the detox and administered the medication prescribed as required.
- Staff assessed the blood borne virus status of the patients at the pre-admission assessment. They would arrange for vaccinations and testing at the local GP and would ensure that clients would continue with any ongoing treatment. The service manager told us that this was documented in the client's care plan and the risk assessment updated in line with blood borne virus and infection control policy. We observed this in one of the care plans we reviewed.
- All clients had agreed their care plan within 72 hours of admission, allowing the clients time to settle into the service. The clients had weekly key work sessions and we observed evidence in the case notes of these. However, the care plans were not always updated at these sessions.
- Care plans were in place in all the files we reviewed. Three of these care plans were individually tailored to the client's needs, with specific, realistic and contained recovery orientated goals. The other care plans had general goals around the programme rather than specific to the individual client. These care plans did not correspond with the contemporaneous notes and observations and had not been reviewed. In two sets of care records, correction fluid had been used to change the care plan dates and other information. The service had recently introduced a new care plan, which included recovery orientated goals in line with the recovery star but this was still to be embedded in the service and was not observed in the files that we reviewed.
- In the client case notes we reviewed, we found that some information was missing. We were told that records on residents were kept in different folders and not all in the clients' care records. There was a separate folder in the office which held the daily records. These were moved when the sheet was full or at night. Similarly, information was logged in several places: the log book, the handover sheet, and the clients' care records. Information was in the log book and not in the handover sheet or the clients' care records and vice versa. This meant there was a risk that all necessary information was not available to staff about the families' care and treatment at the time they needed it.
- We did not observe any assessments in the medication and client case files we reviewed for the ability of clients to self-administer their own medicines, or their children's medication. In the care records we observed, the client administered some medicines but not others with no rationale for this detailed in the record. The service had a medication and detoxification policy in place at the time of the inspection but the section in the policy regarding clients administering medication their own medication and medication to their children, including an assessment of their capabilities was limited in the information it contained with regard to this process. The service was currently reviewing their policy in relation to this.

Best practice in treatment and care

- The National Specialist Family Service provided a 12 or 26, week programme depending on the referrer's requirement and funding. This residential rehabilitation service used the therapeutic community model, which is underpinned by social learning theory. Social learning theory suggests that people learn from each other in a social context through observation, imitation and modelling. The residential rehabilitation service also used cognitive behavioural therapy to support clients in changing their attitudes and behaviours associated with their drug use.
- The programme included recognised and evidenced based techniques used in national and international residential rehabilitation services. The programme included daily structure that included time

management, chores and routine. Clients told us that they all had their roles in the house and set group and childcare times. They said they enjoyed the structure and routine.

- The programme also included weekly one to one key work sessions, daily group based interventions and set session work and homework. The group work covered topics including coping with cravings, responsible behaviour, emotions management, high-risk situations and problem solving. Groups were delivered up to three times a day, five days a week, with additional activities available for families at the weekend. The psychological therapies delivered in these groups and key work sessions were evidence based and recommended by the National Institute for Health and Care Excellence, including motivational interviewing, cognitive behavioural techniques and solution-focussed therapy. The files we reviewed confirmed that clients had regular key work sessions. These sessions and set work utilised some of the interventions in the Public Health England resources and toolkits, including the international treatment effectiveness project, link node mapping, which is the simple technique for presenting verbal information in a diagram.
- There were also "encounter groups" where clients were encouraged to discuss their own issues or to challenge other members of the community. These groups were facilitated by the staff in the service and were based on a model similar to Egan's Skilled Helper Model, which is a three-stage framework used to help people manage their problems more effectively and develop opportunities.
- Clients were encouraged to keep daily diaries to help identify their thoughts and emotions. These were also used to support them in participating in the one to one sessions and group work, including the encounter groups.
- As well as therapeutic interventions, service worked with the whole family in two other areas in order to provide the best opportunity for clients to make and sustain positive changes within their lives: parenting and child development.
- The parenting element included working with clients to explore and identify areas of improvement, and to establish good routines and boundaries. This was underpinned by the "Triple P positive parenting programme," which was an accredited programme run within the service. All clients completed the programme, with the aim of enhancing their self-sufficiency and self-efficiency in managing their children's behaviour, through teaching clients skills for promoting their children's development, social competence and self-control. The Triple P positive parenting programme has been subject to extensive research that has demonstrated its effectiveness.
- The service ensured that the child development was incorporated into the programme through their in-house assessments using the Department of Health "Framework for the Assessment of Children in Need and their Families" as a tool to inform their reports to social care and other external agencies. The residential service was staffed 24 hours a day and completed house checks every 30 minutes, using these observations to inform the support offered to the family.
- The service used the outcome star, as well as the family star with clients and families. These tools are recommended by Public Health England. They are completed with people in relation to different areas of their life so that they can plan where they would like to be. The child development worker completed the family star with the clients to support them in considering where they would like to be with their family, parenting and child development. The outcome star was completed by the therapeutic workers with the clients to support them in where they would like to be in their recovery. The service completed these outcome stars following admission and then reviewed these outcome stars at the mid-point reviews in the programme, which both staff members attended.
- Detoxification medication and reduction plans were a fixed regime based on guidance from the National Institute of Health and Care Excellence. However, there were concerns that all the detoxification protocols were still in draft format, with a number of the procedures and processes still to be agreed.
- There was not a protocol for a benzodiazepine detoxification. The service did not use a recognised tool like the severity of alcohol dependence questionnaire, to assess the severity of a client's dependence on alcohol. There were plans for this to be used in the future. Chlorodiazapoxide was the only medication used

during the alcohol detox to manage the withdrawal symptoms. Other medications, like Lorazepam or Oxazepam, were not used as alternative an option, for example for clients with more severely decompensated livers with poor liver function. Buprenorphine and Methadone were used for opiate detoxifications. Other medications like Lofexodine were not used. Relapse prevention medications, for example Naltrexone, Accamprosate and Disulfiram relapse prevention, recommended by the National Institute of Health and Care Excellence were not offered at the service as the doctor told us that the therapeutic programme offered the relapse prevention. The service manager told us that oral thiamine was prescribed to reduce the likelihood of alcohol-related brain disease in alcohol dependent clients. However, the service did not prescribe and administer intra-muscular thiamine, called Pabrinex, recommended by the National Institute of Health and Care Excellence. The service either did not use recognised withdrawal tools like the clinical opiate withdrawal scale, or did not use them in the way that this was intended. The service did not complete the physical observations on the clinical institute of withdrawal assessment scale, nor did they complete it in the timescales required. The doctor told us that these scales were not necessary. The head of quality told us that some of the issues around detoxification would be addressed when the detoxification protocols were ratified.

- All clients left the service in a planned way in the last six months. They were discharged from the service completely or were transferred to a community substance misuse service where the family were resettling. Transferring to another service for additional support is often required to help prevent relapse. The service completed the Treatment Outcome Profile to demonstrate its outcomes, and submitted this and other data to the National Drug Treatment Monitoring System. This data is reviewed and published by Public Health England. The service manager met with the operational manager on a quarterly basis to discuss the performance of the family service.
- We observed quality audits that reviewed all aspects of the service. These audits were announced and unannounced, and completed annually each year by senior managers from other Phoenix Future's services. The most recent audit was completed in March 2016. We observed the outcomes and learning from this audit. We saw an audit of the staff personnel files in the eight files we reviewed. Action had been taken by the service in line with the recommendations made. A sample of family care records were audited prior to each staff supervision, and used by the programme manager to inform the meeting. Standard tools were used for all these audits.

Skilled staff to deliver care

- The service had job descriptions mapped against the skills and competencies required for the role. The training information we received was unclear about what was mandatory training. In the information we received about the permanent staff, over 75% of these permanent staff had received training in equality and diversity to ensure that staff understood how to work with clients from specific groups in the context of this Act. For sessional workers this was not clear.
- Training information showed that staff had received specialist training above the competencies contained in the job and training mapping document. Training included:
- level three health and social care qualifications
- level three substance misuse qualifications
- groups work and group facilitation skills courses
- hepatitis and blood borne virus training
- counselling skills courses
- international treatment effectiveness project skills training
- cognitive behavioural and motivational interviewing training
- care planning and outcome star training.
- The child development workers had also completed a range of courses to work with children with a range of issues, like attention deficit and hyperactivity disorder, as well courses to communicate with children, work in groups with them and develop activities for them.
- The prescribing doctor at had completed the Royal College of General Practitioners certificate in substance misuse, parts one and two. The evidence-based course gives doctors the knowledge and skills to match the

competency framework in delivering quality care for drug and alcohol users. The doctor was registered with the General Medical Council and the doctor had been revalidated in October 2015. Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice. However, the service did not have a formal process in place to confirm that the doctors had been revalidated at the time of the inspection. Therefore, they could not assure themselves that this was the case for the doctor.

- The programme manager had a level three management qualification and the service manager had a level five management qualification.
- The data submitted by the service stated that 100% staff had received supervision. Staff confirmed that they received supervision. The programme manager supervised the child development staff as she had the appropriate child-care qualifications. She also supervised the therapeutic staff for consistency around discussions about families. The service manager supervised the remaining staff, the sessional workers, and the programme manager. The supervision policy stated that staff must have supervision every four to eight weeks. In the eight personnel files we reviewed, six staff had not had supervision on a number of occasions within the eight week timeframe set out in the policy. However, staff discussed their caseloads daily at the handovers. Staff also discussed their well-being at weekly team meetings. The appraisal information provided by the family service stated that 85% of staff had an appraisal. We observed appraisal documents in the files we reviewed.
- Staff files we reviewed were generally of a good standard containing disclosure and barring information, photographic identification, job descriptions, references, recruitment questions and selection grids. Induction checklists were present and all but two were completed. Probationary reviews were not in all files and there were inconsistencies in the training information. The certificates did not match the training data provided. The service identified and addressed poor performance promptly and we observed actions taken where there were concerns about practice. There was also evidence that senior managers conducted audits on the service's personnel files.

Multi-disciplinary and inter-agency team work

- There was multi-disciplinary input into the comprehensive pre-admission assessments completed prior to admission from the referring agencies and other professionals and services. This included information from the families' GP, children's social care, criminal justice services and community, substance misuse teams. This was important to safeguard the children in the service.
- The service had good working relationships with local services and professionals. These included links with the local schools and nursery so that children could continue with school or statutory nursery provision. The service also had excellent links with local healthcare services, including the GP service, which all families registered with as part of their care plan for their primary healthcare needs. The health visitor attended the service weekly to see every child under the age of five under their usual remit, which included weighing babies and children, providing advice and writing low-level prescriptions. The health visitor would also take part in reviews and co-ordinate with the health visitors in the area where the family was referred from, or was discharged back to. The service also had links with the specialist midwifery teams. We observed a client's record who had given birth whilst in treatment at the service. The family service had collected additional information about the family in order to refer to this specialist team.
- Each client was allocated a named therapeutic worker and the children were allocated a child development worker. The therapeutic worker co-ordinated the families care and treatment at the service and those involved in the patients care, including the referring agency and community care co-ordinators for a statutory referral. The therapeutic worker liaised with social care professionals. For example, to arrange looked after children reviews, child in need meetings and child protection meetings. The therapeutic worker was also responsible for writing the reports for children's social care and the family drug courts. All families had a mid-way review and a final review at either 10 or 20 weeks depending on the length of the programme agreed. These included the external agencies involved in the families care, as well as relatives and carers, if they wished to attend. These meetings were

co-ordinated by the therapeutic worker but the child development worker at the family service would also attend. The final review included examining resettlement plans and the additional support required in the community from other agencies.

- There were four handovers each day. There was one in the morning at 7.30am and one in the evening at 9.30pm between the therapeutic workers and the waking night staff. The service had a thirty-minute overlap between staff members starting and finishing to facilitate these handovers to take place. There were additional handovers throughout the day at 9am and 1pm for all staff to attend. The handovers had a standard agenda. We observed four sets of handover minutes and one handover session. The handover sessions were comprehensive and discussed all the clients and children in detail, including any concerns or issues that families were experiencing. Incidents were discussed and any actions for the day, for example client appointments or follow-up liver function tests or drug tests. The minutes also documented the staff who were present, as well as any that were absent and the staff-cover arrangements. In addition, a client in the senior stage of their rehabilitation would attend at the end of the 9am handover to feedback the feelings of the clients and any concerns for clients or the community. This ensured clients input into the handover sessions.
- Staff meetings were held weekly and followed a standard agenda. Minutes from these evidenced there was a staff check-in where staff discussed how they were feeling and managing their workload. The minutes reflected a staff team that felt comfortable in sharing their frustrations, as well as what was going well. Previous actions, admissions, and high-risk clients and safeguarding were also discussed in the meetings, amongst other governance agenda items like health and safety, policy, incidents, complaints and equality and diversity.

Adherence to the MHA and the MHA Code of Practice

- Phoenix Futures National Specialist Family Service did not admit clients detained under the Mental Health Act.

Good practice in applying the MCA

- One-third of the staff employed at the National Specialist Family Service had completed the Mental Capacity Act (2005) and the deprivation of liberty safeguards training. Staff were not all clear on mental capacity when we spoke to them, and confused this with the Mental Health Act. However, there was a standard operating procedure in place from February 2016 for all staff to refer to with regard to mental capacity and consent, including the five, core principles of the Mental Capacity Act (2005), as well as the Deprivation of liberty safeguards. The standard operation procedures detailed all the staff responsibilities, including the two-stage test used to assess capacity.
- Care records we observed and treatment agreements showed that clients had signed and consented to treatment, sharing of information and confidentiality agreements. Discussions with clients demonstrated that they were all aware of, and agreed with, their treatment and care. Clients could leave the service if they wished. However, they were encouraged not to leave and to complete their treatment.
- There were no clients subject to Deprivation of liberty safeguards.
- The service manager and the programme manager told us that considerations were made regarding a client's capacity to consent where they may be under the influence of substances, for example pre admission or on admission. They told us they would wait to gain the client's consent in these situations. However, they told us that this was rare due to the planned nature of clients attending the service, and they were often escorted by other professionals, like children's social care.

Are substance misuse services caring?

Kindness, dignity, respect and support

- All clients were extremely positive about the care and treatment they had received. They felt supported by staff, and reported that the environment was quiet and calm. Clients told us that all the staff were approachable and helpful, and that they were kind to them and their children. Staff encouraged clients with their recovery from substance misuse, as well as their parenting skills. Clients felt that the staff at the service genuinely cared about the clients' success in completing treatment and in keeping their family unit together. The client survey

for the service in September 2015 reflected this. Eighty-nine per cent of clients rated their relationship with their worker and their satisfaction with the environment as the best assets of the service.

- The interactions with clients we observed were respectful, supportive and person-centred. Clients, relatives, carers, and stakeholders all told us how the staff and the service went the extra mile in delivering care and treatment.
- Staff and clients were aware of the need to respect people's privacy and the importance of confidentiality. We saw examples of staff respecting clients' confidentiality when medications were dispensed. Confidentiality was discussed with clients at the assessment prior to the client's admission and as part of the "respecting others" section of the client agreement. Clients and staff were required to sign this document as confirmation of this discussion and their agreement to adhere to respecting people's confidentiality. Confidentiality was also addressed in "The Guide" that was given to the clients on admission.

The involvement of people in the care they receive

- The service manager told us that clients were fully informed about the service, including expectations and restrictions placed on clients during their pre-admission assessment and on admission. Restrictions which included the use of mobile phones, visits, house rules and drug testing were all included in the admission checklist that was completed on admission with clients. Clients were given a guide to the service that contained this information and information about the therapeutic programme. Clients confirmed that they were made aware of the expectations and restrictions of the service at the point of admission. All clients received a tour of the service, and made aware of the facilities on admission. Clients were also encouraged to visit the service before admission. However, due to the location and urgency of some of the family referrals this was not always possible.
- Clients told us that they felt involved in their care and treatment. All clients told us that they had a care plan. All eight care records we reviewed had care plans. Three out of the eight care plans we reviewed had personalised care plans.
- All clients had a named keyworker as their point of contact. Clients were encouraged to see the service as their home and were included in the structures required for community living, for example house-keeping jobs. Clients were encouraged to attend client only activities, as well as activities that included their children and were given a choice in these/. As clients moved through the stages of the programme from welcome house, through the primary stage and to the senior stage; clients had increased freedom to leave the residential setting, including home visits and linking in with services in the community.
- All the children had a named child-care worker in the crèche.All clients were also inducted into the childcare environment before they left their children so that they could ask questions and feel empowered as a client in the same way they would if they were looking for childcare provision at home.
- Staff and clients in the residential rehabilitation service told us that clients were empowered to have control over large parts of their own care plan towards the end of the rehabilitation programme. They were encouraged to attend activities that they could continue once discharged, for example recovery support, volunteering, education and training. Clients were encouraged to self-administer their own medications.
- The relatives we spoke with told us that they had been encouraged by staff to contact the service if they had any questions or wanted to discuss their family member's progress. The family service had previously held a families and carers' support group that included family mediation and goal setting, called "Flames," similar to other Phoenix Futures organisations. However, they had stopped this meeting in the last 12 months due to families not attending. Family members and staff told us it was hard to visit their family members or attend support at the service because often they lived far away from the service due to the service offering nationwide provision for families. The service manager told us that Flames did not fit with the family service provision and that they were hopeful to get some ideas of how to engage families through the service user consultation meetings. Clients were encouraged by the service to

have contact with relatives and carers who were a positive influence as part of their treatment and care plan. Relatives and carers were encouraged to attend for visits and care plan reviews.

- During the inspection and the focus groups, we met with the national lead for service user involvement, the regional representative for the service user council and the service user representative for the service, who was a client on the programme. They confirmed that the involvement of families and carers had developed within the last 18 months and following a six month benchmarking exercise against other services a national strategy had been written and a service user council had been established. All members of the service user council had a lived experience of substance misuse and treatment and their role was to support the service user representatives in each service. Service user representation was the role and responsibility of those clients who had graduated to the senior stage of the residential rehabilitation placement at the service.
- The design of the programme at the service allowed continual feedback from clients to staff about their concerns, their experience and how the service could be improved. Clients were able to feedback at the daily morning business meeting attended by staff and clients. For example, clients told us they had fed back in the morning meeting about the child stair gates being left open, and the importance of the whole community including staff and patients of adhering to this rule and how this could be enforced. Clients were also able to feedback through completing the bi-annual client satisfaction survey, as well as through the service user consultation meetings that took place every 6 weeks. We saw evidence that the service responded to the issues raised by clients in these surveys and at these meetings, including fixing the payphone and purchasing more pots and pans for the families. Clients stated in the survey that they wanted more emphasis on substance misuse detoxification as a goal and for this achievement to be recognised and reflected in the programme. In response, the service introduced a new "detox pack" that included bubble bath, sleep aids, herbal teas, and nutritious bars. They also had introduced a celebration for completing a substance misuse detoxification with a "welcome house walk" and hot chocolate or coffee.
- The service had a number of local advocacy services, which they could signpost clients to depending on type of advocacy they required.

Are substance misuse services responsive to people's needs?

(for example, to feedback?)

Access and discharge

- At the time of the inspection, there were five families at the service: six children and six adults. The capacity of the service was for 12 families and 30 people. Bed occupancy was one of the performance indicators managed by the service and they aimed to have 16 people, including adults and children, in the service at any one time. The service manager stated that the bed occupancy had recently dipped below this due to a number of successful completions. During our inspection, we observed admissions being planned for the following week.
- Referrals were taken from a range of agencies including the community substance misuse teams, probation and criminal justice services, child social care and council services. These referrals were national.
- The service had a clear admission criteria. All referrals were discussed on a case by case basis as to the families' support needs with the referring agency and further information required to make a decision about the admission or to manage the family in the service, was requested. Where referrals were made by children's social care or from the family drug and alcohol courts, the social worker provided detailed information on the clients' support needs and the concerns in relation to the children. Clients were offered an assessment for the service and had the opportunity to visit to decide if the placement was for them. However, in reality, due to the distance that patients had to travel, or the urgency and coercive nature of the referral, this was not always possible and pre-admission assessments were completed as a telephone assessment.
- Admissions to the service could be facilitated on any weekday. In the last six months there were 10 clients admitted to the service: eight clients were admitted who had problems with opiates only, and two clients admitted with problems with both alcohol and drugs.

The National Drug Treatment Monitoring System data collated, and published, by Public Health England confirmed that between the beginning of April 2015 and the end of March 2016, there were 22 new adult presentations to the service. There were no waits to access the service in the last 12 months, confirmed by both the service manager and the National Drug Treatment Monitoring System data.

- The average placement length was either 12 weeks or 26 weeks depending on the funding or requirements of the referral. The service had recently responded to the requirements of the Family Drug and Alcohol Courts and their legal framework and adapted their programme to be delivered in 12 weeks, and so could offer this dual provision. The average length of stay in the 12 months prior to our inspection was 129 days.
- In the last six months, there were seven discharges from the service, with 100% leaving in a planned way. Four clients completed their substance misuse treatment at the service and did not return to another substance misuse service for aftercare support, whilst three clients transferred to other substance misuse services to continue with their aftercare support following their residential rehabilitation at the service. Transferring to another service for additional support is often required to help prevent relapse. Discharges did not take place at weekends.
- Discharge plans were not discussed at the pre-admission assessment at the beginning of treatment with families. However, the nature of the programme with increased un-escorted leave entitlements and contacts with community services during the stay, as well as empowering clients to care for both themselves and their children throughout their stay, helped clients prepare for discharge. Staff and clients confirmed that they discussed their plans to leave the service at the final placement reviews, and a discharge plan was agreed with the family, their relatives and carers, and other professionals involved in the family's' care. One of the families we spoke with told us that they had a detailed plan in place for when they left the service and this helped them to feel confident to manage when they left the family service. All the clients we spoke with told us they thought highly of the services and that they had helped them to achieve their goals.

The facilities promote recovery, comfort, dignity and confidentiality

- Confidentiality, policies and procedures were discussed with patients on, or prior to admission.
- There were a range of rooms to support clients' treatment and care, including a fully equipped room for complimentary therapies, an outside garden and patio area that clients could access throughout the day and evening, group rooms and meeting rooms. There was a lounge that included a TV, DVD player and a range of games available for families. There was also a suite of computers available for clients to complete their written work and accredited parenting courses.
- There was a sensory area for babies and children that was available for clients to use when they wanted some quiet time. There was a child's play area in reasonable condition but there were plans in place to upgrade these facilities ready for the summer as the service had been successful in procuring funds from Public Health England to complete this work.
- The service did not have a specific medication room. Medication was dispensed from the administration office at the front of the building that had the medication cupboard contained in it. However, the service was due to start building work for a specific medication room. This work was due for completion in the next six months. The doctor used one of the meeting rooms to assess clients but did not complete any physical health examinations at the time of the inspection that would require additional equipment.
- Kitchen, dining and laundry facilities were available for families, with a maximum or two or three families sharing these. Clients were supported to cook healthy and nutritional meals. As clients catered for themselves and their children, snacks and drinks were available throughout the day, and clients packed snacks for their children for break times in the crèche.
- The service provided all the cots and childcare essentials. However, clients were able to bring their own Moses baskets. In addition, a list was given to clients prior to admission of what they need to bring for themselves and their children for their stay in treatment.

All staff and clients told us that they were able to personalise their own rooms and there was a safe in all the family rooms, which we observed during a tour of the service.

- Patients were not allowed to keep their mobile phones during their stay at the service but could use a payphone in the evenings between 4.30pm and 11pm. Staff arranged calls to professionals, as well as to contact other children not in the service in line with agreed care plans with the client. Mobiles phones were returned for home visits where clients were in the senior stage of residential rehabilitation. Family members told us that they could ring the service at any time. Clients told us that they were aware prior to admission that they could not have their mobile phones whilst in treatment. This information was also discussed on admission and was contained in The Guide and in the admission handbook. There was a risk that clients could contact dealers and put themselves and the recovery community at risk.
- Families could not have visits from relatives and carers in the first six weeks of the clients' residential rehabilitation placement, unless there was pre-arranged contact with other children. This pre-arranged contact was facilitated by the service. This was to ensure that they settled in to the programme and to increase the likelihood that they would stay in treatment during the initial stages of rehabilitation, which could be more difficult for individuals. Visits were limited to four people per family and took place in the families' rooms or kitchen and dining areas. Home visits could be agreed in consultation with other professionals involved with the clients, and were considered in the final stages of the residential rehabilitation placement on a case-by-case basis to help the family re-integrate back into the community.
- Along with the groups provided in the morning, afternoons and evenings as part of the therapeutic programme, the service ensured that the families engaged in leisure activities. Every week, there was a client only activity, like going to the cinema, bowling or to the gym. This was to help build the relationships between the peers and to support clients in learning how to enjoy substance free time. At the weekend there was a community activity that was planned by the clients in the service. This was generally a family focused activity, like a visit to the park or other local attraction, or a visit to the seaside. The clients we spoke to confirmed this.

Meeting the needs of all people who use the service

- The service was not fully accessible for clients and children with a disability as there was no equipment to help people with a disability to access the bathroom facilities. The service manager told us they risk assessed the suitability of the family for placement in the service with regard to any disability prior to admission. If they could not accommodate the family's mobility needs they would suggest alternative services. However, the service could accommodate families with some level of mobility issues as the service had ground floor rooms and bathrooms. Whilst clients with mobility issues would not be able to access the bungalow that was external to the main building for group work, the service would ensure there was group work provision or treatment provision for clients unable to access the bungalow in other parts of the service.
- Staff told us that they encouraged clients to access appropriate support groups, including Alcoholics Anonymous, Narcotics Anonymous, and Self-Management and Recovery Training. Clients confirmed this and told us they were encouraged to make links with services and support in the community in the later stages of their treatment and on discharge in their local area.
- The service manager told us that the need for spiritual support was identified during the assessment process and that families would be supported to access any faith based support regardless of the stage they were at in their treatment and the associated leave entitlement from the service. One of the people we spoke with told us that they had observed a person attend for prayers at their local religious establishment.
- A detoxification handbook was available for clients on admission. This included information about medication, as well as what clients may experience during their detoxification. The service manager informed us that they could access interpreters or use translation services to ensure all information, including information about detoxification, was appropriate for those who first language was not English.

- Staff had identified a range of advocacy service that families could access in the area local to the service. As many of the families would return home following their treatment in the family service, staff told us that they would support clients and families to access advocacy in their own communities.

Listening to and learning from concerns and complaints

- The service had three complaints and three compliments in the last 12 months.

  The compliments were all regarding the service that families had received and the support from their therapeutic workers. We also saw a number of thank you cards displayed in the service during the inspection.

  The complaints included an issue raised by a client about a cancelled appointment for their child, a concern about a message not being passed on to the client from a family member and a complaint from two clients about a staff member. All three of these complaints were resolved locally by the service at stage one of the complaints policy and were dealt with in accordance with this policy. We observed the investigation into the concerns over a worker's alleged behaviour, including the agreed resolution with the complainants.

- Information on how to complain was given to clients on admission and this was included in the admission checklist to confirm that they had received this information. However, there was a lack of information regarding complaint resolution if clients were not satisfied with the final response from Phoenix Futures complaints procedures, including being directed to the local government ombudsman.

- All clients told us that they were aware of how to complain but that they would generally discuss any issues in the morning business meeting, or just approach a member of staff and their concern would get resolved. Staff told us that if someone wanted to complain they would try to resolve it and would inform the services manager. If the complaint could not be resolved, staff told us they would support clients to make a formal complaint.

- Complaints forms were available for people and we observed these complaint/compliment feedback forms. Staff also told us that clients could complain via a complaints email address. We observed signage about how to complain to Phoenix Futures, as well as signage about the role of the Care Quality Commission. The service manager told us that complaints information could be made available in other languages and accessible formats if this was necessary but this had not previously been required. However, the service user representatives in the service, who were senior community members, or a service user council member, were also available in the family service to support clients with advice on the process of how to complain, or to advocate for them.

- The head of quality and performance, the quality assurance manager and the quality administrator had an active role in overseeing, recording and managing the complaints process for Phoenix Futures, with service manager having overall responsibility for responding to compliments and complaints at a local level, and identifying and implementing any changes in response to them.

- Staff informed us that feedback was given following complaints or compliments in the team meetings. We observed evidence in the staff team meeting minutes that complaints, compliments and learning was discussed as a standard agenda item. We noted that the complaint by a client about the cancelled appointment for a child was discussed. The learning and action from this complaint was implemented in the service. This included a more formal system to request appointments and appointment cards given to the client to confirm the appointment.

Are substance misuse services well-led?

Vision and values

- Phoenix Futures Group provides residential services, community services, supported housing and prison services across England. Phoenix Futures National Specialist Family Service is one of four residential rehabilitation services registered with the Care Quality Commission. Phoenix Futures services all shared the same purpose, values and beliefs. These were recovery focussed in nature.

- The Phoenix Futures Group Purpose is:

Substance misuse services

- The Phoenix Futures Groupis dedicated to helping individuals, families and communities recover from drug and alcohol problems.
- The Phoenix Futures Group Values and Beliefs are:
- We believe in being the best
- We are passionate about recovery
- We value our history and use it to inform our future
- The senior managers we spoke with during the inspection clearly articulated these beliefs and values. Whilst not all staff could state the purpose, values and beliefs, all staff could explain a service culture that these represented. Staff demonstrated this through their dialogue and the interactions we observed with the families. There was a strong culture of recovery embedded in the service. This was demonstrated in the discussions we had with staff, clients, relatives and carers.
- Staff we spoke with knew the senior managers and the chief executive by name. The chief executive held annual road shows to discuss the provider's achievements and plans, which fed into the corporate strategy for the coming year. This was mandatory for staff to attend. Staff told is that they had found this useful and enjoyable. The recent road shows had included a workshop by the service user council to demonstrate the services from a service user perspective. Staff also confirmed that senior managers, including the director of operations and the head of quality regularly visited the service every two to three months. The programme manager and the service manager were visible and accessible to staff, and were actively involved in the programme.

Good governance

- The Phoenix Futures Group executive board, including the trustees and the executive management team, was responsible for the governance of the whole organisation.
- The Board had three delegated committees; the audit committee, the clinical governance committee, and the remuneration committee both of which reported to the full Board meetings.
- Local governance structures at the National Specialist Family Service linked in to the Phoenix Futures Group clinical governance framework, via the head of operations. The service manager could agree for issues to be put onto the Phoenix Futures Group risk register, in conjunction with the head of operations. The head of operations provided supervision and support to the National Specialist Family Service and the service manager. They also met quarterly to review the service outcomes. The service manager told us that the main performance indicator for the service was the bed occupancy. However, the head of quality confirmed that there were a range of service performance indicators which the operations manager discussed quarterly. We observed these performance indicators, which included the treatment outcome profile and outcome star compliance, retention and discharge of families and staff performance and well-being.
- The service had local governance arrangements in place to help ensure safe and quality care including policies, procedures and protocols. However, these were either still in draft format and yet be finalised, or recently introduced and so not embedded into the service delivery. The client admission, assessment, care planning and discharge policy was yet to embedded. The medication administration policy was under review to include current best practice, and the clinical protocols for detoxification were still in draft format. There remained some significant areas regarding the detoxification policies where processes needed to be risk assessed and agreed between the service and the lead clinician, for example issues around clinical areas that needed to be risk assessed and agreed, for the requirement of emergency medication and the use of recognised withdrawal scales. The service completed a number of audits, for example, care file audits, the pharmacy audit and the infection control audit. However, these audits were not successful at ensuring the client records were complete, appropriate infection control procedures were in place and that medications management procedures were in place and audit actions completed, for example appropriate fridges and medication storage temperatures.
- In addition, we observed some processes that were duplicating and had the potential to cause confusion, or for staff to miss information. This included the

inconsistencies in staff documenting information in the log book, handover sheet and the client's case notes, and the doctors notes and other notes not being kept in the clients' case files.

- Mangers found it difficult to provide training information about permanent and sessional workers, and it was unclear what training was mandatory. Whilst some staff had not had supervision within the eight weeks as outlined in the supervision policy, there were lots of opportunities for staff to discuss the families on their caseload and their own well-being and concerns in handover sessions and team meetings. Incidents, complaints and policies were discussed in the team meetings. However, we were aware of two incidents that had not been dealt with effectively: one was not reported as an incident and the other medication incident did not have the learning discussed and actioned.

Leadership, morale and staff engagement

- The service manager and the programme manager were family focussed and had experience working in the substance misuse field and with vulnerable families and safeguarding.
- All staff told us that the managers at the service and in Phoenix Futures were approachable and supportive. They felt confident in being able to approach them with concerns without fear of victimisation. Staff were aware of whistleblowing procedures. There had been no whistleblowing incidents in the last 12 months. All staff were enthusiastic about their work, the service and the organisation.
- In the 12 months prior to the inspection, the service reported 11.3 days of sickness. They also reported a 23% staff turnover rate. The staff turnover was attributed to a staff member who was on long-term sick and then left the service and maternity cover. However, at the time of the inspection the service had a full staff team. The service had a range of new and long-term staff members, with some staff working up from volunteering to paid employment. The service had team away days twice a year. The staff team reported that this had a motivating and energising effect on the team. The managers reported that the staff responded well to these away days.
- Staff, clients, relatives and carers were able to feedback into the planning, delivery and development of the service. They could do this through the feedback forms available in the service, as well as the bi-annual client satisfaction survey. Clients were able to feedback through the morning meetings and the service user consultation meetings in the service, and through the service user representatives the service user council representatives. Staff were encouraged to feedback on the service through supervision, appraisal and weekly team meetings. Staff were able to feed back into the design and delivery of the service, and the annual business plan, through the annual road shows held by the chief executive. These road shows were also a forum for staff to be informed of the external and national pressures on the service and why any proposed changes to the services were important.

Commitment to quality improvement and innovation

- The service was innovative s due to the specialist nature of what it offered. It gave clients the opportunity to complete residential substance use treatment with their children in their care. They were supported in developing their parenting skills and their relationships with their children at the same time.
- The service was involved in making a documentary at the time of the inspection.The provider felt this would help to raise the profile of this specialist service and their approach, as well as substance misuse treatment and the positive outcomes for clients and families. This would also support the public in understanding recovery and facilitate the reduction of stigma faced by families where the clients use substances.
- The service had recently responded to the requirements of the Family Drug and Alcohol Courts and their legal framework and adapted their programme to be delivered in 12 weeks, as well as the usual 26 weeks. This gave clients further opportunities to address their substance misuse and keep their family together.
- The service ensured that client and staff views were sought through a variety of feedback mechanisms in order to improve their services delivery and the experience of the clients during their treatment.
- The service completed the annual Footprint's survey that reviewed all the admissions to the service including

recovery, offending, criminality and health. This information was used to shape and inform the service design and delivery, and to inform commissioners and referrers about the service demographic and outcomes.

- The service and staff had been encouraged to participate in the Phoenix Future's fundraising and innovation projects. These have included a "voyage of recovery," where clients and staff from the service sailed around the United Kingdom coast, as well as clients planting a tree in the Heartwood Forest, for all the clients completing programmes to support the Woodland Trust.

Outstanding practice and areas for improvement

Outstanding practice

- The National Specialist Family Service was an innovative service due to the specialist nature of the service it offered. It recognised and promoted the importance of a whole family approach in line with the "think family" and "troubled family" government initiatives. It gave clients the opportunity to complete residential substance use treatment, with their children in their care. They were supported in developing their parenting skills and their relationships with their children at the same time. The service had adapted its programme to offer a 12 week placement for families in line with requirements of the Family Drug and Alcohol courts and their legal framework, giving more clients the opportunity to address their substance misuse problems to keep their family together. All parents left the service in a planned way.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure infection control procedures and practices, especially in relation to drug and alcohol screening, are undertaken in a way to minimise the risk of the spread of infection.
- The provider must risk assess the requirement for physical health examinations and observations to be completed during detoxification, and the use of a recognised withdrawal scale.
- The provider must risk assess the requirement of emergency medications, oxygen, and emergency equipment like the defibrillator for both adults and children, and the emergency doctor's provision outside the contracted on-call hours. It must agree the final contract with the doctor.
- The provider must ensure that systems are in place to ensure that client information is recorded consistently and that all information in one place so that information is accessible to all staff at all times.
- The provider must ensure that systems are sufficient to ensure managers can access accurate training information for permanent and sessional staff, and to be clear which training is mandatory and when this needs to be repeated.
- The provider must ensure that necessary training is completed to ensure that staff are equipped to meet the needs of the children and the clients they support.
- The provider must ensure that staff have completed the necessary training to use the clinical tools used in the service.
- There provider must ensure that staff have sufficient training to manage challenging behaviour, aggression and violence.
- The provider must ensure that the doctors providing treatment at the service have been revalidated with the General Medical Council.
- The provider must ensure that medication is stored appropriately and that records of controlled drugs are completed in accordance with legislation
- The provider must ensure that risk assessments and management plans follow the contemporaneous records, and be reviewed and updated following incidents.
- The provider must ensure that incidents are reported using the incident procedures and learning from incidents is shared, including from medication incidents.
- The provider must ensure that its protocols for detoxification from opiates and alcohol are ratified and in line with best practice, and agree whether a protocol for detoxification from benzodiazepines is required.
- The provider must be able to evidence that records are accurate, complete and contemporaneous, and that care plans and risk assessments are reviewed.

Outstanding practice and areas for improvement

- The provider must ensure that assessments are completed on a client's ability to self-administer their own medication, and their children's medication, and ensure that the medications administration policy is ratified to include more detailed information around self-administration and administering medication to children.
- The provider must ensure that the governance systems operated effectively and were sufficiently established and embedded to assess, monitor, and improve the quality and safety of the service provided.

Action the provider SHOULD take to improve

- The provider should consider the risk of mixed sex couples sharing bathroom facilities and people having to use these with other unrelated clients of the opposite gender.
- The provider should ensure that the safeguarding adults policy is reviewed and ratified.
- The provider should ensure that it updates its serious incident policy to include the duty of candour.
- The provider should ensure that staff supervision is completed within the eight week period outlined in the supervision policy, and that the information in the personnel files is consistent for each staff file.
- The provider should ensure that discharge plans are agreed and in place at the beginning of treatment.
- The provider must ensure that staff have a clear understanding about mental capacity
- The provider should consider to review options for the ground floor bathroom to be fully accessible for patients with mobility issues.
- The provider should ensure that the complaints information includes details of the local government ombudsman.
- The provider should ensure that local managers and staff have a clear understanding of performance indicators and how the service performs against them.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The service used minimal personal protective equipment to complete drug screens with clients. It did not dispose of clinical waste from these urine tests in the bathroom where the test was completed. It re-used breathalyser tubes rather than using a new tube for each test. The service had not risk assessed the requirement for physical health examinations and observations to be completed during detoxification, or the use of a recognised withdrawal scale. The service had not risk assessed the requirement for emergency medications, oxygen, and equipment like a defibrillator for both adults and children, or the emergency doctor's provision outside the contracted on-call hours. The service did not have risk assessments in place regarding the management of aggression or violence. The service did not always store medication appropriately and records of controlled drugs were not always completed in accordance with legislation. The service did not complete assessments on a client's ability to self-administer their own medication, and their children's medication.

This section is primarily information for the provider

Requirement notices

This is a breach of regulation 12 (2) (a) (b) and (h)

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Risk assessments, care plans and risk management plans did not follow the contemporaneous records. They were not reviewed, and risk management plans were not updated following incidents Not all incidents were reported using the incident reporting systems, and learning was not always shared despite the systems in place. The governance systems established to assess, monitor, and improve the quality and safety of the service, and manage risk effectively, did not operate effectively and were not embedded in the service. The service had not agreed the final contract with the doctor completing the detoxifications. Systems were not in place to ensure that client information was recorded consistently and that all information was in one place so that information was accessible to all staff at all times. Systems were not sufficient to ensure managers could access accurate training information for permanent and sessional staff, and to be clear which training was mandatory and when this needed to be repeated. Also, a system was not in place to assure the service that the Doctor had been revalidated.

This section is primarily information for the provider

Requirement notices

The service's protocols for detoxification from opiates and alcohol had not been agreed and ratified, in line with best practice, between the service and the doctor. The service had not agreed whether a protocol for detoxification from benzodiazepines was required.

The medication administration policy was under review and had not been ratified to include current best practice, and had limited detail around self-administration and administering medication to children.

This is a breach of regulation 17 (2) (a) and (b)

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: Staff had not completed paediatric first aid training and the therapeutic staff had not completed basic childcare training. Three quarters of staff had not completed mental health awareness training. Staff completing the clinical institute of alcohol withdrawal scale had not been trained to use this tool. Staff had not completed any training in managing aggression and violence, or working with challenging behaviour. This is a breach of regulation 18 (2) (a)