St Anne's Community Services - Alcohol Services

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:

- St Anne's Alcohol services were not assessing and managing risk effectively. Service risk assessments had not been completed on the use of mixed sex accommodation and client call alarms in the 18 bed residential rehabilitation unit. The medication and equipment required in an emergency, including a defibrillator, and the response time from the emergency services and distance to the nearest accident and emergency had not been risk assessed. Also, the service could not be sure that their equipment was in working order, for example, the staff communication radios. The system to record client risks was unclear and in the care records reviewed, risk assessments and risk management plans were either not present or incomplete. Not all staff were clear about reporting incidents where they felt intimidated as a risk. In addition, risk assessment was not included in the visit's policy to safeguard children and vulnerable adults.
- Patient physical observations and baseline observations were either not completed or not recorded, or discussed in the staff handover sessions. Similarly, assessments and observations for medication prescribed as the patient required it were either not completed or not documented in line with the services' policy.
- St Anne's Alcohol Services had low compliance for some of its mandatory training, including moving and handling patients. This could impact the safety of the staff and the patients. Staff could not all identify child safeguarding risks and concerns, and staff had not received any child-safeguarding training to an appropriate level for their role. There was no formal programme of specialist substance misuse training for the administration of medication, including a schedule of competency assessments or supervised practice.
- Care plans were not holistic and individually tailored to the client's needs, and clients in the alcohol detoxification service did not get a named nurse on admission. None of the care plans had clear actions, and were not signed and dated by both the client and the staff member. Similarly, the alcohol detox could not be tailored to the client as there was no use of alternative medications.For example where a client had poor liver function. Clients in the alcohol services did not have a discharge plan in place on admission. Staff did not document decision specific mental capacity assessments in the client record where capacity had been a concern. Also, the services did not have any input from a dietician to ensure that they were meeting the nutritional requirements of the clients.
- The mission, vision and values (core principles) were not embedded in St Anne's Alcohol Services because staff were unclear what they were. Also, there was not a vision or statement of recovery specific to alcohol misuse for staff to embed in their practice, and for clients to work towards. The governance systems established had not operated effectively and were not embedded to assess, monitor and improve the quality and safety of the service provided. In addition, information required by the alcohol services management team to manage the services, for example for supervision, appraisal and training, was not held in one place, and was not accurate.

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

- Staff were caring and treated clients with kindness and respect. The staff had a strong person-centred approach. The service tried to meet the needs of all the clients who used the service and where they were unable to meet a client's needs, they were transparent with the client and found them alternative service provision in partnership with the community, substance misuse service.
- The psychological therapies, group-based interventions, medications and detox regimes used were evidence based and recommended by the National Institute for Health and Care Excellence. Staff received regular managerial and clinical supervision, and completed annual appraisals. The service completed a number of outcome tools to

Summary of findings

demonstrate that clients were making progress and meeting their goals. The alcohol services outcomes demonstrated that clients were making changes and leaving treatment having met their goals.

- The environment at St Anne's Alcohol Services was clean and well maintained, including the outside space. The services were responsive in their approach with clients. Clients had a pre-admission assessment within 10 days of being referred to the service and the usual wait time to access the alcohol services was 11 days from the pre-admission assessment to admission for both the alcohol detoxification service and the residential rehabilitation service. Clients had also been admitted immediately following the pre-admission assessment where this had been required. The doctor saw clients in the alcohol detoxification service immediately on admission. Also, St Anne's Alcohol Services had been proactive in taking action to reduce their waits to enter the service and improve the service for the clients.
- St Anne's Alcohol Services were committed to improving the quality of treatment for clients, and the treatment outcomes, through their involvement in national research and projects. Staff, clients, relatives and carers felt able to feedback into the planning, delivery and development of the service. All staff told us that the service manager was approachable and supportive. They felt confident in being able to approach them with concerns without fear of victimisation. Lessons learned from incidents and complaints or compliments were also used to develop and improve the service.

Summary of findings

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Services we looked at
Substance misuse services

Summary of this inspection

Background to St Anne's Community Services - Alcohol Services

St Anne's Alcohol Services includes a detoxification service and a residential rehabilitation service. They provide treatment to men and women over 18 years of age.

A five-bed detoxification service provides residential alcohol detoxification to adults who require a safe and supervised place to withdraw from alcohol. This includes clients who are stable on substitute prescriptions for opiate dependency.

An additional18-bed residential rehabilitation service provides adults who have been experiencing alcohol-related problems with an intensive period of support to maintain abstinence from alcohol.

Clients can attend the detoxification service without attending the residential rehabilitation service, and vice versa. Clients can also attend for a detoxification from alcohol and then continue into the residential rehabilitation service.

The detoxification and rehabilitation services are in adjoining buildings on the Woodhouse Lane site, and share facilities, for example one to one consulting rooms and group rooms. There are separate sleeping areas and bathrooms for clients completing a detoxification from those clients completing the residential rehabilitation. However, clients in the detoxification and rehabilitation services share communal areas in this building, for example the dining room and games room.

The referral route for both the detoxification and the rehabilitation services is through the community-based substance misuse services in Leeds.

St Anne's Alcohol Services are close to the city centre of Leeds and can be reached easily on foot, by car and by public transport. The service is not fully accessible for clients who need to use a wheelchair.

St Anne's Alcohol Services are one of 58 locations registered with the Care Quality Commission provided by St Anne's Community Services. St Anne's Community Services provides a wide range of services to people who require support for a variety of different reasons. They provide services across Yorkshire and the north east for people who require support because they have a learning disability, have mental health problems, have issues around substance use, and to people who are or have been homeless. Services provided by St Anne's Community Services include a variety of housing and accommodation based support and care, day services, and community based support.

St Anne's Alcohol Services registered with the Care Quality Commission on the 15 March 2011 to provide accommodation for persons who require treatment for substance misuse as its regulated activity. It had a registered manager appointed to manage the regulated activity on behalf of St Anne's Community Services. It also had a nominated individual who is a senior person in the organisation who has overall authority over the regulated activity.

Three inspections have been undertaken since St Anne's Alcohol Services were first registered. The last inspection on the 5 February 2014 found that St Anne's Alcohol Services was meeting all the Care Quality Commission national standards.

Our inspection team

The team leader of the inspection was Kate Gorse-Brightmore, Inspection Manager, Care Quality Commission.

The inspection team consisted of one inspection manager, two inspectors, one inspection assistant, a pharmacist inspector, and a specialist advisor in the substance misuse field.

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.

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During the inspection visit, the inspection team:

- looked at the quality of the environment and observed how staff were caring for clients
- spoke with six clients on the day of the inspection and collected feedback from 14 clients using comment cards
- spoke with 28 clients at the focus group prior to the inspection
- spoke with one relative or carer
- spoke with the registered manager
- spoke with11 other staff members, including the senior nurse, the rehabilitation co-ordinator, nurses, alcohol support workers, the catering co-ordinator, the finance clerk and administrator, and volunteers
- attended and observed one handover meeting
- attended and observed a morning community meeting and a therapeutic group session
- attended and observed a client admission appointment
- looked at seven care and treatment records for clients, including five current clients and two discharged clients
- reviewed five staff personnel files
- carried out a specific check of the medication management

What people who use the service say

- Every client we spoke to had positive things to say about the services. They felt the services were safe and clean. They told us that the staff were caring and always treated them with dignity and respect. We were told that staff were approachable and never too busy to talk and would go the extra mile to support people. Clients were confident that any issues they

Summary of this inspection

raised with staff about their treatment would be listened to, and dealt with, promptly. Clients told us that they felt actively involved in decisions about their care and treatment.

- Six clients we spoke to during the inspection told us that details of their treatment had been clearly explained before admission, along with the expectations of the service. For example, clients were advised about the attendance at the groups and completing domestic chores around the service. Clients told us that the restrictions placed on them whilst using the service, for example clients in the rehabilitation service having to return to the service by a certain time each evening, had been had been explained to them along with the reasons for the restrictions.
- We were only able to contact one carer during the inspection. The feedback about the service we received was very positive. The carer thought the service was good and that the staff were very professional. The feedback we received from people who commissioned the service, and those who made referrals into the service, confirmed St Anne's Alcohol Services were highly thought off, and put the client front and centre.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

- There was low compliance for some mandatory training, including moving and handling patients. This could impact the safety of the staff and the patients.
- Staff could not all identify child safeguarding risks and concerns, and staff had not received any child-safeguarding training to an appropriate level for their role.
- There was not a clear and consistent system in place for assessing and managing client risk.
- Clients did not have current care plans in place, which include risk assessments and risk management plans, in line with the National Institute of Health and Care Excellence.
- Risk assessments and risk management plans were not completed on admission and did not include all the risks identified for each individual client.
- Risk assessments and risk management plans were not reviewed and updated regularly or where the risk changed.
- Physical health observations and ongoing physical health risk assessments, as well as baseline observations were not completed or documented, or discussed in staff handover sessions.
- Observations and assessments for PRN (as required) medications for clients were not completed and recorded as per the St Anne's Alcohol Services medication administration policy.
- There was not a risk assessment in place for the services response to emergencies, including contact 111 (non-urgent help-line), the provision of emergency medication and equipment for resuscitation including the defibrillator, and the response time for urgent treatment and distance to accident and emergency.
- The service did not have access to emergency equipment, like a defibrillator, to use to help resuscitate a client in an emergency.
- There was not a system in place to ensure that the staff radios were in working order so that staff could be alerted to respond to emergencies.

Summary of this inspection

- Call alarms were in place in the detoxification bedrooms. However, they were not in place in the 18 residential rehabilitation bedrooms and a risk assessment had not been completed to confirm if these were required or mitigated.
- Risk assessments and risk management plans had not been completed on the mixed sex-accommodation provision.
- The visits policy did not reflect the requirement to safeguard children and vulnerable adults.
- Whilst staff gave us some information about what they should report, we observed evidence that staff did not always know when to report all incidents where they felt intimidated by clients.

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

- The environment at St Anne's Alcohol Services was clean and well maintained, although staff had not completed and signed the cleaning schedule following cleaning.
- There were sufficient staff to cover the service. Regular bank and agency staff were employed where there was a need to increase staff due to the case mix, last minute sickness, or for short-term maternity cover.
- There were two serious incidents in the last 12 months. There was evidence that new learning had been implemented following these incidents.

Are services effective?

We found the following areas of good practice:

- Confidentiality and information sharing, and the treatment contract were discussed and agreed on admission.
- Clients were seen by a doctor immediately on their admission to the alcohol detoxification service.
- Clients were required to attend a therapeutic recovery programme as part of admission to the service. This was five days per week for the residential rehabilitation service, and seven days for the alcohol detoxification service.
- Psychological therapies, group-based interventions, medications and detox regimes used were evidence based and recommended by the National Institute for Health and Care Excellence.
- Staff received regular managerial and clinical supervision appropriate to their role, as well as annual appraisals.

Summary of this inspection

- The service had good working relationships with the community services, who attended the client mid-point review meetings and pre-discharge meetings in the residential rehabilitation service.
- The service completed a number of outcome tools to demonstrate that clients were making progress and meeting their goals. The outcomes demonstrated that clients were making changes and leaving treatment having met their goals.

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

- The service did not offer alternative medications for the alcohol detoxification, for example where clients had a poor functioning liver.
- Care plans were not holistic and individually tailored to the client's needs, with clear actions. There was a lack of evidence to show clients were given a copy of their care plans The provider should ensure that the alcohol detox is personalised to the client, for example the use of alternative medication for physical health conditions.
- Discharge plans were not in place at the start of the clients' treatment in the alcohol services.
- Clients in the detoxification service did not have a named nurse as a contact throughout their treatment.
- There was no formal programme of specialist substance misuse training for the administration of medication, including a schedule of competency assessments, or supervised practice.

Are services caring?

We found the following areas of good practice:

- Staff were caring with a strong emphasis on person-centred care. Staff treated clients with kindness, dignity and respect.
- Families and carers were invited to become involved in a client's treatment through attendance at sessions in the rehabilitation programme.
- Families and carers were supported in accessing local services for on-going support.
- Clients were able to input into the service they receive through treatment review meetings, daily morning meetings and weekly one to one sessions.

Summary of this inspection

Are services responsive?

We found the following areas of good practice:

- Clients had a pre-admission assessment within 10 days of being referred to the service. The usual wait time to access the alcohol services was 11 days from the pre-admission assessments to admission, and there was evidence that clients had been admitted immediately following the pre-admission assessment.
- The service had been proactive in taking action to reduce their waits to enter the service and improve the service for the clients. They had obtained capital funding from Public Health England for a four bedroom step-down unit for the residential rehabilitation service and one extra bed for the alcohol detoxification service.
- Between 1 October 2015 and 31 December 2015, 92% of clients left both the alcohol detoxification service and the residential rehabilitation service in a planned way.
- Clients could access a clean and well-maintained outside space. They told us that the food was of a good standard.
- The service was not fully accessible due to the design of the building. However, the service tried to meet the needs of all the clients who used the service. Where they were unable to meet a client's needs, they were transparent with the client and found them alternative service provision in partnership with the community, substance misuse service.
- Staff told us there was access to religious and spiritual support, and treatment information in a format that they could understand, and the service catered for their spiritual and dietary requirements.
- Clients knew how to complain and staff were clear about the complaints procedure. The service also had a procedure for informal complaints which allowed them to identify any themes and implement any lessons learned.

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

- There was no input from a dietician into the clients' diet to ensure that their nutritional requirements were being met.

Are services well-led?

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

Summary of this inspection

- The governance systems established had not operated effectively and were not embedded to assess, monitor, and improve the quality and safety of the service provided. This included systems to ensure that mandatory training was appropriate and completed by staff, including child safeguarding training. This also included the effective use of audits to ensure appropriate service risk assessments and management plans were in place, that client risk assessments and risk management plans were in place, and that observations for as required medications and physical health were being completed, including baseline observations.
- The mission, vision and values (core principles) were not embedded in St Anne's Alcohol Services as staff were unclear what they were.
- There was not a vision or statement of recovery specific to alcohol misuse for staff to embed in their practice, and for clients to work towards.
- Information on supervision, appraisal and training was not held in one place, and was not accurate.

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

- All staff told us that the service manager was approachable and supportive. They felt confident in being able to approach them with concerns without fear of victimisation.
- Staff and clients, families and carers were able to feedback into the planning, delivery and development of the service.
- St Anne's Alcohol Services were involved in national research and projects. The outcome of these will support alcohol residential services in evidencing the efficacy of their residential services to commissioners in order to procure future contracts, and to improve the quality of treatment for the clients, and the client outcomes.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff had received the mandatory training in the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards. There was also a resource pack on mental capacity and the Deprivation of Liberty Safeguards in the staff office.
- There were no clients subject to Deprivation of Liberty Safeguards.
- Clients could leave the service if they wished as they were assessed as having capacity to make decisions, even if it was an unwise one. However, they were encouraged not to leave to complete their treatment.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

The environment at St Anne's Alcohol Services observed was clean and tidy. There was some evidence of wear and tear but client areas were comfortable and the furniture, fixtures and fitting were generally in good condition. The services were in the process of refurbishing some of the bedrooms and the lounge areas. All rooms, including the consultation rooms, the dining room, the lounges and games room were accessible to staff and clients.

There were some environmental risk assessments in place, including health and safety, slips, trips and falls, and the control of substances hazardous to health. There were management plans to reduce risk and environmental impact for each of these risk assessments that were in place. We observed that two of these risk management plans were reviewed, and updated, following an incident. Updated guidance on slips, trips and falls was introduced and uneven pavings were repaired. We observed the staff Health and Safety handbook that staff completed as part of their induction, which included food hygiene, fire safety and security.

The infection control policy for St Anne's Alcohol Services 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 services had two additional infection control and prevention champions. The senior nurse completed an infection control audit using the Leeds Infection Control kits. The findings were fed into the senior management meetings where actions were agreed, for example a rolling programme of changing the current mattresses. Daily, weekly and specialist cleaning schedules were in place. However, there was no written evidence that these had been completed as the cleaning logs were not being used.

The services could accommodate 23 clients at any one time: five in the detoxification service and 18 in the residential rehabilitation service. All the accommodation was mixed-sex. The bedrooms were single occupancy, with shared bathrooms along the corridors. There were no gender-specific bathroom and toilet facilities. Bedrooms were allocated to clients on admission depending on availability. There was no evidence that the service had risk-assessed the mixed sex accommodation and bathroom provision, and the potential impact on clients in either an environmental, or individual client risk assessment and management plan.

Four of the bedrooms in the 18 bed residential rehabilitation service were in a recently refurbished independent living house for those clients in the last four weeks of their residential rehabilitation placement.

In the residential rehabilitation service, clients could lock their bedroom doors. The five bedrooms in the detoxification service did not have lockable room doors. The services manager told us that the beds used for detoxification were not locked so that nurses could access the rooms easily in case the clients needed urgent support. Clients were made aware of this prior to admission.

The staff office was situated on the first floor. There were restricted lines of sight from this office to the majority of the client areas. A ligature risk assessment had been completed in March 2016, which included control measures. For example, there was a ligature cutter on site and client observations were sighted as a mitigating factor for these risks. During the inspection, the hand-rails, robe hooks and shower-rails were identified as additional ligature risks. St Anne's Alcohol Services were not aware of

these at the time of the inspection but updated their ligature risk assessment and management plan using the National Client Safety Standards during the inspection period.

In the detoxification service, client observations were to be completed every 15 minutes for the first 72 hours of a client's alcohol detoxification. After 72 hours, observations were reduced according to the client's presenting risk. The nurses made the decisions to increase or decrease observations. All staff were able to complete client observations and they recorded them on the observation sheet.

We observed the completed observation sheets and noted that there were missing entries on these sheets. As such, there was no evidence that clients were being observed at the identified intervals appropriate to their personal circumstances, or the increased risks associated with an alcohol detoxification. This meant that the staff may not be able to identify and manage the increased risks associated with an alcohol detoxification, or a patient ligaturing, with the urgency required.

In the rehabilitation services, clients were not placed on observation.

The five-bed alcohol detoxification service had client call buttons, which were audible throughout the service. Contractors maintained the alarm system annually.

Call buttons were not installed in the 18 bedrooms of the residential service. There had been no incidents in the rehabilitation service where the clients would have benefitted from having a client call button in their room. However, the service had not completed an environmental risk assessment for the requirement of client call buttons in the rehabilitation service.

Staff working across the alcohol services collected radios at the beginning of each shift to enable them to contact each other in case of a client emergency or staff emergency, for example a client seizure or an incident of violence or aggression. The services manager told us that staff checked their radios at the beginning of each shift. However, there was no formal system in place to maintain these radios or to check that they were working at the beginning of each shift. If a staff member was unaware a radio was faulty, this could delay the response of their colleagues and put clients and staff at risk.

St Anne's Alcohol Services had a detailed search policy. Clients' belongings were searched on admission, bag searches were completed on return from leave, and random room searches were performed during a client's stay. Clients were informed about the searches prior to admission. There were no invasive searches. The services had safeguards in place to protect the staff and clients during searches. Searches were completed in private, by two staff, using gloves, and with the client's verbal consent. The centre manager and nursing staff told us that clients were informed of the search policy prior to admission. The terms and conditions of treatment for both services detailed the search policy, which the clients were required to sign and agree.

The clinic room was small but with sufficient room for the medication cupboard, emergency aid and the medication trolley. There was no examination couch for physical examinations but the medical and clinical staff confirmed that they did not complete in-depth physical examinations that would require an examination couch.

There were basic supplies of emergency medicines and oxygen, and daily checks were carried out to ensure they were fit for use. Eighty-three per cent of staff had completed the emergency aid training, which includes basic life support and intermediate life support. However, the service did not have a defibrillator. During an alcohol detoxification, clients are at an increased risk of seizures from the withdrawal from alcohol. A defibrillator is for use should the client have a cardiac arrest following a seizure, or any other health complication. We did not observe a risk assessment for the detoxification service's need for a defibrillator, nor did we see a risk assessment for any contingency plan for the absence of a defibrillator, for example, taking patients to the nearest accident and emergency.

Safe staffing

St Anne's Alcohol Services had 18 staff in total at the time of the inspection. This included a services manager, a senior nurse, a rehabilitation co-ordinator, five whole time equivalent registered nurses, seven whole time equivalent support workers, a catering co-ordinator, a domestic, a finance clerk and administrator. Five volunteers were employed in addition to these staff. A doctor worked in the service for six hours per week. The senior nurse managed the detoxification service and the rehabilitation co-ordinator managed the rehabilitation service. This

services manager was responsible overall for both the detoxification service and the rehabilitation service. The staff team at St Anne's Alcohol Services work across both the detoxification service and rehabilitation service.

There were three shifts: 8am to 3pm, 2pm to 9.30pm, and 9pm to 8.15am. On these shifts, there was always a minimum of two staff on duty at any one time. These two staff would be the responsible cover for both the detoxification and the residential services. Four days of the week the staffing arrangement for the two staff, was for a waking night nurse and a sleep-in support assistant. The services manager told us that this system had been in place for three years. We observed a detailed risk assessment for this arrangement. He told us that this was a manageable risk as the four days included, Friday, Saturday, Sunday and Monday. During this part of the week, clients who had started their detoxification from alcohol on Tuesday would be more stable, and would have been seen by the doctor twice for an assessment and then review. The room the sleep-in support staff member stayed in had a mobile phone, a radio and a pager. The services manager regularly reviewed the incidents at night and the impact of this sleep-in support on the response to clients. There were two incidents recorded and no impact on the response received by the clients.

Between 8am and 4pm there would be additional staff to support the delivery of the rehabilitation programme in the rehabilitation service, including the rehabilitation co-ordinator and additional support workers. There would also be additional staff to cover the day-to-day management of the service, including the services manager, finance clerk and administrator and the catering co-ordinator.

The detoxification service requires a nurse to be on-site in order to be operational. Where a nurse could not attend for a shift due to leave, sickness or vacant posts, the service uses the St Anne's Community Services bank staff to cover in the first instance. Previous members of staff from the St Anne's Alcohol Services, as well as substance misuse workers from their community services, were included in the St Anne's pool of bank staff. Where bank staff were unavailable, St Anne's Community Services had a contract with a regular agency who complete all the necessary pre-employment checks, which both St Anne's Alcohol Services could use. The services manager told us that where they request agency staff, regular agency staff were used.

Between 1 October 2015 and 31 December 2015, the alcohol services covered 76 shifts using bank or agency staff. Agency staff covered 36 shifts and bank staff covered 31 shifts. A high use of agency staff can impact on the safety of clients and continuity of their care. The services manager informed us that during this time, between 1 October 2015 and 31 December 2015, there were two nursing vacancies and one support worker vacancy in total across both the detoxification service and the rehabilitation service. At the time of the inspection, there was a regular agency staff member covering the remaining maternity leave of a support worker. We observed the induction checklist completed for agency staff. One staff member told us that the service was often short-staffed and so it relied on volunteers to deliver the detoxification or rehabilitation group programme. However, the staff rotas we observed demonstrated that there were sufficient numbers of staff to deliver both group programmes. All the clients we spoke to told us that staff were always available if they needed them, and that groups and activities were not cancelled.

At the time of the inspection, there remained a 22 hour per week nursing vacancy and a maternity vacancy for a full time support worker across both the detoxification service and the residential service. The services manager told us that as the maternity vacancy for the support worker was only until June 2016, they were covering this position with a regular agency worker.

The staffing ratios were based on a staffing tool used across St Anne's Community Services. The tool we observed considered the client group, risk, needs, the number of beds and the service level agreement in determining the number of staff required. The service manager confirmed that if additional staff were required due to a particular case mix at the services, they would increase staff numbers as required. A recent example was provided where the numbers of nursing staff was increased to support a client admitted with more complex physical health needs.

St Anne's Alcohol Services had a contract arrangement with a local GP to attend for up to four hours per week on Tuesday to assess clients, and a further two hours per week on Thursdays to review clients. There was an arrangement in place for another GP to cover annual leave and sickness.

Substance misuse services

The nursing staff were responsible for administering the client medication and overseeing the clients' treatment and care, after the initial admission assessment by the doctor. There was management cover 24 hours a day, seven days per week, including an on-call rota. However, the nurses, the service manager and the doctor told us that whilst the doctor could be contacted in an emergency, the doctor input was considered a primary care service. Therefore, the staff would contact a doctor out of hours using NHS111, and the nurses would manage the medical emergencies and re-direct to accident and emergency. 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 the services as required for staff to fulfil their role and to keep themselves and patients safe. At the time of the inspection, the mandatory training completed for all staff was above 78%, except for moving and handling people and objects training. This included:

- Emergency Aid
- Safeguarding Adults
- Positive Behaviour Support
- Food Hygiene
- Mental Capacity Act and Deprivation of Liberty Safeguards
- Equality and Diversity
- Infection Control
- Health and Safety
- Fire Safety
- Medication

Seven per cent of staff had completed the moving and handling people training and 25% of people had completed the moving and handling objects training. This meant that staff could put themselves at risk through using incorrect techniques to move and handle objects. Plus both patients and clients could be put at risk of harm if patients were moved using the incorrect handling techniques. Moving and handling patients may be required where a patient is physically unwell during a detoxification, or where a patient has poor mobility. The services manager confirmed that patients had attended the alcohol services for treatment with poor mobility who had required additional support whilst they were in treatment at the alcohol services, as they were not fully accessible. We observed a training action plan in place to improve the mandatory training for all staff working in the St Anne's Alcohol Services.

The service used support workers to assist the nurse in administering medicines to ensure there were two people present when controlled drugs were administered. Nursing and support staff had undertaken basic medicines training. This was reviewed annually. The service manager told us that they tried to observe medication administration practice and would amend the training accordingly. However, there was no formal programme of specialist substance misuse training, including a schedule of competency assessments or supervised practice.

Client information was stored in paper note form. These notes were accessible to staff. All notes were kept in a lockable filing cabinet in the staff office, except the medication administration review charts. These were kept in the locked medication room.

Assessing and managing risk to clients and staff

The admission criteria for both the residential rehabilitation service and the detoxification service did not exclude people with particular risk factors, for example complex physical or mental health problems, or offending behaviour. The services manager told us that the service had no exclusion criteria, and that each client was reviewed individually. The service would try to accommodate them on a case-by-case basis, including where patients had been in poor physical health and with terminal conditions. The service did require that clients admitted for alcohol detoxification, who were also dependent on opiates, were stable on a substitute medication.

The referring agencies were required to complete a risk assessment as part of the referral to both the detoxification service and the rehabilitation service. Following the referral, the services manager or a nurse from the alcohol services completed a pre-admission risk assessment, including substance misuse, physical and mental health, allergies and their expectations of detox or rehab. The service manager gave examples of where they had requested further information from the client or the referrer in order to make a decision as to whether the client was suitable for admission, for example information from probation about offences.

Substance misuse services

The nurses and the doctor reviewed the pre-admission assessment was reviewed on admission. The nursing staff and doctor told us that the services rely on information from the GP, referring agency or any other professionals involved in the clients' care. The services manager told us that on admission the doctor discussed relevant physical health history with the client. The doctor measured the height and weight of the client, and the nurse took the client's blood pressure and pulse and shared this with the doctor.

Nursing staff and the services manager told us that risk information was reviewed three times a day at the shift handover sessions, which were attended by the nursing staff and support workers. However, a handover was observed. Clients who had been admitted that day for an alcohol detox were discussed. Their background was discussed, alongside some previous risk information gathered at the pre-admission assessment. However, physical health observations, including base line observations were not discussed, in line with guidance from the National Institute of Health and Care Excellence. This meant that the service would not know if a client was becoming increasingly physically unwell during an alcohol detoxification, where the client is at an increased risk of seizures related to alcohol withdrawal.

Eight care records were reviewed for clients receiving treatment in the alcohol detoxification service and the residential rehabilitation service. Risk assessments were not updated on admission in these records, or during the clients' treatment, or were incomplete. The risk identified by the referrer or in the pre-admission assessment was not followed through into the St Anne's risk assessment for the clients' treatment in both the detoxification service and the residential rehabilitation service. This meant that staff would be unaware of a client's current presenting risks during their treatment, particularly for bank or agency staff employed in the service who may have no previous knowledge of the clients. This meant that clients and staff could be unsafe during their treatment at the St Anne's Alcohol Services.

The system for recording risk was unclear. For example, it was unclear if the clients should be risk assessed daily whilst they were in the detoxification service or in the residential rehabilitation service as they were all incomplete, and the scoring on one risk assessment was different to the other risk assessments. Also the services has implemented a risk overview sheet that staff were to sign and update but this was not completed fully, or updated at all in the files we reviewed. This meant that a client's presenting risk was unclear to staff, particularly for bank or agency staff employed in the service who may have no previous knowledge of the clients. This meant that clients and staff could be unsafe during their treatment at the St Anne's Alcohol Services.

There were no risk management plans in place for clients in the alcohol services, except in one client record but this did not correlate to all the presenting risks for that client. Nursing staff described the risk management plan as an additional care plan. For this one client record we observed an additional care plan referring to the management of one health risk. However, there were three additional current mental, and physical, health risks that did not have a management plan in place. This meant that staff would not only not be aware of a client's risks due to the lack of risk assessment for patients in both of the alcohol services, but staff would also not be aware of how to manage the risks in an appropriate way, and in a way agreed with the client. This could impact on the client and staff safety across the St Anne's alcohol services.

The services manager told us how they responded promptly to a client's deterioration, including a recent admission to the alcohol detoxification service, where a client was in poor physical health. The nurse rang 999 and the client was transported to accident and emergency. The services manager also told us that the detoxification service had increased observations where a client was in poor physical health and increased staffing numbers to facilitate this. We did not confirm evidence of these increased observations.

The services manager and the nurses confirmed that both the detoxification service and the residential rehabilitation service would contact the local crisis team if a client became mentally unwell. The services manager also gave an example where they had requested the senior nurse to complete a mental health assessment. The training records we observed demonstrated that almost all of the staff had training in basic mental health. However, this was not mandatory.

Contingency plans for unplanned discharges, called an unexpected event care plan, were observed in all client files for both services, including who the service would ring if the client left, where the client would stay, an explanation

around medication and money reconciliation, and harm minimisation information. This was a standard form completed on admission in an attempt to mitigate the risk of a client relapsing or suffering from alcohol poisoning following a period of detoxification.

We looked at the systems in place for medicines management for St Anne's Alcohol Services and spoke with nursing staff who were responsible for medicines. Medicines were 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). Medicines requiring refrigeration were stored appropriately and records were maintained in accordance with national guidance.

Ninety-four per cent of staff at St Anne's Alcohol Services had received mandatory training in positive behavioural support. A positive behaviour support policy was in place, which included a detailed flow-chart for staff to follow for managing conflict and escalating behaviour. All the staff we spoke to provided examples of how they would manage client's behaviour, which was in line with the policy. This included situations where they would call the police.

Eighty-nine per cent of staff at St Anne's Alcohol Services had completed mandatory training in adult safeguarding. There was a detailed safeguarding adults' policy. We observed the contact details for the relevant local service displayed in staff areas should an adult safeguarding concern be identified. There was a detailed child safeguarding policy which included signs and types of abuse, and a process for staff to follow. However, staff were not clear about the policy, or their role with regard to safeguarding children. The staff at the St Anne's Alcohol Services had not completed any training in child safeguarding. Level one to three child safeguarding training was not mandatory at the time of the visit. This meant that staff may not be able to identify child safeguarding concerns appropriately and protect children from harm. Child safeguarding was not discussed in the handover we observed, despite it being relevant.

There were procedures in place for children to visit both the alcohol detoxification service and the residential rehabilitation service. These were included in the visiting policy for the services, which stated that the decision to bring the child to service to visit was a parent's decision and that during the visit the child was the responsibility of the parent. However, this policy did not refer to any risk assessments required prior to any visit, for example considering any adult or child safeguarding risk with regard to the client, the visitors or other clients. There were terms and conditions for the alcohol detoxification service signed by the patient that advised against children visiting during the programme. However, these terms and conditions, or the information on visiting in them, were not included in, the St Anne's Alcohol Services' visiting policy.

All staff and volunteers had been checked by the disclosure and barring service.

Track record on safety

There were two serious incidents recorded in the last 12 months at the St Anne's Alcohol Services. This included a client assault on another client in the residential rehabilitation service and a death on the first day of a client's detoxification in the detoxification service.

We observed a detailed investigation into the client death and the incident escalation in line with the services incident reporting policy. This resulted in them reviewing the need for emergency equipment at the services. The paramedics and the coroner confirmed that having better emergency equipment at the time of the incident would have not changed the outcome. The services manager told us that following the death, a senior manager from St Anne's Community Services attended the St Anne's Alcohol Services to debrief the staff. A letter of condolence was sent to the family. The services manager told us that the other clients were offered support but there were no detailed records to confirm this.

The services manager informed us that they had interviewed the staff and clients involved in the assault as part of the investigation but that they did not complete a full investigation. Since this serious incident, a new incident reporting form had been introduced to ensure that all serious incidents were investigated fully, and recorded, including details of the investigation, plus actions and any learning.

Reporting incidents and learning from when things go wrong

The staff we spoke with at St Anne's Alcohol Services stated that there were rarely any incidents. They gave examples of the types of incidents that they would report, including medication errors, deaths, violence, self-harm and

environmental concerns, using the incident reporting procedures. They confirmed that investigations had been conducted into incidents by the services manager, and that staff received a de-brief, and a lessons learnt session following incidents.

We saw evidence of a de-brief session in a team meeting, which was attended by all the staff working across the alcohol services. The services manager facilitated this session. Whilst this session demonstrated that there was a full debrief, with staff identifying lesson learnt regarding an aggressive incident in the alcohol services, it highlighted that staff did not always report incidences of aggression or intimidation as an incident, as staff had not completed an incident form for all these occasions. At this team meeting, staff were actively encouraged to do so.

We observed information in the quality audit that the services manager and rehabilitation co-ordinator had attended the St Anne's Community Services' training on duty of candour, and there was some understanding evidenced by the senior staff we spoke to. St Anne's Alcohol Services had introduced an incident reporting form in the last month, which highlighted where an incident meets the duty of candour threshold. There had been no incidents since the introduction of the form that met the duty of candour.

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

Assessment of needs and planning of care

All eight care records we reviewed for clients in St Anne's Alcohol Services had holistic self-report referral information and pre-admission assessments completed by St Anne's Alcohol Services. The pre-admission assessments included information about substance misuse, mental and physical health, social circumstances and motivation to complete the programme. This included a risk assessment. Confidentiality, information sharing, and the license agreement for treatment at the alcohol services, were discussed and agreed on admission.

Prior to entering the alcohol rehabilitation service, clients had a Community Care Assessment completed by the service. This was a detailed, holistic assessment used to agree the funding with the commissioners at that the treatment service to demonstrate that the service met the clients' needs.

A doctor and a nurse would assess the clients on the day of admission to the alcohol detoxification service. The doctor told us that they relied on the information provided by the GP and the referring service to inform their admission assessment for a client entering the alcohol detoxification service. This included a liver function test for the client prior to admission. On admission to the alcohol detoxification service, height and weight measurements were taken, as well as the client's blood pressure and pulse.

The doctor prescribed a fixed alcohol detox regime. The nurse oversaw the detox and administered the medication prescribed as PRN doses (doses when required), using the selective severity assessment for alcohol withdrawal. This included the nurse measuring the client's blood pressure and pulse at least once a day, and more if required.

Clients admitted to the residential rehabilitation services were not seen by the doctor on admission.

On admission to both the residential rehabilitation service and the alcohol detoxification service, staff completed a breathalyser test with the clients. Clients who had a positive alcohol reading on the breathalyser were still admitted. They were asked to remain in their room until they had a negative reading. This was so that there was not a negative impact on the client community.

St. Anne's Alcohol Services did not complete blood borne virus tests as the clients attending the service were offered testing and treatment via the community, substance misuse service that was the referral route for all clients. The services manager told us that the alcohol services would support the client to continue with any on-going treatment.

All clients had a care plan meeting and a care plan review within 24 hours of admission to both the alcohol detoxification service and the residential rehabilitation service. In the eight care records we reviewed, standard care plans were used in both alcohol services for clients during treatment. There was one care plan for the detoxification service, and three care plans for the residential rehabilitation service representing the three stages of residential treatment as the client moved through

the programme. These care plans were not person centred, and clients had not signed or dated the care plans in the eight care records we reviewed. There was no space for the client to input into the care plan itself.

A goal for the detox, for example, was for clients to "remain safe and free from injury during the alcohol withdrawal." In the rehabilitation service, one care plans had a goal for clients to "participate in the structured rehabilitation programme with the aim of developing skills, commencing problem solving, and managing change." This was the same for the interventions listed.

In the eight care records we observed, the client continuation notes, which staff completed after each client meeting and weekly one-to-one sessions, were used to address the clients holistic support needs, for example housing issues and attending with the GP. However, these did not clearly define the individual goals set and the actions agreed to achieve it. It did not demonstrate the collaboration between the worker and client in achieving those goals, and the recovery capital the client had to achieve those goals. Recovery capital is the client's assets, like their own knowledge and skills, their relationships and social support.

In addition, all the care plans we reviewed in the eight care records were incomplete because following the pre-admission assessment, there was no further evidence of comprehensive risk assessment and risk management in line with the National Institute of Health and Care Excellence. In the eight care records, risk assessment and management plans were either absent or incomplete. Staff we spoke to told us that additional care plans were used for additional issues to the generic care plans, including risk management. However, we saw only one additional care plan in one client record to manage a physical health risk.

The services manager showed us worksheets that workers in the residential rehabilitation service could use to review client's holistic goals, like employment, and the client's recovery capital to achieve it. However, none of the care records we reviewed contained this documentation. All client care records had a detailed plan if the client left treatment early, including who should be contacted and the address they would return to.

We looked at six sets of medication records. Prescriptions and administration records were completed fully and accurately, and clients were given their medicines as they had been prescribed. Medical staff checked (reconciled) clients' medicines on admission to the service by contacting their GP, and we saw examples of how this worked to ensure clients received the right treatment. Nursing staff routinely made judgements about dosing adjustments for 'when required' medicines, however we found regular observations and assessments had not always been carried out or recorded as per the services policy and, good medical practice.

St Anne's Alcohol Services had a therapeutic programme. These group programmes were separate for alcohol detoxification service and the residential rehabilitation service.

There was a seven day a week group programme in the detoxification service, and the residential rehabilitation group programme was five days a week. The detoxification service groups were separate to the residential rehabilitation service groups. The residential rehabilitation service had a more comprehensive therapeutic group programme as clients stayed in the residential rehabilitation service for 12 weeks, compared to the 7 days the clients stayed in the alcohol detoxification service.

Groups included relapse prevention, alcohol awareness and the effects of detox, exploring relationships, problem solving, and anger management. We observed an assertive communication group during the inspection, which was delivered as part of the residential rehabilitation service group programme. The clients who attended actively participated.

Art groups, music groups, gardening groups and information technology sessions were also on the residential rehabilitation programme. Plus in this service, evenings and weekends were more relaxed with clients having more free time to build relationships with each other and have family visits. Clients were also encouraged to attend mutual aid meetings in the evenings if they were in the rehabilitation service.

Clients in both services were empowered to complete daily chores, including cooking and cleaning, to learn daily living skills.

Best practice in treatment and care

St Anne's Alcohol Services used the Leeds Dependency Questionnaire as part of the pre-admission assessment for

clients accessing both the detoxification and the residential rehabilitation service. This is a recognised tool completed with clients to indicate how addicted a person is to alcohol and, therefore, how difficult it will be to achieve a positive outcome.

The psychological therapies delivered in one to one sessions and in a group setting in both alcohol services were evidence based and recommended by the National Institute for Health and Care Excellence (NICE), including motivational interviewing, cognitive behavioural techniques and solution-focussed therapy. We observed the assertive communication group, which included reviewing homework and other cognitive behavioural techniques. The therapeutic group sessions also used 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. All the groups had a facilitators guide to ensure a consistent delivery.

Detox medication and reduction plans were a fixed regime based on the NICE guidelines. 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. Accamprosate and Disulfiram relapse prevention medications were also offered and prescribed to clients. 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. We observed plans for the service to be in a position to administer it in the future, including writing a new protocol and training staff.

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The residential rehabilitation service at St Anne's Alcohol Services used the alcohol spider diagram, which was similar to the outcome star, to demonstrate client outcomes. This was completed in the rehabilitation service at the mid-point review and pre-discharge meetings. The alcohol outcome record was also completed at the beginning, and at the end, of residential rehabilitation treatment. This was a requirement of Public Health England. Clients also completed the alcohol treatment perception questionnaire. This was more a measure of how the client thought the service was doing.

The number of clients leaving the alcohol services in a planned way from the detoxification service and the residential rehabilitation service, having completed their goals was also monitored. This was used by the services as an outcome measure to demonstrate its effectiveness. Between 1 October 2015 and 31 December 2015, 92% of clients left both the alcohol detoxification service and the residential rehabilitation service in a planned way. The service targets set by the commissioners to ensure that the services were effective were 90% for the alcohol detoxification service and 70% for the residential rehabilitation service.

The nursing staff completed the medication audits and infection control audits for the alcohol services. A pharmacy audit was completed fortnightly. We also observed the findings of monthly quality audits completed by the services manager at the alcohol services. A standard tool was used. It reviewed the service and the systems within the safe, effective, caring, responsive and well-led Care Quality Commission domains.

Skilled staff to deliver care

St Anne's Alcohol Services had jobs descriptions mapped against the skills and competencies required for the role. We observed a recent skills and competency audit completed in January 2016. The services had an action plan in place to improve the mandatory training rates. Staff received mandatory training on the Equality Act (2010) to ensure that staff understood how to work with clients from specific groups in the context of this Act.

Training records we observed demonstrated training that would support staff in completing their various roles, for example mental health awareness levels one and two, training on the Mental Health Act, self-harm and eating disorders, dual diagnosis training, courses on motivational interviewing and other behavioural therapies, and alcohol awareness. There was evidence of staff being supported to complete the national vocational qualifications in health and social care. We observed meeting minutes, which demonstrated that in-house, training sessions were delivered, for example liver function tests and building resilience.

Substance misuse services

The doctor at St Anne's Alcohol Services had completed the Royal College of General Practitioners certificate in substance misuse, parts one and two. This was a requirement for working in the service. 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 had been revalidated to 2018.

All registered nurses, and workers in other roles, had been trained in the last 12 months in administering medication. We saw evidence in the staff files that nurses were qualified and registered.

The data submitted by St Anne's Alcohol Services stated that 100% staff had received supervision. One member of staff told us that they had not had supervision for eight months. However, the rest of the staff we spoke to told us that they received supervision every month, and that they were well supported. The appraisal information provided by St Anne's Alcohol Services demonstrated that 82.4% of non-medical staff had received an appraisal.

The services manager supervised and appraised the senior nurse and the rehabilitation co-ordinator. The senior nurse supervised and appraised the nurses. The rehabilitation co-ordinator supervised the support workers. Group supervision was facilitated on a three weekly cycle. Clinical supervision, including reflective practice and clinical observations had been part of the managerial supervision. However, in line with the nursing and midwifery council guidance, the nurses' clinical supervision had recently separated from the management supervision and was being facilitated quarterly by the senior nurse. We observed notes on the first session. A clinical supervisor from St Anne's Community Services had been arranged to facilitate the senior nurse's clinical supervision.

During the inspection, we observed five staff personnel files and saw evidence that supervision had been completed monthly for those we reviewed, and that appraisals were present. We also observed a comprehensive induction booklet completed by staff. Managers signed this as key tasks were completed. Job descriptions and training certificates were also present in all the files. There was evidence of probationary meetings prior to staff being employed in permanent posts. The service identified and addressed poor performance promptly and we observed actions taken where there were concerns about practice. In two files there were stress and risk assessments, and evidence of quality return to work interviews and referrals to occupational health where these were required.

Multi-disciplinary and inter-agency team work

There was multi-disciplinary input into the comprehensive pre-admission assessments completed prior to admission for both the alcohol detoxification service and the residential rehabilitation service. This was appropriate to the individual client, and included input from the community, substance misuse team, the client's GP, and other services involved in the client's care. This was important for the clients' care and treatment, particularly in the detoxification service, as there was no physical health assessment completed by the doctor on admission.

The doctor completed a medication review two days after the client's admission assessment at the alcohol detoxification service. This included feedback from the nurse and the client. Both were able to input into the review.

The clients in the residential rehabilitation service all had a mid-point review meeting and a pre-discharge meeting. The rehabilitation service included other appropriate services in these meetings, including the community substance misuse teams, housing agencies, and relatives and carers. We observed these mid-point review meeting discussions and pre-discharge plans in the two care records for the clients who had been discharged.

The clients in both the detoxification service and the residential rehabilitation service remained with their own GP for their primary care and physical health needs. If their local GP was too far from the service, then St Anne's Alcohol Services had an arrangement with a local GP for a temporary transfer of the client's care. The clients could also access the walk-in centre at the local accident and emergency,

Each client was allocated a named support worker when they were admitted to the residential rehabilitation service. The client would have a one-to-one appointment with them weekly and they would be the client's care co-ordinator, referring to external services where this was identified in the care plan.

In the detoxification service the client did not get a named nurse. All aftercare was arranged and co-ordinated by the community service prior to admission.

There were three handovers each day: in the morning, afternoon and evening. We observed an afternoon handover. Three nurses and the support worker attended. The client admissions for that day were discussed, which included the clients' history, including the some of the risks identified in the pre admission assessment, and the medication prescribed. The doctor did not access or review these handovers.

Each week there was either a team meeting, group supervision or training session. The management team facilitated these and all staff attended. The minutes we observed demonstrated discussions including client and service issues, incidents and complaints. A desk diary and communication log were used to facilitate staff communication.

Good practice in applying the MCA

Care records we observed and treatment agreements showed that clients had signed and consented to treatment, sharing of information and confidentiality agreements, and had the capacity to do so. 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.

All staff had received the mandatory training in the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards. There was also a resource pack on mental capacity and the Deprivation of Liberty Safeguards in the staff office.

There were no clients subject to Deprivation of Liberty Safeguards.

A client who had self-harmed on two occasions whilst at the service did not have the item they used to self-harm removed. The client record stated that they had capacity to make the decision to keep these items. However, there was no evidence in the client record of an additional capacity assessment specific to that decision.

Are substance misuse services caring?

Kindness, dignity, respect and support

All clients were extremely positive about the care and treatment they received in both the detoxification and residential rehabilitation service, as well as the attitude of the staff. We saw staff interacting with clients informally around the service, during groups, and in a morning meeting. There was a good rapport between staff and clients. Staff were friendly, warm and treated people with respect. We saw a strong emphasis on person-centred care.

Clients told us that staff at St Anne's Alcohol Services were approachable, and always available. Clients said that staff were never too busy and would go the extra mile to help and support them. We were told that the staff were kind and clients felt that staff cared about how successful they were in completing their treatment. The client's relative we spoke with echoed these clients' comments.

Staff and clients were aware of the need to respect people's privacy and the need for confidentiality. Confidentiality was discussed before admission and reiterated during the first session of the group programmes. Clients told us that they were comfortable in sharing sensitive information in group settings. We observed a group session on Assertive Communication delivered in the residential rehabilitation service as part of its group programme. The alcohol support worker facilitating this session showed a good understanding of the social networks of the clients and was able to give examples real meaning for the clients by referencing significant people in their lives or key events.

We observed an exercise on dignity in the staff team meeting, including how this was reflected in staff behaviour. There was also a display on these behaviours observed in the service hallway.

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 pre-admission and admission assessments. Clients were given a guide to the service that contained this information. All clients confirmed that they were made aware of the expectations and restrictions of the service at the point of admission. We were told that staff show all new clients the facilities that are available around the building.

In the detoxification service, the client was not allocated a named nurse or support worker to work with them throughout their stay in treatment. However, each client was allocated a keyworker in the residential rehabilitation

service who worked with them throughout their treatment. They offered the clients support and worked with them to plan their care. Clients in the residential rehabilitation service told us they were involved in planning their treatment, care and support but none thought that staff had offered them a copy of their care plan. We found standardised care plans in place in the eight care records that we reviewed but additional personalised care plans were not completed. None of the care plans we reviewed were signed by the patient to confirm they agreed with their care plan.

The service had a "In Touch" session every week where clients in the alcohol services were able to meet with people who have previously used the service to share their story and gain from the experiences of other peoples' successes and challenges in maintaining abstinence from alcohol.

Clients and staff told us about the positive impact that a number of volunteers had in the service. The services manager told us that some of the volunteers at St Anne's Alcohol Services have previously used the services. We spoke to one volunteer who told us how valuable the opportunity to give something back to the service has been for them.

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 services manager told us that the services tried to help families access the support networks that they might need in their own right. Staff told us that St Anne's Alcohol Services welcomed the input from families, carers and friends in support of clients during their admission. The clients we spoke to said that their families and other people from their support network, including professionals, had been encouraged by the staff to attend for the pre-admission assessment. In the residential rehabilitation service where clients were in treatment for longer and had a more comprehensive therapeutic group programme, relatives, carers and other professionals were also encouraged to attend the review, and discharge planning meetings held in that service. Clients could invite relatives and carers to attend two sessions held as part of the programme in the residential rehabilitation service that were based on Social Behavioural Network Therapy. These sessions were designed to help relatives and carers to understand the client's rehabilitation, and what role they could play in supporting the client during and after the admission.

Clients were able to give feedback about their treatment through daily morning meetings. At a morning meeting, we observed staff giving all clients the opportunity to raise any issues or concerns they may have with their treatment. Clients told us that they were also able to raise issues in one to one sessions and the use of daily diaries that were reviewed helped make this possible. In addition, clients told us that review meetings, as well as discharge-planning meetings, were a forum for giving feedback on the service received.

Clients told us that staff were open to their ideas about improving the service. For example, a group of clients told us about ideas they had suggested for fundraising at a community event. We were told that staff had been very positive about their idea and the clients were hopeful that their plans would be implemented.

The alcohol services had identified local advocacy to signpost both clients and carers to where they needed this additional support.

Are substance misuse services responsive to people's needs?

(for example, to feedback?)

Access and discharge

At the time of the inspection, there were ten clients in treatment in the residential rehabilitation service, though the capacity of the residential rehabilitation service was 18 clients. Admissions into the alcohol detox service were every Tuesday. On the day of the inspection, four clients were admitted into the detox service, though the capacity of the detox service was five beds. The average bed occupancy between the beginning of October 2015 and the end of December 2015 for the alcohol detoxification service was 91%. It was 92% for the residential rehabilitation service. St Anne's detoxification service had missed the bed occupancy target set by the local commissioners of 95% for detoxification provision for the last nine months.

The doctor was contracted for one admission session, one day per week in the alcohol detoxification service. This meant that if clients did not attend the detoxification service for their alcohol detoxification on their admission date, there would be vacant beds for that seven-day treatment period in that service. This had a negative impact on bed occupancy in the detoxification service. This was demonstrated during the inspection, where one client did not attend the detoxification service as planned for admission, so there was one vacant bed in the detoxification service for the following week. Clients admitted to the residential rehabilitation service were not seen by the doctor and so could be admitted on any day of the week. Therefore, there was not this same impact on bed occupancy in the rehabilitation service.

All the clients we spoke to said that once the community, substance misuse teams referred them, they had quick admissions into both St Anne's alcohol services. If clients completed an alcohol detoxification, their length of stay would be seven days in the detoxification service. The length of stay for patient in the residential rehabilitation service to complete the therapeutic programme was 12 weeks. It was thirteen weeks for a client to complete an alcohol detoxification in the detoxification service, as well as the therapeutic programme in the residential rehabilitation service.

Both alcohol services had a clear admission criteria, which were advertised on their website. All staff told us that they would try to accommodate all clients and meet their needs if it was possible, and that they would review all admissions to both services on a case-by-case basis. There were 61 admissions to the alcohol detoxification service between 1 October 2015 and the 31 December 2015, and 19 admissions to the residential rehabilitation service in the same time-period. These admission numbers were typical of the two previous quarters.

All referrals into St Anne's Alcohol Services came via the community, substance misuse teams. This was mainly the local community service as the commissioners funded the whole local care pathway for alcohol misuse. There was a local target for both the services to make contact with a client two days following the referral. St Anne's had not met this target since January 2015. However, the services always managed to assess the client within the 10 days local target.

The average maximum wait between 1 April 2015 and 31 December 2016 2015 for a client admitted to both the alcohol detoxification service and alcohol residential rehabilitation service was 31 days. However, the usual wait time for clients in this same time-frame was 11 days for the alcohol detoxification service and 20 days for the residential rehabilitation service. The service also recorded minimum wait times between referral and admission of zero days, which suggests that some clients were admitted immediately.

St Anne's Alcohol Services had attempted to reduce the wait times for clients to access both the detoxification service and the residential rehabilitation service. They were successful in obtaining capital funding from Public Health England to increase the number of beds in the detoxification service from four to five, and the residential rehabilitation service from 14 to 18 beds. However, the bed occupancy levels below the commissioner's target of 95% in the detoxification service, could also negatively impact the wait times to that service.

A doctor saw all the clients who were completing an alcohol detoxification on admission and completed their assessment of the treatment required. The nurse then coordinated the treatment and care. The doctor reviewed the client's prescribing and detoxification regime two days after admission. All clients' primary care needs were addressed by their GP, or the service arranged a temporary GP local to the service or supported the client to attend the walk-in centre.

Between 1 January 2015 and 31 December 2015, there were 297 discharges in total from St Anne's Alcohol Services. Discharge care plans were not discussed when the client was admitted to treatment by either service, and were not observed in any of the eight client records we reviewed. However, for clients in the residential rehabilitation service, we observed discharge discussions in the mid-point review paperwork for clients that had reached that milestone. We also observed the pre-discharge meeting review paperwork for the two clients discharged from the residential service. These mid-point and pre-discharge meeting discussions were holistic and detailed. The paperwork had sections for both staff and clients to input. These were all signed by the worker and dated. However, there was no space for the client to sign to confirm that they agreed with the meeting content and the actions.

Substance misuse services

Staff told us that four weeks prior to discharge from the residential rehabilitation service, clients had to identify other community services that could support them when they left. The staff at the alcohol services would support the client to link in with these services, including voluntary courses, education, employment and training. Clients were also encouraged to attend recovery support in their local community, for example Narcotics Anonymous and Alcoholics Anonymous mutual aid groups, and the self-management and recovery training self-help groups.

The successful outcomes local target was 90% for the detoxification service, and 70% for the residential rehabilitation service. Between 1 April 2015 and 31 December 2015, 92% of clients left both alcohol services in a planned way. St Anne's alcohol Services did not follow clients up after discharge as the clients were followed up by the community substance misuse service. In addition, the service offered a weekly "In touch" session for former clients. All the clients we spoke to spoke highly of the services and how they had helped them to achieve their goals.

The facilities promote recovery, comfort, dignity and confidentiality

St Anne's Alcohol Services had a range of rooms to support clients' treatment and care. It has an accessible clinic room but there was not a treatment bed available. There were rooms available for one to one appointments and two lounges for group activities that were used by both services. In the communal area for clients from both the detoxification service and the residential rehabilitation service, there was a pool table that clients had access to in the evenings, and at weekends.

Four flats available in the residential rehabilitation service that allowed clients who were moving towards the end of their rehabilitation programme to live in a more independent setting where they were expected to cook and clean for themselves. A dining room included the facilities to allow clients to get involved in community chores such as washing up. Laundry facilities were also available.

There was an outside space used by clients in both the detoxification service and the residential rehabilitation service that was clean and well maintained. This included an area for clients to smoke. Clients were able to access the outside area throughout the day and evening.

St Anne's Alcohol Services did not have a family room or any other designated space for clients to meet with visitors. Staff and clients told us that they were encouraged to leave the service for visits or alternatively visits occurred in client bedrooms. The service manager told us that there were plans to use one of the television lounges as a family room. However, to access this room it was necessary to walk past a number of client bedrooms, up the stairs and along narrow corridors. Therefore, the access was not appropriate for families with small children, and the clients' dignity and privacy compromised if this were a family room.

Clients in both alcohol services were allowed to keep their mobile phones throughout their admission on the understanding that they were turned off during therapeutic sessions. All clients confirmed they were aware of this expectation prior to admission. One client who did not have a mobile phone said that his family often rang when he was not available but staff always passed on messages. St Anne's Alcohol Service provided free internet access with clients able to use their own devices or available desktop computers.

We observed a choice of available meals, including healthy options. All clients were extremely happy with the quality of the food available. Admission assessments identify any specific dietary needs and each client confirmed that they had met with the catering co-ordinator who was very flexible in providing food to satisfy individual needs and tastes. The services manager told us that the service could cater for all dietary requirements, or religious or ethnic groups. Every client said that they were able to prepare snacks and hot drinks throughout the day. The services manager told us that for any clients who were not able to leave the services, for example those mainly in the detoxification service, staff would go to the shop to buy any snacks if requested to do so. There was no input from a dietician at the service.

All staff and clients told us that clients were able to personalise their bedrooms if they wanted to. Clients told us that staff respected that bedrooms were the clients' private space.

Clients could lock their possessions in their room to keep them safe. In addition, there was a safe in the staff office if clients wished to store things there. We were told that there was a system for logging things in and out of the safe. Clients told us that they looked after their own money but

staff could support with this if needed. One client told us that they had received support from the finance clerk in managing their debts, and budgeting with their income appropriately.

All clients in the alcohol services said that there were enough activities available during the times they were not actively involved in programme sessions. Clients in the residential rehabilitation service were allowed to leave the service each evening and return home at weekends. Clients in the detoxification service were not allowed to leave the service.

Within the service, we observed a range of board games and DVDs that clients could use. There were two television lounges. Every Thursday clients organised their own entertainment and we were told about a recent quiz. Clients told us about a range or arts and crafts that they were able to pursue independently or with staff support.

Meeting the needs of all people who use the service

St Anne's Alcohol Services had limited access for people with disabilities. The age and layout of the building meant making the service fully accessible was extremely challenging. Many of the corridors and rooms were not wheelchair accessible. However, there was an accessible wet room with grab rails on the ground floor and a stair lift to allow access to upper floors. The services manager told us that additional staff were brought in to help with personal care if this was required but that there were risks with moving and handling as the service did not have access to hoists. The services manager told us that if the service was not able to safely meet an individual's needs they would be transparent with the patients and the referrer about this situation. They told us they would work with the community, substance misuse team to find alternative service provision for the client.

The services manager told us that the service had good links with local support groups such as AA (Alcoholics Anonymous) and SMART (Self-Management and Recovery Training) groups. All clients confirmed that they were given information about these groups and had been encouraged to make use of these groups towards the end of their detoxification and rehabilitation programme in the services, and upon discharge. All clients confirmed that they were given information about their rights and how to complain as part of the admission process to both the detoxification service and the residential rehabilitation service.

The unit manager told us that the need for spiritual support was identified during the assessment process. We were given examples of how the service had previously supported clients to observe Ramadan and Lent.

Listening to and learning from concerns and complaints

St Anne's Alcohol Services had six complaints in the last 12 months, and 71 compliments. The alcohol detoxification service had three complaints, the rehabilitation service and two complaints and there was one complaint at the client assessment stage. One of these complaints resulted in an apology to the client and the family regarding an error in the decision making process at the client assessment stage. We observed evidence of two complaints investigated where there was alleged staff misconduct. In both cases, other appropriate action was taken and agencies, like the Public Protection Officer and the Care Quality Commission, were informed. Neither of these allegations were substantiated and the complaints were not upheld.

We observed information on how to complain in the license agreement signed by clients entering the residential rehabilitation service. The compliments and complaints policy stated that all clients should be given the "tell us what you think" leaflet on their admission to treatment to both services. We observed these leaflets and the services manager told us that these leaflets were available in other accessible formats and languages, or taped recordings.

All clients told us that they were aware of how to complain but that they would generally 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.

Staff informed us that feedback was given following complaints or compliments in the team meetings. We observed evidence of compliments fed back to staff at the St Anne's Alcohol Services in team meeting minutes, as well

as an action regarding the staff completing a skills, competency and knowledge audit following a complaint about the quality of therapeutic interventions delivered by staff and volunteers.

Are substance misuse services well-led?

Vision and values

St Anne's Alcohol Services are one of 58 locations registered with the Care Quality Commission provided by St Anne's Community Services. St Anne's Community Services provides a wide range of services to people who require support for a variety of different reasons. They provide services across Yorkshire and the north east for people who require support because they have a learning disability, have mental health problems, have issues around substance use, and to people who are or have been homeless. Services provided by St Anne's Community Services include a variety of housing and accommodation based support and care, day services, and community based support. All these services, including the St Anne's Alcohol Services, share the St Anne's Community Services' mission, vision and values.

St Anne's Community Services' mission was "to support individuals to achieve their aspirations by providing services that promote dignity, independence, opportunity and inclusion."

St Anne's Community Services' vision was "to be the most innovative and creative provider of care, support and housing in the North of England."

The values, known by St Anne's Community Services as core principles, were as follows:

- We ensure the individuals we support are always at the centre by actively listening, responding to, and involving people.
- We provide and can demonstrate that services are of the highest quality.
- We learn together, sharing, celebrating, and promoting good practice across the whole organisation.
- We recruit, motivate and develop a highly competent and compassionate workforce.
- We ensure St Anne's is financially sound and delivering value for money.

The services manager demonstrated a good working knowledge of the St Anne's Community Services' mission and values. Whilst other staff could not state the mission and values, they demonstrated that they always put the client at the centre of their work. For example, through their client interactions that we observed, and in the way they spoke about the clients.

During the visit, we did not observe a clear statement, or vision, of recovery specific to substance misuse for St Anne's Alcohol Services for clients and staff to work towards together. For example, there were no posters or displays on recovery from alcohol dependence, or a recovery aim for clients in the terms and conditions, client expectations or client guide. However, there was visible recovery for clients as they could meet peers who had been through the programme at the "In Touch" meetings.

Despite a number of changes in senior management, the alcohol services manager gave examples of where senior management had attended the detoxification and residential rehabilitation services. On the day of the inspection, the area manager attended the service and all staff knew them by name.

Good governance

St Anne's Community Services' Board (Council of Management) was responsible for the governance of the whole organisation. Members of the Board were St Anne's Directors for the purposes of the Companies Act, and Trustees for the purposes of the Charities Act. The powers of the Board were defined in St. Anne's Board Terms of Reference. The role of the Board included:

- to define and ensure compliance with the values and objectives of the organisation
- to establish policies and plans to achieve those objectives
- to approve each year's budget and accounts prior to publication
- to establish and oversee a framework of delegation and systems of control
- to agree policies and make decisions on all matters that might create significant financial or other risk to the organisation, or which raise material issues of principle

The Board had two delegated committees; the Audit Committee and the Remuneration Committee both of which reported to the full Board meetings. The Board met ten times a year.

St Anne's Community Services told us that the fit and proper person checks, for example financial checks and disclosure and barring checks, were completed on the directors/trustees of St Anne's Community Services.

Local governance structures at St Anne's Alcohol Services linked into the St Anne's Community Services' clinical governance framework, via an area manager. The area manager provided supervision and support to the alcohol service manager. The senior nurse was offered clinical supervision by another clinician in St Anne's Community services. The services manager presented an annual service review report to the senior managers.

St Anne's Alcohol Services had local governance arrangements in place to ensure safe and quality care, for example, the monthly quality audits that we observed, the pharmacy audit, and the infection control audit. However, these audits were not successful at ensuring the client records were complete, that clients were risk assessed, and that all staff followed procedures, like completing the observation sheets and cleaning schedules.

St Anne's Alcohol Services used a variety of key performance indicators to monitor how well the service was performing. These were the targets set by the local commissioners and nationally by Public Health England. These included a two-day timescale for responding to referrals, an admission timescale of 10 days to the services, and bed-occupancy rates of 95% for the alcohol detox service and 90% for the residential rehabilitation service. Between 1 April 2015 and 31 December 2015, the services missed the targets each quarter for contacting the clients referred and the detox bed occupancy. This could impact on the clients' motivation. However, the alcohol services met their target for people accessing the service within 10 days, and the planned completion rate for clients admitted for an alcohol detox in the detoxification service was over 90% each quarter in the same time-frame, and over 70% for the residential rehabilitation. The services manager met quarterly with the commissioners to review their performance and we observed explanations for the performance of both the detoxification service and the residential service on their submissions to the commissioners.

Mandatory training was above 78% and we observed an action plan to increase this compliance. Staff had regular supervision and appraisal, and systems were being put in place for the nursing staff to have clinical supervision in line with the Nursing and Midwifery Council. However, the documents for supervision, appraisal and training were not all held in one central place. Some of the information was held centrally in St Anne's Community Services and some of the information was held at St Anne's Alcohol Services. This made it difficult to access this information, and to ensure this information was accurate. This meant that the services managers of the St Anne's detoxification services and the residential rehabilitation services may not have the accurate information required to deliver the service effectively. For example, the staff training data held at St Anne's Community Services was much lower than the training data provided by the local system implemented by St Anne's Alcohol Services.

Local governance meetings at St Anne's Alcohol Services, included the alcohol services manager, the senior nurse and the rehabilitation co-ordinator. Client and service issues were reviewed in these meetings, including incidents and accidents, compliments and complaints, audits and performance. Relevant issues were fed up from this meeting to the St Anne's Community Services' risk-register. For example, the ability for the service to attract and retain appropriate staff, mandatory training compliance, and client injuries afflicted by other clients, were observed on the St Anne's Community Services risk-register. There was also evidence that relevant issues were fed back to staff from this meeting, including feedback from compliments, complaints and incidents at staff team meetings and client meetings, as well as the implementing lessons learnt.

Leadership, morale and staff engagement

The service manager for St Anne's Alcohol Services was client focussed and experienced in the substance misuse field. All staff told us that the service manager was approachable and supportive. They felt confident in being able to approach them with concerns without fear

of victimisation. They were aware of the whistleblowing policy, though they thought it was unlikely they would need to use it. Staff talked positively about their work at the service, and with the clients.

The sickness rate at St Anne's Alcohol Services was 3.12% and below the national average of 4% between December 2014 and November 2015. The staff turnover rate was 11% in the same time-frame. The service manager informed us that this was due to one staff member re-locating and some staff members moving to work in the community services where the hours were more favourable. We spoke to staff members who had worked for St Anne's Community Services for over 15 years, including in St Anne's Alcohol Services, and who had worked up from support worker positions to managerial positions.

Staff, clients, relatives and carers were able to feedback into the planning, delivery and development of the service. Clients, relatives and carers could feedback through the "tell us what you think" forms, and the 'client treatment perception questionnaires'. The client daily community meeting and monthly "how are we doing meeting" were also forums for clients to suggest change and for the service to be accountable to its clients. Staff were encouraged to feedback on the service through supervision, appraisal and monthly team meetings. There was a staff representation body at St Anne's Community Services and there were forums where staff could engage directly with the board of directors. St Anne's Community Services recognised trade unions. There was an annual awards celebration for St Anne's staff that recognised long services, training, outstanding practice, new employees, and teamwork. One of the staff members at St Anne's Alcohol Services achieved a learner's award and was nominated for learner of the year.

Commitment to quality improvement and innovation

St Anne's Alcohol Services 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.

St Anne's Community Services had the gold level investors in people award. This accreditation demonstrated that the services were committed to improvement, leadership and staff involvement.

St Anne's Alcohol Services were involved in the tracer project with Kings' College London, which was a study to produce the evidence base for the effectiveness of residential services and the impact of this treatment on society. The outcome will support the alcohol residential services in evidencing the efficacy of their residential services to commissioners in order to procure future contracts, and to improve the quality of treatment for the clients.

St Anne's Alcohol Services worked with Alcohol Concern on the Blue Light Project, which was a national initiative to develop alternative approaches and care pathways for change resistant drinkers. The Project, supported by Public Health England and 23 local authorities, oversaw the development of a manual to support substance misuse workers in their approach to this population of alcohol misusers. In this way, the services shared their knowledge and expertise with other services and improved the quality of treatment for clients, and the treatment outcomes.

Outstanding practice and areas for improvement

Outstanding practice

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Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that mandatory training is completed by staff.
- The provider must ensure that staff are able to identify child safeguarding risks and concerns, and that staff receive child-safeguarding training to an appropriate level for their role.
- The provider must ensure that there is a clear and consistent system in place for assessing and managing client risk.
- The provider must ensure that all clients have current care plans in place, which include risk assessments and risk management plans, in line with the National Institute of Health and Care Excellence.
- The provider must ensure that all risk assessments and risk management plans are completed on admission and include all the risks identified for each individual client, and that both are reviewed an updated regularly or where the risk changes.
- The provider must ensure that they complete and document physical health observations and ongoing physical health risk assessments, as well as baseline observations.
- The provider must ensure that these physical health observations and baseline observations are documented, and also discussed in the staff handover sessions.
- The provider must ensure that observations and assessments for PRN (as required) medications for clients are completed and recorded as per the St Anne's Alcohol Services medication administration policy.
- The provider must ensure that there is a risk assessment in place for their response to emergencies, including contact 111 (non-urgent help-line), the provision of emergency medication and equipment for resuscitation including the defibrillator, and the response time for urgent treatment and distance to accident and emergency.
- The provider must ensure that there is a system in place to ensure that the staff equipment is in working order so that staff can be alerted to respond to emergencies.
- The provider must ensure that the alcohol detoxification is personalised to the client, for example the use of alternative medication where the liver is not functioning properly.
- The provider must ensure that the governance systems established operate effectively and are

Outstanding practice and areas for improvement

embedded to assess, monitor and improve the quality and safety of the service provided. The provider must ensure that the governance systems operate effectively and are embedded to assess, monitor and improve the quality and safety of the service provided. This includes systems to ensure that mandatory training is appropriate and completed by staff, including child safeguarding training. This also includes the effective use of audits to ensure appropriate service risk assessments and management plans are in place, that client risk assessments and risk management plans are in place, and that observations for as required medications and physical health are being completed, including baseline observations.

Action the provider SHOULD take to improve

- The provider should ensure that the cleaning schedules are completed and signed following the completion of the work.
- The provider should ensure that they complete a risk assessment and management plan around the requirement of client call alarms in the 18 residential rehabilitation beds.
- The provider should ensure that they complete a risk assessment and risk management plan around their mixed sex accommodation.
- The provider should ensure that there is a formal programme of specialist substance misuse training for the administration of medication, including a schedule of competency assessments or supervised practice.
- The provider should ensure that the service has access to a defibrillator and that staff trained to use this equipment.
- The provider should ensure that the visits policy reflects the requirement to safeguard children and vulnerable adults, and is representative of the terms and conditions agreed by the clients.
- The provider should ensure that staff are clear which incidents to report, including situations where they feel intimidated.
- The provider should consider clients in the detoxification service having a named nurse as a contact throughout their treatment.
- The provider should ensure that all care plans are individually tailored to the client's needs, with evidence that the client agrees to it, and that the client has been offered a copy.
- The provider should ensure that a discharge plan is in place at the start of the clients' treatment.
- The provider should that all decision specific capacity assessments are documented in the client record.
- The provider should consider input from a dietician to ensure that clients' nutritional needs are being met
- The provider should ensure that the mission, vision and values (core principles) are embedded in St Anne's Alcohol Services.
- The provider should consider a vision or statement of recovery specific to alcohol misuse for staff to embed in their practice, and for clients to work towards.
- The provider should ensure that information on supervision, appraisal and training are held in one place, and that this information is accurate.

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:** There was low compliance for some mandatory training, including moving and handling patients. This could impact the safety of the staff and the patients. Staff could not all identify child safeguarding risks and concerns, and staff had not received any child-safeguarding training to an appropriate level for their role. There was not a clear and consistent system in place for assessing and managing client risk. Clients did not have current care plans in place, which include risk assessments and risk management plans, in line with the National Institute of Health and Care Excellence. Risk assessments and risk management plans were not completed on admission and did not include all the risks identified for each individual client. Risk assessments and risk management plans were not reviewed and updated regularly or where the risk changed.

This section is primarily information for the provider

Requirement notices

Physical health observations and ongoing physical health risk assessments, as well as baseline observations were not completed or documented, or discussed in staff handover sessions.

Observations and assessments for PRN (as required) medications for clients were not completed and recorded as per the St Anne's Alcohol Services medication administration policy.

There was not a risk assessment in place for the services response to emergencies, including contact 111 (non-urgent help-line), the provision of emergency medication and equipment for resuscitation including the defibrillator, and the response time for urgent treatment and distance to accident and emergency.

The provider did not offer alternative medication for alcohol detoxification, for example for situations where a client's liver may not be functioning properly.

There was not a system in place to ensure that the staff radios were in working order so that staff could be alerted to respond to emergencies.

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

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:**

This section is primarily information for the provider

Requirement notices

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.

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

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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