SMART Howard House Project

Quality Report

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Date of inspection visit: 17 - 18 May 2016
Date of publication: 30/06/2016

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

Overall summary

We do not currently rate independent standalone substance misuse services.

We found the following areas of good practice:

- The service had enough trained and experienced staff to care for this number of clients and their level of need. Staff knew and put into practice the service's values, and they knew and had contact with managers at all levels, including the most senior.
- The service had safe policies and practice in line with national guidance to support people undergoing detoxification programmes.
- Clients and some members of their families were highly complementary about the support and care they received during their detoxifications.
- There were strong policies in place to manage risk including for clients who wanted to terminate their detoxification early.
- The service had strong links with community services to support clients prior to starting their detoxification and for support when they left.

However:

- There were no photographs of patients to identify them on their medicine charts.
- Staff searched patients when they were admitted but were not trained in search techniques.

Summary of findings

Contents

SMART Howard House Project

Services we looked at:
Substance misuse/detoxification

Summary of this inspection

Background to SMART Howard House Project

SMART Howard House is registered to provide residential detoxification for up to 12 weeks and to provide care and support to 10 clients with alcohol and/or drug dependency. Clients who are undertaking an opiate detox are stabilised on methadone (a heroin substitute medicine) in the community before admission and are then admitted to Howard House to begin a reduction programme to achieve abstinence. Clients who are undertaking an alcohol detox may be asked to stabilise or reduce their drinking before being admitted to Howard House; they then start a medication regime on admission to manage the withdrawal symptoms. There were eight patients receiving treatment at the time of our visit.

Howard House is the detoxification service which forms a substance misuse pathway of services under the umbrella organisation called SMART. The service is commissioned by Oxford Public Health Drug and Alcohol Team.

Howard House is registered to provide:

accommodation for clients who require treatment for substance misuse; and treatment of disease, disorder or injury.

There is a registered manager for the service.

The service receives referrals from Turning Point in Oxfordshire for people over the age of 18 who live in Oxfordshire.

We inspected Howard House in 2013. At that time Howard House met most essential standards, now known as fundamental standards. However they did not meet essential standards in the requirements relating to workers. This meant they did not have appropriate reference or Disclosure and Barring Service (DBS) checks in place for staff. During our recent inspection in May 2016 we were satisfied that the service met all fundamental standards, including those relating to workers regarding reference and DBS checks.

Our inspection team

Team leader: Linda Burke, Care Quality Commission

The team that inspected the service comprised of two Care Quality Commission inspectors and one specialist advisor who was a senior nurse with experience in substance misuse.

Why we carried out this inspection

We inspected this service as part of our inspection programme to make sure health and care services in England meet fundamental standards of quality and safety.

How we carried out this inspection

To understand the experience of people who use services, we ask the following five questions about every service:

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

Summary of this inspection

- Is it well led?

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

During the inspection visit, the inspection team:

- looked at the quality of the physical environment, and observed how staff were caring for clients
- spoke with all eight people who were using the service
- spoke with the registered manager, deputy manager and the lead nurse
- spoke with six other staff members employed by the service provider including a move-on co-ordinator and support workers
- spoke with one volunteer
- attended and observed one hand-over meeting, a structured group, and a daily check in for clients
- collected feedback using comment cards from ten clients, two volunteers, one external visitor, and three family members
- looked at all eight care and treatment records, including medicines records, for clients
- looked at one unplanned discharge file
- looked at nine staff files including supervision, reference and DBS checks
- observed medicines administration in the morning
- looked at policies, procedures and other documents relating to the running of the service
- looked at food preparation procedures in the communal kitchen.

What people who use the service say

We spoke with eight clients. They said staff were kind, respectful, hard working and supportive. There were a large number of comment cards from clients supporting this view.

Clients said that staff understood their needs, ensured their physical and emotional health was supported. They also told us that staff ensured there were varied activities available throughout the week and that they had regular one to one meetings and had full access to the service nurse.

Clients told us that they were very happy with the choice of food, especially one client who discovered they were gluten and sugar intolerant and were supported to cook meals to meet their dietary needs.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- The service had enough staff to care for the number of clients and their level of need. Vacancy rates, turnover and sickness absence were all low. Staff supported bank and agency staff covering shifts, and kept shifts filled. All staff had appropriate references and Disclosure and Barring Service (DBS) checks.
- Naloxone was available at various points around the service. This was a medicine used to treat opiate overdose in an emergency situation.
- Overdose prevention training was given to all staff and clients.
- The buildings were clean and tidy.
- Clients said they had regular key working sessions and always had access to supportand medical staff whenever it was needed.
- Alcohol admissions took place on Mondays as the GP was on site then.
- The assisted alcohol and opiate detoxification programmes were in line with National Institute for Health and Care Excellence (NICE) guidance.
- There was a detailed risk assessment and discharge plan on one file we read for a client who left the service in an unplanned way.
- The service had safeguarding policies for children and adults.
- The service had good incidents reporting and management practices in place.

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

- Medicine charts did not have photographs of clients on them. This might lead to medicine errors if a new member of staff joined the team and was not familiar with people in the service.
- Staff searched clients when they first were admitted, however staff had not been trained in search techniques.

Are services effective?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- All clients were assessed prior to admission and when they began their detoxification programmes.

Summary of this inspection

- Care plans were in all eight files we reviewed.
- National guidance was followed for people undergoing alcohol and opiate detoxification.
- The service offered a structured group programme and individual sessions.
- Family members of clients were invited to meetings prior to their discharge dates.
- The service staff team included a nurse, key workers, a move on co-ordinator, volunteer counsellors, a massage therapist, and a visiting GP.
- Staff had access to mandatory and specialised training
- All staff received annual appraisals and monthly supervision.
- There were clear processes in place to refer clients to other support.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- We observed staff being kind, supportive and caring. They were polite and treated clients with dignity and respect.
- Clients and some family members praised the staff for their dedication, care and professionalism.
- All clients received an induction when they were admitted and were linked to a buddy who showed them around the building and offered peer support in the early days of their detoxification.
- Clients were involved in their care.

Are services responsive?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- The service had separate male and female sleeping areas.
- People who used the access had free access to the garden and smoking areas.
- A range of activities were available such as yoga, art, mindfulness, swimming and gym sessions.
- The service provided a good range of food and clients took it in turns to cook for each other.
- Clients knew how to make complaints and pay compliments.
- Clients told us that staff were committed and professional.
- The service offered a range of treatments such as opiate detoxification using subutex and methadone

Summary of this inspection

Are services well-led?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Staff were aware of the organisation's core values of respect, trust, flexibility, perseverance, and simplicity.
- The service had a clear definition of recovery which was based on the core values.
- Staff felt able to raise concerns without fear of victimisation.
- Staff we spoke to felt good about their jobs, told us they were a happy team and that they had good working relationships with senior staff.
- The organisation had an internal quality assurance committee which was led by the consultant medical director.

Detailed findings from this inspection

Mental Health Act responsibilities

- All staff had undertaken Mental Health Act training prior to the inspection.

Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff had undertaken Mental Capacity Act training prior to the inspection.

Substance misuse/detoxification

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse/detoxification services safe?

Safe and clean environment

- The clinic room was clean and tidy. There was sink for handwashing and a couch for physical examinations. A blood pressure monitor and alcometer for measuring alcohol use were available. The clinical fridge was clean and the temperature was checked daily. The temperatures were within the recommended range.
- Medicines were stored in locked cupboards and the clinic fridge. The nurse had keys to the clinic room and when they were not on duty the keys were stored in the staff office.
- The non medical prescriber nurse (nurse) ordered medicines through a GP linked to the service. They had an arrangement with the local pharmacy from delivery of prescriptions.
- Adrenaline for emergency resuscitation was stored in the clinic room and on the wall of the staff office and was in date. This meant that staff had access to emergency resuscitation in the event of an emergency.
- Naloxone was available at various points around the service. Naloxone is a medicine used to resuscitate someone if they had taken an overdose of opiates. This meant that people could give emergency medicine to someone in the event of an opiate overdose.
- Overdose prevention training, including use of Naloxone, was given to all staff and clients. Clients received the training during their stay in a group and one to one setting and again at discharge. This was in line with NICE guidance.
- The service comprised of three buildings and all were clean and tidy. Clients cleaned the buildings as part of a rota. This was agreed at point of admission as part of their therapeutic agreement. A laminated card was displayed in each room detailing what needed to be cleaned and how often. The cards were colour co-ordinated to indicate which coloured bucket should be used when mopping different floors. This supported good infection control practice. Staff told us that a deep clean of the service was undertaken every Sunday.
- Staff undertook monthly infection control audits.
- Weekly health and safety risk assessments were undertaken in the service. These included assessing risks in the bedrooms, kitchen, communal rooms, laundry room, garden and service activities.
- The entrance to the site had a locked door controlled by staff. Closed circuit television was used inside and outside the buildings and was monitored by staff in the main staff office.
- Fire equipment was maintained and checked in April 2016 and the fire alarm was tested weekly. The service held monthly fire drills to monitor evacuation times and assess any relevant risks. The service had four trained and named fire wardens and all other staff had received on-line fire training.
- The service had a comprehensive contingency plan outlining the process to ensure service continuity if the site could not be used. This included which medicines and equipment to take to another site. A copy of the contingency plan was stored with the emergency fire evacuation file.
- Clients stored valuables in a locked safe in the staff office. Clients had keys to their bedrooms. Bathrooms were shared in gender specific buildings in the service.

Safe staffing

Substance misuse/detoxification

- The service's management team comprised of a service manager and a deputy manager. The team also had one non prescriber nurse,one move-on co-ordinator, three keyworkers, three sleeping night workers, one volunteer co-ordinator, one kitchen co-ordinator and five established SMART bank staff. The service also had a team of 10 volunteers who supported weekly activities, and four therapists. From June 2016 the nurse was replaced with an interim non prescribing nurse while the manager undertook recruitment to replace the nurse as they resigned from their post.
- Night duty was covered by a sleeping night worker. This meant that clients could call for their support during the night. The sleeping night worker reviewed the service's CCTV footage recorded during their night shift before they left the site. This was done to identify any concerning activity, for example drugs being thrown into the grounds over the gate, to be reported to the rest of the team.
- The majority of staff had worked in the service for a number of years. Out of 12 substantive members of staff, one left in the previous year giving a turnover rate of 8.3% for that period. There were no vacancies at the time of our visit. The sickness level in the previous year was 5.8% which included a member of staff who was on long term sick.
- The service had 10 beds and at the time of our visit eight were occupied.
- There was good use of experienced bank staff who were familiar with the service. Of the total 51 shifts available in the three months to February 2016, 20 (39.2%) were covered by bank staff. All bank staff received induction into the service and received mandatory training and supervision. The service did not use agency staff for shift cover, however at the time of our visit a new interim nurse was hired from through agency.
- The service used a group of supervised and trained volunteers to support additional activities. Clients told us that sometimes volunteers did not show up for their shifts and this often caused stress for members of team on duty as sometimes they then had to facilitate additional activities.
- Staff were able to contact the doctor linked to the service during the day and accessed general emergency medical services at night. The nurse was available during the day on Monday, Tuesday, Wednesday and Friday.
- Clients said they had regular key working sessions and always had access to supportand medical staff whenever it was needed.
- Alcohol admissions took place on Mondays as the GP was on site then. This meant a safer clinical assessment could be made with the GP and nurse together. Staff numbers were adjusted on the preceding Fridays to ensure enough staff were on site to assess and meet the needs of new people coming into the service.
- We reviewed the employment records of nine members of staff. DBS and appropriate references were in place for all staff.

Assessing and managing risk to clients and staff

- Clients were referred to Howard House through a community substance misuse service called Turning Point Oxfordshire. Turning Point carried out risk assessments and referral assessments for all new referrals. The nurse spoke with Turning Point staff to agree that new referrals needed to be stabilised on the drug and/or alcohol they used prior to admission to the service. Once the client had stabilised on their drugs and/or alcohol the nurse assessed them for admission. If they found that the client needed to do more preparation work, such as attend support groups or reduce their drinking further, the nurse would agree this with the referrer and the client. The service assessed risk and people's readiness for detoxification prior to admission so they could ensure the right people were accepted and alternative support was found for people needing higher intensity of support. For example, if a client had a history of experiencing alcohol withdrawal related seizures and were not deemed suitable for the detoxification programme, they were referred for an inpatient hospital detoxification.
- The nurse, GP and move-on co-ordinator carried out risk assessments on clients on admission. Risk assessments included risks related to physical health, mental health (including self harm and suicidal thoughts), motivation,

Substance misuse/detoxification

safeguarding, aggression and violence to self and others. There were up to date risk assessments on the eight client files we reviewed which was in line with NICE guidance

- Staff developed risk management plans together with clients when they decided to leave treatment early. The plans included risk management regarding overdose, risk from or to others, and risk arising from housing issues.
- Staff risk assessed all clients before they could use the kitchen. All clients were given an induction in the kitchen, including watching a DVD promoting food hygiene.
- Clients paid their benefits or weekly income to the service. This was held in a safe account for them and was agreed as part of their therapeutic agreement. their money was used to buy individual food treats kept in cliental tuck boxes, toiletries, and to pay towards ingredients for communal meals. Clients gave lists of food treats and toiletries they wanted to staff who then bought the items on their behalf. This agreement managed the risk of clients having money which could be a trigger to buying drugs or alcohol.
- The assisted alcohol detoxification used reducing doses of chlordiazepoxide and was in line with NICE guidance.
- The nurse used a CIWA) scale to monitor any discomfort experienced by the client undergoing detoxification. This meant she could measure when to adjust the reduction dose to make the client was comfortable. The nurse also administered medicine for clients to ease symptoms such as nausea as it was required.
- The detoxification programme took people's cliental needs into account. For example, the nurse offered a variation in lengths of detoxification and offered prescribed additional medicines to make the process more comfortable. This meant that clients had access to medicine to reduce nausea or to support sleep. The nurse was trained and regularly supervised. Medicine was administered every morning from pouches allocated to each client who used the service. The nurse supervised each client taking their medication in private and briefly assessed their health and wellbeing.
- There was a plan for unexpected exit from treatment on one of the eight files we read. This outlined what the client who used the service wanted staff to do to encourage them to complete their treatment.
- There was a detailed risk assessment and discharge plan on one file we read for a client who left the service in an unplanned way. Staff used a discharge checklist to ensure they discussed all aspects of leaving the service and informed all relevant parties, for example GPs, social services, housing, community support services.
- Clients were searched on admission by staff. This meant that staff asked clients to empty their bags, pockets and turn out their socks. However, the service did not have a search policy and staff were not trained in search procedures. Clients agreed to be searched as part of their therapeutic contract with the service.
- Staff observed clients at 15 minute intervals on the first day of their alcohol detoxification. They also ensured new admissions did not have a lock on their door in the first few days of detoxification so staff could access rooms quickly if there was a medical emergency. Clients agreed to this as part of the therapeutic contract to ensure their safety.
- The service did not have a policy for managing visitors under the age of 16, however they did risk assess these visits and held them in a group room in the garden. This meant the service supported clients to keep in contact with family members which was in line with NICE guidance
- The service had safeguarding policies for children and adults. All staff were trained in safeguarding at specialist and generalist levels which was mandatory.
- The service had a good relationship with local safeguarding. No safeguarding alerts were made by the service to the CQC for the period may 2011 to February 2016. Staff made three alerts relating to children of people known to clients in the last 12 months. The service was not required to notify the CQC of these alerts as they did not directly relate to clients.
- The service had an administering medicine policy. This meant that all staff were trained in medicine management and had clear guidelines to follow when doing this work. However, medicine charts did not have

photographs of clients on them. This meant it might be difficult to match the medicine chart to the client if a new member of staff was working there and could result in medicine errors.

- Adrenaline was kept on site for emergency resuscitation. This was stored in the clinic room and was in date.
- The nurse carried out medicines reconciliation on admission. This meant she checked medicines clients were prescribed, checked dates on medicines and labelled and locked it securely in the clinic cupboard.
- All clients were subject to restrictions on their movement and interactions with others. Clients were not allowed to leave the grounds as they pleased and were restricted to phone calls and visits from others at certain times. They were not allowed to use their mobile phones throughout their stay. Clients agreed to these restrictions as part of their therapeutic agreement to protect their recovery and reduce risk of using substances.
- Smoking was permitted in bedrooms but not in communal areas in the buildings. All bedrooms had self extinguishing ashtrays and fire alarms. There was a designated smoking area in the garden. Smoking cessation sessions were held weekly and staff were reviewing the use of e-cigarettes at the time of our visit.

Track record on safety

- In the previous 12 months one client who used the service broke their wrist punching a punch bag. As a result the bag was risk assessed and the service decided to remove it as its safety could not be guaranteed.

Reporting incidents and learning from when things go wrong

- Incidents were reported by the manager or deputy manager to the health and safety electronic mailbox which was monitored by the health and safety committee which included quality and clinical leads.
- Learning from incidents was fed back to teams across all SMART services in the quarterly feedback sheet. Incidents were discussed as an agenda item in weekly team meetings.
- Teams were de-briefed after incidents in weekly team meetings and in informal briefing sessions. The last serious incident involved a client who had an alcohol induced seizure. The incident was de-briefed in a meeting with all team members. Following this incident the service changed their admission criteria for people who used alcohol. This meant that the level of clinical need that the project could support was more clearly defined, including what level of alcohol consumption the project could detox someone from. The nurse assessed people's readiness to begin the programme with the referrer and advised of any additional preparation work which had to be undertaken, for example further reduction or engagement in support groups..

Duty of candour

- There was no policy related to duty of candour. However, there was evidence that the service was being transparent and we heard of one serious incident regarding a client who used the service where staff had worked with the family to explore what happened.
- Complaints and the manager's responses were displayed on a notice board in the dining room.

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

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

- All clients were referred from the Turning Point Oxfordshire service. Staff liaised with Howard House staff to ensure appropriate steps were taken to stabilise or reduce people to clinically agreed levels in the community people before they were admitted for the detoxification programme. This meant that people met the criteria to safely begin the programme. If, prior to admission, staff assessed that a client had not prepared sufficiently the nurse would agree further steps to take, e.g. reduce their use further or attend more preparation groups.
- All clients were assessed by the nurse and GP from the first day of admission to the service. This meant they were assessed in person before they were prescribed

medicines as part of their detoxification programme. Assessments addressed the physical, mental health and social needs of people and were in all eight care files we reviewed. This was in line with NICE guidance.

- The move on co-ordinator assessed people's accommodation needs to ensure people had a safe place to move to at the end of treatment.
- Assessments for alcohol admissions took place on Mondays with the GP and nurse. All alcohol admissions were admitted to a room close to the clinic room for the first day and had their blood pressure monitored four times daily before taking medicine for the first three days of their detoxification. This was to ensure safety during the most vulnerable early stage of alcohol detoxification when the client who used the service may experience a seizure. The nurse monitored clients' blood pressure at least twice daily for the remainder of the programme.
- The assessment process included a full GP summary and risk assessment from the referrer which was in line with NICE guidance This meant that staff could identify additional support needs of clients, for example co-existing mental health issues which was in line with NICE guidance. The service had links with the local mental health complex needs service who supported clients with particular support needs around personality disorders.
- Care plans were developed between clients and their key workers which was in line with NICE. Care plans were up to date on the eight files we reviewed.
- Care plans were strengths based, holistic and addressed issues such as cliental choice around recovery, hobbies, families, self care, fitness and diet which was in line with NICE guidance.
- People who decided to leave their detoxification programme early completed a discharge assessment with a member of staff. The assessment ensured that people were referred back to their GP, had somewhere safe to move on to, that they had clear overdose prevention and relapse management information, and were given Naloxone where appropriate.
- The service outlined steps they took if clients breached terms of the therapeutic contract which was explained prior to admission. For example, if a client used their mobile phone or began a relationship with another client. Steps included a verbal warning, written warning and a final written warning. All warnings were given to clients by two members of staff. The contract explained that if a client was asked to leave the programme they had to be re-referred to commence a new detoxification programme.
- Assessments of patients for alcohol detoxification included completion of the Severity of Alcohol Dependence Questionnaires (SADQ). This was in accordance with recommended NICE guidance for assessing people for alcohol detoxification.
- The service had strong working links with a local health centre where all clients were screened for blood borne viruses and received treatment as appropriate. People were referred to a local optician and dental practice for additional treatment and routine check ups. At the time of our inspection, three clients told us they had received dental treatment.
- Clients saw the staff every day. This meant that they could respond to changes in people's physical health needs and ask the nurse to prescribe medicines to make people comfortable during their detoxification. The service was linked to a local GP who offered medical support where appropriate and when the nurse was not available. During our visit one client was escorted to the dentist for dental pain and another client received medicine from the nurse to reduce nausea.
- Staff assessed each client's mental health at the end of their detoxification. This ensured the client received appropriate support post discharge and was in line with NICE guidance.
- The prescription charts for all eight clients were up to date and did not contain any errors.

Best practice in treatment and care

- National guidance was followed for people undergoing alcohol and opiate detoxification. The service had policies for both alcohol and opiate detoxifications. The nurse administered methadone and buprenorphine (subutex) for the management of opioid dependence. This was in line with NICE guidance.
- The nurse administered chlordiazepoxide (librium) for assisted alcohol withdrawal. This was in line with NICE guidance.

Substance misuse/detoxification

- Detoxification policies were reviewed annually and covered aspects such as assessment, medical emergencies, prescribing regimes, vitamin replacement, monitoring and review.
- The service offered a structured group programme and individual sessions using psychological interventions including cognitive behavioural therapy, The International Treatment Effectiveness Project (ITEP) and motivational interviewing. These psychological treatment approaches were in line with NICE guidance
- Outcomes were measured by the use of Treatment Effectiveness Profiles (TOPS). Staff used the TOPS tool to measure change and progress in key areas of a client who used the service's life such as substance use, mood, crime, social life and health.
- Staff engaged in audits based on SMART's practice standards which were based on accepted best practice, such as NICE guidance. These audits were reviewed and talked through in weekly team meetings. Staff took part in a client file audit in March 2016. This audit identified 100% score in all areas except for 50% score where staff needed to use a drop down box to identify interventions used. The audit reviewed quality regarding how well completed forms including completed outcomes monitoring forms, care plans and risk assessments.
- The manager fed audit results to staff in team meetings and via email updates.
- Family members of clients were invited to meetings prior to their discharge dates. Family members and friends were able to request fortnightly visits to see clients. This was in line with NICE guidance. Clients were offered additional support around the time of family visits to support their emotional needs particularly after seeing their children.

Skilled staff to deliver care

- The service staff team included a nurse, key workers, a move on co-ordinator, volunteer counsellors, a massage therapist, and a visiting GP.
- The nurse received mandatory training such as emergency first aid and anaphylaxis training.
- Staff had access to mandatory training which included, emergency first aid, and safeguarding children and vulnerable adults. Mandatory training completion rates for all staff were 100% except for safeguarding children (generalist level) which was at 80%.
- Staff had access to specialised training including drug awareness, harm minimisation, motivational interviewing and groupwork. Staff also had CIWA and SADQ training. This meant they could use these tools in the assessment and management of a client's alcohol withdrawal. The move on co-ordinator received specialist housing training from St Mungo's which was a housing charity.
- Specialised training and completion levels for all staff included NVQ Level 3 in Drug and Alcohol (75%), group facilitation (100%), motivational interviewing (100%), risk assessment (100%), drug awareness (100%) and harm minimisation(100%).
- All staff were knowledgeable about prevention of blood borne viruses, overdose prevention and prescribing practice for different types of substance misuse issues.
- The nurse had appropriate knowledge of prescribing options for different types of substance misuse problems experienced by clients. These options were alcohol detox using librium and opiate reducing regimes using subutex.
- All staff received annual appraisals, monthly supervision which was in line with NICE guidance. The nurse also received monthly clinical supervision from an external prescriber.

The nurse was a non medical prescriber, who was not a doctor, who was trained to prescribe medicines. Their additional skills and qualification meant that there was increased access to prescribing interventions for clients.

- There was leadership training for the service manager. The service manager had Level seven training in Leading Places of Change. Management training completion rates for subjects such as supervision skills and health and safety management training were 100%.
- The manager and deputy manager addressed staff performance issues in supervision and followed the internal capability procedure where necessary. There were no staffing issues requiring the capability procedure at the time of our visit.

Substance misuse/detoxification

- The manager and external clinical supervisor monitored the nurse's registration and ongoing professional development every six months.

Multidisciplinary and inter-agency team work

- All staff on the shift rota attended daily morning handovers. The night workers wrote upnight handover notes and these were shared the following morning to update staff on any issues.
- Weekly multi disciplinary meetings were held. Minutes were distributed by email to all staff members and case notes were updated by relevant key workers.
- The service had strong links with local GPs, social services, local mutual aid support groups, and local counselling services. The team were building stronger links with local mental health services.
- There were clear processes in place to refer clients to other support. For example, an effective assessment at admission planned for move on to housing, residential or community rehabilitation, and work experience. This was in line with NICE guidance.

Adherence to the MHA

- Mental Health Act (MHA) training was not mandatory but all staff received MHA training.

Good practice in applying the MCA

- Mental Capacity Act (MCA) was not mandatory but all staff received MCA training. There was an MCA policy which staff could refer to for further guidance. Staff assumed clients had capacity and the team assessed this ongoing throughout their detoxification. They did this with the support of the visting GP. The service was not suitable for clients who lacked capacity so ongoing assessment was important to ensure clients were in the right treatment setting to meet their needs.

Equality and human rights

Use this new section to report on how the service supports people with protected characteristics under the Equality Act 2010 and its use of blanket restrictions (if any).

- The service had an equal opportunity policy.
- Staff received training in equality and diversity and training completion rate was 70%. Assessment paperwork showed evidence of identifying diverse needs. The service engaged people with support needs relating to parenting, drug and alcohol use, and mental health needs.
- The service's therapeutic agreement stated that discrimination or abuse to any clients in regard to difference and diversity would be accepted.
- Clients agreed with a therapeutic contract in advance of treatment. This contact outlined clients were not permitted to use their mobile phones during their stay, had limited access to telephones to communicate with family, and were not allowed to leave the premises without staff to accompany them.

Management of transition arrangements, referral and discharge

- Clients were assessed for move-one when they began treatment. This meant that the housing worker identified where clients would move to after their detoxification, for example to rehabilitation, to their home or if they required housing referrals as they did not have a home. The assessment also identified support they would need, for example, counselling, group work, training, volunteering work, and local mutual aid such as alcoholics anonymous (AA).

Are substance misuse/detoxification services caring?

Kindness, dignity, respect and support

- We observed staff being kind, supportive and caring. They were polite and treated clients with dignity and respect.
- There was a large board in the dining room where clients wrote notes to say thank you to staff for their support and care.
- We collected ten comment cards from clients and three from family members who all praised the staff for their dedication, care and professionalism.
- We observed staff taking time to explore people's needs in a handover session. This conveyed the care they had for clients. Staff spoke about people with respect and consideration and took time to resolve issues for them.

Substance misuse/detoxification

- We observed care and respect when the nurse held her medicine clinic and took time with each client to find out how they were on the day before moving onto clinical issues.

The involvement of people in the care they receive

- All clients received a welcome pack on admission. The pack contained a handbook, health and safety information, consent forms and a mindfulness CD for relaxation. The handbook included the therapeutic agreement, daily diary, guidelines for visits, concerns and complaints, fire procedure, weekly group programme, and house meetings.
- All clients received an induction when they were admitted and were linked to a buddy who showed them around the building and offered peer support in the early days of their detoxification.
- All clients received information and individual and group training regarding prevention of drug and alcohol related harm during their stay. This training was repeated prior to discharge from the service. For example, Naloxone training was offered to people who were undergoing an opiate detoxification.
- Clients were involved in their care. They planned their detoxification with the GP and nurse and this was reviewed weekly. They also planned their recovery using a document called My Recovery Goals. These goals were monitored fortnightly with staff to ensure people were progressing towards their recovery.
- Staff assessed clients' strengths when they developed their recovery plans. The plans included aspects such as developing other interests.
- Clients were referred to other services for additional support such as smoking cessation and local services providing a range of hobbies, for example the gym.
- The service offered a range of treatments such as opiate detoxification using subutex and methadone. They also offered a range of lengths of detoxification to suit each client's needs and increase levels of comfort through the process in line with NICE guidance.
- All clients had the opportunity to access advocacy, although this was not advertised well and there were no leaflets on display. Advocacy people to self advocate. This meant that clients could find out about their rights to make the right decisions for themselves.
- Feedback about the service was gathered in weekly house groups, using complaints or compliments leaflets, during quarterly snap shot surveys and in exit questionnaires. Complaints and management's responses were displayed on a notice board in the dining room.
- Clients were involved in making decision about how the service was run. For example, a client who used to use the service was involved in the recent recruitment for a new key worker.

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

Access and discharge

- The service was rarely full which meant that people could be admitted without being referred out of area for treatment.
- The service had separate male and female sleeping areas. This meant that sometimes people were placed on a waiting list until a room in the gender specific area became available.
- The service did not monitor average time from point of referral to admission. However, if someone who wanted to use the service did not meet the criteria, for example, if they had not undertaken sufficient preparation work to reduce their substance misuse, then the wait could be two to three months. Weekly telephone contact was offered to anyone working towards accessing the service. Once the service had all the relevant information they required to confirm a patient was ready to be admitted, they could admit a person quite quickly as soon as a bed was available.
- Staff identified barriers to people accessing the services through the assessment process. For example, they

supported victims of domestic abuse by liaising with community services and worked with local housing teams to meet the accommodation needs of homeless people.

The facilities promote recovery, comfort, dignity and confidentiality

- Clients had access to their rooms throughout the day and had their own keys to lock their doors throughout their stay.
- Patients were not permitted to use their mobile phones throughout their stay. Staff stored patients' mobile phones in a safe for the duration of their treatment. This was agreed as part of the therapeutic agreement. Cliental calls could be made every other day for 15 minutes in the office where staff could listen to help protect people's recovery and safety. Staff read letters sent to clients. This was agreed in their therapeutic agreement and ensured their detoxification was supported. For example, one client who used the service was supported by their key worker on how to respond to upsetting correspondence they had received in order to safeguard their progress. The client decided, with their key worker's support, that they would not respond to avoid entering into stressful communication exchange which could put their recovery at risk.
- People who used the access had free access to the garden and smoking areas.
- A range of activities were available such as yoga, art, mindfulness, swimming and gym sessions. At the weekends activities included visits to the cinema and golf. Clients were supported to attend mutual aid groups throughout the week. These were groups led by people who used misused substances and offered support to other people undergoing recovery or maintaining abstinence. This was in line with NICE guidance.
- Clients could make snacks and hot drinks from 7am until 11.30pm. Out of these hours they could make hot drinks in their rooms.

Meeting the needs of all clients

- The buildings were not adapted for use by people who required disabled access. However, there was ramp access the women's block. This meant the service was not suitable for people who used wheelchairs.
- Leaflets were not available in a range of languages, however staff could down load these from the internet if needed.
- Information was provided to clients about prevention of drug related harm. For example, people who were undergoing opiate detoxification received training and information about emergency Naloxone overdose treatment. People received detailed information about detoxification and the any associated risks and symptoms in line with NICE guidance.
- There was access to translators if clients needed the support.
- The service provided a good range of food and clients took it in turns to cook for each other. One client who used the service was supported to buy and cook halal meat and another was supported to cook sugar and gluten free meals after they were diagnosed with an intolerance to both ingredients. Clients told us they had lots of fruit to eat and that the food was very good.
- Clients were supported to meet their spiritual needs. For example, staff escorted some people to attend church.

Listening to and learning from concerns and complaints

- Clients knew how to make complaints and pay compliments. Complaints and compliments leaflets were displayed in communal areas. Learnings from complaints were shared at team meetings and were displayed on a notice board in the dining room. One client who used the service complained that there were not enough staff available to drive the service's mini bus for outings. The manager arranged for more staff to be trained and insured to drive the bus to increase opportunities to hold outings. This was communicated on the notice board.
- Clients told us that staff were committed and professional.

Are substance misuse/detoxification services well-led?

Vision and values

Substance misuse/detoxification

- Staff were aware of the organisation's core values of respect, trust, flexibility, perseverance, and simplicity. The team's annual cliental development plans were based on these core values.
- The service had a clear definition of recovery which was based on the core values. The definition was understood by all staff and the approach was flexible to meet and support the varied needs of clients. For example, there was a choice in how quickly clients could reduce off substitute medicine.
- Staff knew the most senior managers in the organisation and told us that the Quality Director and Chief Executive had visited recently.

Good governance

- The service's commissions collected key performance indicators on a quarterly basis to monitor the service's performance targets which the service met.
- The service manager had enough authority to do their job and felt very supported by senior managers in the organisation.
- Staff had the ability to submit items to the organisation's risk register. At the time of our visit the service did not have any items listed on the register.

Leadership, morale and staff engagement

- Staff felt able to raise concerns without fear of victimisation.
- Staff we spoke to felt good about their jobs, told us they were a happy team and that they had good working relationships with senior staff. We observed this while we were in the service during our inspection.
- Staff understood the service's whistleblowing policy. No whistleblowing concerns were raised with the CQC for the period March 2014 to Feb 2016.

Commitment to quality improvement and innovation

- The organisation had an internal clinical governance committee which was led by the consultant medical director. An investigation took place a year ago following someone who used the service experiencing an alcohol related seizure. An audit was undertaken on the clinical processes and staffing which led to improvements in many processes. This meant that the level of clinical need that the project could support was more clearly defined, including what level of alcohol consumption the project could detox someone from.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that photographs of clients are attached to their medicine charts.
- The provider should ensure that staff are trained in search techniques.