

Turning Point – Croydon

Quality Report

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Date of inspection visit: 15 and 16 January 2018
Date of publication: 14/03/2018

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

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

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

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

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

Overall summary

We do not currently rate independent standalone substance misuse services.

We undertook this unannounced focussed, follow up inspection to find out whether Turning Point Croydon had made improvements since the previous inspections in June and November 2016.

Following the June 2016 inspection, the provider was served a warning notice for not providing safe care and treatment, and six requirement notices for breaches of regulation.

We told the provider that they must improve on the following areas:

- The provider must ensure that potential risks to clients and others are appropriately assessed. Clients must have risk management plans addressing identified potential risks.
- The provider must ensure that staff are able to identify all clients at risk of abuse and that appropriate action is taken. The provider must ensure all children at risk of abuse are identified and appropriate action is taken.
- The provider must ensure that a physical examination takes place before commencing clients' treatment.
- The provider must ensure that clients having community alcohol detoxification have their withdrawal symptoms assessed consistently.

Summary of findings

- The provider must ensure that all complaints made about the service are investigated. People who complain must receive a written response including how they can appeal against the complaint response.
- The provider must ensure that all clients have a comprehensive, detailed, assessment. Assessments must identify client's religious and cultural needs.
- The provider must ensure that all medical devices are calibrated in accordance with best practice.
- The provider must ensure that all incidents are reported and recorded. The provider must ensure that all incidents which should be notified to the Care Quality Commission are notified, without delay.
- The provider must ensure a system is operate effectively to monitor the quality of assessments, risk assessments and risk management plans.

At the November 2016 inspection, we found that the provider had made improvements and had met the warning notice requirements. Whilst the service had made improvements to areas of practice, the inspection found that further improvements were required and systems needed embedding into everyday practice. The provider was re-issued the same requirement notices to ensure that improvements continued.

At the January 2018 inspection, we found the following areas of improvements.

- The provider had significantly improved on the quality of client risk assessments. Clients received a comprehensive risk assessment and potential risks were minimised. This included communication with clients' individual GPs, risk assessment of clients who drove a vehicle, and assessment of clients who were vulnerable to financial and emotional abuse, or whose children were potentially at risk.
- When required staff completed recognised withdrawal tools such as COWS (clinical opiate withdrawal scale) and CIWA-Ar (the clinical institute withdrawal assessment for alcohol) prior to and during treatment.

- The quality of initial assessments had improved. Clients received a detailed initial assessment which included an assessment of a clients' health and wellbeing, including physical and mental health history and cultural or religious needs.
- Clients received regular comprehensive medical reviews. The quality of assessments had improved.
- The monitoring of physical health had improved. Clients received a thorough and comprehensive physical health assessment prior to and during treatment.
- Staff regularly reported all types of incidents including prescription printing issues. We saw an example of the service reporting an incident that related to a client but had been caused by another service provider.
- The complaints system had improved and complaints were appropriately managed in accordance with the provider's complaints policy.
- The provider ensured that they routinely reported notifiable incidents to the Care Quality Commission (CQC).
- Client records reflected that clients had been assessed for whether they wished for their families or carers to be involved in their care and treatment.
- The provider had ensured that clinical equipment had been serviced, including the glucose equipment, blood pressure monitoring machine and weighing scales.
- Staff ensured sharps bins were completed and red bags were available in the event of a spillage contaminated with bodily fluids.

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

- Although the provider carried out regular caseload reviews of clients receiving treatment, the recent caseload review in December 2017 demonstrated that 11% of clients receiving treatment did not have an up to date risk assessment in place. Prior to the January 2018 inspection, the provider had plans in

Summary of findings

place to address the outstanding number of incomplete risk assessments. For example, for three hours per week the service closed to allow staff the opportunity to complete administrative work.

- At the January 2018 inspection, most clients had up to date care plans. However, two out of 16 care plans

were either not available or had not been updated since May 2017. There was a risk that without a care plan or an updated care plan, there was no record in place to demonstrate how clients were supported.

Summary of findings

Contents

Summary of this inspection

	Page
Background to Turning Point - Croydon	6
Our inspection team	6
Why we carried out this inspection	6
How we carried out this inspection	7
What people who use the service say	7
The five questions we ask about services and what we found	8

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards	10
Outstanding practice	15
Areas for improvement	15

Turning Point - Croydon

Services we looked at

Substance misuse/detoxification

Summary of this inspection

Background to Turning Point - Croydon

Turning Point - Croydon provides advice, support, and treatment for young people and adults with drug and alcohol problems within the London Borough of Croydon. The service has been operating for just over three years. The service team structure had changed since our previous inspection in November 2016. The service now has the following teams:

Generic recovery team – The largest part of the service providing substitute opiate prescribing, community alcohol detoxification, key-working, counselling, alternative therapies, benefits and housing advice, a needle exchange, blood borne virus testing and vaccinations. This team now provides engagement and

outreach. Staff work with people who are street homeless including the provision of a weekly breakfast club. The service now employs a long-term conditions nurse who provides outreach work at the local general hospital.

Young person's team – Provides support for young people using alcohol or drugs.

All adults using the service are also able to access a psychosocial group programme operating six days per week. Young people access their own programme.

Turning Point – Croydon is registered to provide the regulated activity: treatment of disease, disorder or injury. The service is commissioned by the London Borough of Croydon and Croydon Clinical Commissioning Group. Since our previous inspection in November 2016, a new registered manager has taken over the role.

Our inspection team

The team that inspected the service comprised of two CQC inspectors and one specialist advisor who was a consultant psychiatrist with a background in substance misuse.

Why we carried out this inspection

We inspected this service to review the provider's progress in addressing the breaches of regulations from the previous inspections in June and November 2016 and whether the required improvements had been made. At the November 2016 inspection, we found that the service had made some improvements but areas of practice had not embedded in to everyday practice.

The provider still needed to improve on the following areas of practice:

- Whilst the provider had put plans in place to address the management of client risk, the provider had not ensured that this was consistent for all clients. Clients did not always receive a regular risk assessment and risks were not mitigated. Risk assessments did not always assess whether clients

drove a vehicle, were vulnerable to financial and emotional abuse, or whose children were potentially at risk. There was a lack of communication with clients' individual GPs.

- Staff did not complete detailed initial assessments with clients. Initial assessments lacked a clear record of clients' health and wellbeing including physical and mental health history and cultural or religious needs.
- Clients did not always receive appropriate medical reviews. The quality of an assessment was dependent on which clinician undertook the review.
- Clients did not always receive a physical health assessment prior to treatment commencing and

Summary of this inspection

clients' physical health was not monitored thereafter. Staff were not assessing clients' withdrawals symptoms prior to and during alcohol or drug detoxification.

- Staff did not report all incidents, such as prescription errors and aggressive behaviour from clients.

- The provider's complaints system was not working effectively. Clients told us that they did not always receive a response to their complaint.
- The provider did not ensure that reportable incidents were notified to the Care Quality Commission (CQC). All services registered with the CQC are required to notify the Commission of certain incidents, without delay.

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?
- Is it well led?

As this was a focussed inspection, we only looked at some areas of Safe, Effective, Caring and Well-Led.

Before the inspection visit, we reviewed the provider's last two inspection reports from 2016.

During the inspection visit, the inspection team:

- spoke with two clients
- spoke with the registered manager and the operations director
- spoke with six staff members employed by the service provider, including nurses and keyworkers
- looked at 16 care and treatment records
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

Clients were positive about staff and the care they received. Clients described staff as being understanding and patient.

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 improvements since the previous inspections:

- We found a significant improvement and clients now received a comprehensive risk assessment and risk management plan that demonstrated how risks identified would be mitigated.
- When required, staff completed recognised withdrawal tools such as COWS (clinical opiate withdrawal scale) and CIWA-Ar (the clinical institute withdrawal assessment for alcohol) prior to and during treatment.
- Staff ensured sharps bins detailed the appropriate information and red bags were available within the clinical rooms.
- Clinical equipment was serviced regularly.
- Staff regularly reported all types of incidents. The service reported all incidents that related to their clients, even if the incident related to another service provider.

Are services effective?

We do not currently rate standalone substance misuse services.

We found the following areas of improvements since the previous inspections:

- Staff completed thorough initial assessments with clients that contained records of clients' well-being, physical and mental health history, and cultural and religious needs.
- All 16 records that we reviewed detailed that clients received a comprehensive medical review.
- Clients received a thorough and comprehensive physical health check prior to and during treatment.

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

- Out 16 care plans reviewed, one was not available and one had not been updated since May 2017.

Are services caring?

We do not currently rate standalone substance misuse services.

Summary of this inspection

We found the following areas of improvements since the previous inspections:

- All clients had been assessed for whether they wished for their families or carers to be involved in their care.

Are services responsive?

We do not currently rate standalone substance misuse services.

We found the following areas of improvements since the previous inspections:

- Clients had access to a range of leaflets available in English and other languages.
- Complaints were appropriately handled in accordance with the provider's complaints policy.

Are services well-led?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- The service had improved and implemented new systems to ensure clients were receiving safe care and treatment. This included the implementation of a full caseload review every two weeks to ensure the completion of records was regularly checked.
- The provider now regularly notified the CQC of reportable incidents.

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

- The provider had not ensured that all clients had a completed risk assessment in place. Eighty- nine percent of clients had a completed risk in place, despite the provider's compliance target of 100%. All clients require a risk assessment that is regularly reviewed and updated to reflect the clients' risks.
- The provider had reviewed its policies in line with national guidance. The prescribing policy was progressing through the organisations governance process and would be signed off shortly.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood how to assess a client's capacity and knew to escalate to a clinician if they were concerned.

Substance misuse/detoxification

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse/detoxification services safe?

Safe and clean environment

- During the January 2018 inspection, we reviewed the provider's December 2017 infection control audit. The audit stated that the service did not have pedal operated clinical waste bins. This was highlighted to the registered manager, as the issue had not been rectified. Following the inspection, the registered manager confirmed that five new pedal waste bins had been ordered.
- During the inspection in June 2016, we found that the labels on sharps bins were not completed with the necessary information. The service did not have any red bags in case there was a spillage contaminated with bodily fluids. At the January 2018 inspection, we found that this had been addressed. Staff ensured that labels on sharps bins were correctly completed and red bags were available within the clinical rooms.
- At the inspection in June 2016, we found that the weighing scales, blood glucose-monitoring machine, blood pressure monitoring machine (sphygmomanometer) and breathalyser used in the service had not been calibrated. During the January 2018 inspection, we found that all of the equipment had been calibrated. Drug testing kits were within their expiry date. Staff told us that a new disposable urine dipstick supply was on order.

Assessing and managing risk to clients and staff

- At the inspection in November 2016, we found that not all clients had a risk assessment and risk management plan in place. Clients were not advised of their responsibilities to report their circumstances to the Driver and Vehicle Licensing Agency (DVLA) when this

was required. At the inspection in January 2018, we found that the service had improved in the management of risk. We reviewed 16 treatment records and found all clients had a risk assessment and clients had up to date risk management plans. Risk management plans describe how identified risks were managed by the service. Records demonstrated staff advised clients, to notify the DVLA if they drove.

- At the previous inspection in November 2016, we found that the service did not ensure that they communicated with clients' general practitioners (GPs). During the January 2018 inspection, we found that this was no longer the case. We reviewed 16 treatment records and found that the service consistently sent GPs regular updates on treatment plans and when clients did not attend their appointment. We found evidence that the service encouraged clients who did not have a GP to attend a local NHS walk-in clinic in order to register with a GP prior to treatment commencing. The service employed an administrator who was responsible for the communication sent out to GPs.
- At our previous inspection in November 2016, we found that staff did not regularly monitor the withdrawal symptoms of clients receiving treatment. During the January 2018 inspection, we found that this was no longer the case. We reviewed 16 treatment records of clients who were new to the service and clients who had been receiving treatment during the last inspection in November 2016. When required, staff monitored clients' withdrawal symptoms and used recognised withdrawal tools such as COWS (clinical opiate withdrawal scale) and CIWA-Ar (the clinical institute withdrawal assessment for alcohol).
- During our inspection in June 2016, we found that the provider's risk assessment document did not include all types of potential abuse including financial and emotional abuse. The risk assessment template did not

Substance misuse/detoxification

guide staff in identifying potential risks to children. This meant staff may have not have been prompted to check these areas. We found examples of where children at risk had not been referred to the local safeguarding team. At the inspection in January 2018, we found that this had improved. All clients had been comprehensively assessed for safeguarding risks. We did not find in the records any examples where safeguarding risks had not been appropriately explored or escalated.

- At the January 2018, we found that the provider had implemented staff competencies to ensure staff were trained in specific areas, such as risk assessment and risk management. Seventy three per cent of staff had completed risk assessment, risk management, and recovery planning training. Ten members of staff still required the training. The outstanding members of staff had been booked in for training on 1 March and 13 March 2018.

Reporting incidents and learning from when things go wrong

- At the inspection in June 2016, we found that staff did not report all incidents such as aggression from clients and prescription errors. During the January 2018 inspection, we found that this was no longer the case. Staff reported incidents on the electronic reporting system. We found that staff had recently raised an incident for a problem with the prescription printer and a client who had not been to collect their script following a hospital admission. This triggered staff to complete a safeguarding referral. We found that the provider had also reported an incident, which had been caused by a community pharmacy. The registered manager told us that the service reported all incidents that related to clients, even if the incident was not caused by the service.

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

Assessment of needs and planning of care

- At the inspection in June 2016, we found that staff did not complete a thorough initial assessment with clients. Gaps in client records included a lack of evidence that a

motivational intervention was carried out during the assessment, no record of clients' physical and mental health history and lack of detail regarding clients' cultural or religious needs. At the recent inspection in January 2018, we found that this had improved. All of the records included a thorough and detailed initial assessment. In some records, staff had ensured that initial assessment was reflected in the clients' overall care plan. The service had added a prompt to the initial assessment document to ensure staff explored clients' cultural and religious needs.

- During the inspection in January 2018, we found that most client care plans were up to date. However, we found that two out of 16 care plans were either not available or had not been updated since May 2017. The treatment records demonstrated that both clients had been comprehensively assessed but there was no care plan in place. Without a care plan, there was no record in place to reflect how the client would be supported and monitored.
- At the June 2016 inspection, we found that the quality of medical assessments was dependent on the staff member undertaking it. At the January 2018 inspection, we found that all of the clients had received comprehensive medical reviews.
- At our previous inspection in November 2016, we found that clients did not always receive a physical health assessment prior to treatment commencing and did not have their physical health monitored thereafter. During the January 2018 inspection, we found that this had significantly improved. We reviewed the records of clients who were new to the service and clients who were receiving treatment during the last inspection in November 2016. All clients had received a thorough and comprehensive physical health assessment. Clients who were prescribed medicines received a physical health check prior to the treatment starting.

Multidisciplinary and inter-agency team work

- The service had a new consultant psychiatrist in post. The doctor told us that the service has formed a good working relationship with the local general hospital.

Good practice in applying the MCA

- At the inspection in June 2016, we found that staff had not been trained in the MCA and did not have a good

Substance misuse/detoxification

understanding of the MCA. During the January 2018 inspection, we found that this had improved. Staff told us that they had received MCA training and were able to explain when an MCA assessment would be necessary. Staff understood that if they had concerns about a client they would raise it to the doctor.

Are substance misuse/detoxification services caring?

The involvement of clients in the care they receive

- During the June 2016 inspection, we identified that clients' carers and families were not consistently offered support by the service. At the time of the January 2018, we found that this was no longer the case. We reviewed 16 treatment records and found that all clients had been asked if they wished for their families or carers to be involved in their care. The treatment records demonstrated when necessary, staff ensured that support was provided. We found examples in records of staff working with families and involving carers in key working sessions.

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

The facilities promote recovery, comfort, dignity and confidentiality

- During the June 2016 inspection, we found that the service did not have a range of leaflets available to clients that reflected the local population. At the inspection in January 2018, this was no longer the case. The provider had a wide range of leaflets available in English and other languages. The leaflets covered various subjects including local mutual aid services.

Listening to and learning from concerns and complaints

- At the June 2017 inspection, we found that the complaints system in place was not effective. Clients who had complained had not received a response. During the January 2018 inspection, we found that the complaints process had improved. We reviewed two recent complaints and found that the service had

followed the provider's complaints policy. Both complaints were acknowledged and appropriately investigated within set timescales. A formal response was given to the complainants including information about the complaints appeal process. We spoke with two clients who told us that they felt confident to make a complaint and would speak with their keyworker.

Are substance misuse/detoxification services well-led?

Good governance

- At the June 2016 inspection, the provider's systems and processes were not operating effectively to ensure monitoring and improvement in the quality and safety of the service. The system in place to risk assess clients was not working properly and children at risk of potential abuse were not always identified. During the January 2018 inspection, the service had put effective systems in place to ensure that clients' health and wellbeing was closely monitored. The service had implemented a two hour, monthly safeguarding meeting for all staff to attend. This provided staff with an opportunity to review the safeguarding log. The safeguarding lead led this meeting and was responsible for updating the safeguarding log. The service ensured that the local early help team and multi-agency safeguarding hub (MASH) attended the meetings in order to share information. The provider had implemented a new morning meeting agenda, which was more detailed. The agenda included a discussion of clients who were attending, safeguarding concerns, and client referrals.
- During the January 2018 inspection, we found that the provider had implemented a full caseload review every two weeks and senior managers carried out monthly audits. The caseload review and audits checked to ensure clients had a risk assessment, GPs were updated, and clients received regular medical reviews. Outcomes of the audits were shared with managers and individual members of staff.
- Whilst the provider carried out regular full caseload reviews, the December 2017 review demonstrated that 49 out of 452 (11%) clients, who received structured treatment, such as prescribing, counselling, and psychosocial interventions, did not have an up to date

Substance misuse/detoxification

risk assessment in place. The registered manager was aware of this and told us part of the reason for the service closing early on Mondays, from the beginning of 2018, was to provide staff with the opportunity to focus on their administrative work. The management team were addressing the issue with staff in supervision sessions. We reviewed four keyworker supervision records and found that performance issues were followed up. Some staff had been put on performance improvement plans to ensure they were supported to improve.

- Whilst the service had improved systems in place to assess and monitor the quality and safety of the service, the provider had not ensured that all clients had a completed risk assessment in place. The provider's auditing system indicated that the provider was 89% compliant for completed risk assessments of clients in treatment. The compliance target was 100%. Because of the risky behaviours linked to clients who presented to the service, all clients required an up to date risk assessment or a written justification stating why this was not necessary.
- During the June 2016 inspection, we found that the needle exchange policy was outdated, the incident and accident policy had not been reviewed and the provider's prescribing policy was not in accordance with national guidance. At the January 2018 inspection, we found that this had improved and most policies had been updated. The provider's needle exchange policy

was up to date and the incident and accident policy had been published in November 2017. The provider's new prescribing policy was being updated through internal governance processes and was due to be signed off shortly. The provider was able to refer to other available protocols such as the drug formulary, which had been updated, whilst awaiting the publication of the new prescribing policy.

- At the June 2016 inspection, we found that the provider did not ensure that reportable incidents were notified to the Care Quality Commission (CQC). All services registered with the CQC are legally required to notify the CQC of certain incidents, without delay. During the January 2018 inspection, we found that this had improved. We found that the provider regularly notified CQC of reportable incidents. The registered manager told us once staff raised an incident internally, the manager would be notified and would be prompted to notify the CQC.

Leadership, morale and staff engagement

- At the January 2018 inspection, staff told us that there had been an improvement in the service since the inspections in 2016. Staff were positive about their job and felt supported by colleagues and their line manager. Staff were able to describe areas of the service that required improvement and were confidently able to explain how the issues had been addressed.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **SHOULD** take to improve

- The provider should ensure that all clients in treatment have a completed risk assessment and this is reviewed regularly in order to reflect the risks associated with substance misuse.
- The provider should ensure that the prescribing policy for drug and alcohol services is written in accordance with best practice guidance and is published for staff to use as soon as possible.
- The provider should ensure that the quality and safety of the care and treatment provided is monitored and continues to improve. This includes ensuring staff continue to improve on record keeping.