The Haynes Clinic

Quality Report

6-7 Warren Court
Chicksands
Bedford
SG175QB
Tel: 01462 851414
Website: www.thehaynesclinic.com

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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	**Requires improvement**
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Inadequate**

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 rated Haynes Clinic as requires improvement because:

- The provider's arrangements of governance oversight were not robust. We found policies were not detailed and did not include current national guidance for staff on how to deliver care. Including the safe guarding policy, infection control, fire, medicines management, duty of candour, supervision, Mental Capacity Act, Equality Act, mandatory training, emergency and business continuity, the control of substances hazardous to health and the complaints policy.
- There was no evidence of learning from incidents. For example, we found an unreported Care Quality Commission notifiable incident were a client drank half a bottle of bleach and was taken to hospital by paramedics. During the inspection we found cleaning chemicals including bleach in the bathrooms and kitchens.
- Ligature risks were not adequately mitigated. We found the ligature risk assessment was generic for all locations and did not identify specific risks. Fire risk assessments were not updated annually. We noted fire risk assessments were completed in 2013 and 2016.
- Client risk assessments did not include risk management strategies.
- There were blanket restrictions in place. Clients were not able to lock their bedroom doors and did not have anywhere secure to store their valuables in their bedroom.
- The provider did not store emergency medications in line with guidance such as Naloxone which is used to reverse the effects of an opioid overdose or an Epi Pen which is used to reverse an allergic reaction.
- We were not assured staff knew and understood the vision and values of the service. We reviewed the vision and values which were honesty, integrity and caring. There was no description detailing what the values meant and how the provider ensured staff applied them in their daily working.
- Maintenance issues were not identified at the at the residential houses. We found splits in the laminate flooring in the hallways and broken kitchen floor tiles.
- Cleaning chemicals were not stored in accordance with the Control of Substances Hazardous to Health Regulations 2002. We found cleaning chemicals including bleach in and disinfectants in the kitchen and bathrooms.

However

- The treatment centre had adequate space for staff to meet with clients. There was a small room where clients were seen on admission and received a physical health check. The service had access to emergency defibrillation equipment which was stored in the staff office and was calibrated and checked regularly. The three accommodation houses and treatment centre were visibly clean.
- Staff had access to individual alarms. Staff told us they were aware of personal safety procedures.
- Mixed gender accommodation at the three houses was managed appropriately.
- The registered manager had established the number of support workers and therapists required to meet the needs of the clients. At the time of inspection there were no staffing vacancies.
- Staff screened client's physical health observations on admission and regularly reviewed the client's vital observations during detoxification in line with best practice guidance.
- Clients were given information regarding the service and the detoxification programme and the risks involved in the process. Clients spoken with confirmed this. We saw clients were involved in planning their care. Care and treatment records were recovery focused and based on smart goals. Clients completed life stories and a 12-step recovery booklet that included preparation for discharge.
- We observed staff interacting in a kind and respectful manner throughout the day. Clients told us that staff

Summary of findings

at the service were supportive. Generally, the staff knew their clients and were aware of their needs. Clients told us they felt supported through the admission process and reported the pre-assessment was thorough.

Summary of findings

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The Haynes Clinic

Services we looked at:
Substance Misuse/detoxification

Summary of this inspection

Background to The Haynes Clinic

Haynes Clinic is a specialist substance misuse service that provides residential rehabilitation and detoxification treatment for clients who wish to enter treatment for addiction. All clients self-refer and are privately funded. The service provides a holistic therapy approach to addiction that includes supporting clients access the 12-Step principles of Narcotics Anonymous and Alcoholics Anonymous. Clients could engage in one to one cognitive behavioural therapy, family relationship groups and group therapy sessions.

Haynes Clinic has a treatment centre and three residential houses which are Cople (six beds), The Spinney (five beds) and Everton Park (seven beds). The treatment centre is located in Chicksands. The residential houses are located a short drive away. The provider has two minibuses which the clients utilise Monday to Friday to access the treatment centre.

The Haynes Clinic is registered with the Care Quality commission to provide:

- treatment of disease, disorder or injury.
- accommodation for persons who require treatment for substance misuse.

The last inspection of The Haynes Clinic was carried out in February 2018. Following the last inspection, we told The Haynes Clinic that it must take the following actions:

- The provider must adhere to a robust recruitment policy that ensures that all staff the service employs are qualified and competent and safe to work with the client group.
- The provider must ensure that staff are up to date with all mandatory training requirements.
- The provider must ensure emergency equipment is available on site.
- The provider must ensure that male and female clients have designated bathrooms.

We found the provider had taken action to address some of these issues.

Our inspection team

Team leader: Scott McMurray

The team that inspected the service comprised three CQC inspectors.

The inspection team would like to thank all those who met and spoke with them during the inspection.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme to make sure health and care services in England meet the Health and Social Care Act 2008 (regulated activities) regulations 2014.

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?

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:

- visited all three residential houses and the treatment centre, looked at the quality of the ward environment and observed how staff were caring for clients;
- spoke with 11 clients who were using the service;
- spoke with the registered manager;
- spoke with four other staff members
- attended and observed one hand-over meeting;
- looked at six care and treatment records of clients:
- carried out a specific check of the medication management;
- examined a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Clients told us that staff were kind, caring and responsive to their needs. However, clients felt there wasn't enough physical activity and access to outside space. They were either at the houses or the treatment centre and could only access the gym twice per week.

Clients told us they felt safe and that staff were always available at the service and they were involved with all aspects of their treatment which included planning for discharge.

Some clients told us they were unhappy because they were unable to lock their bedrooms.

One client told us they felt the website was misleading. The pictures of the houses on the website did not reflect the house where they are staying.

Clients told us they had not raised any formal complaints with the provider but were aware of the complaints process should they wish to do so.

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?

Requires improvement 

We rated safe as requires improvement because:

- Managers failed to identify maintenance concerns at the residential houses. There were splits in the laminate flooring in the hallways and broken kitchen floor tiles which was a health and safety risk to clients.
- Cleaning chemicals were not stored in accordance with the Control of Substances Hazardous to Health Regulations 2002.
- Ligature risk were not adequately mitigated. We found the ligature risk assessment was generic for all locations and did not identify specific risks.
- Fire risk assessments were not updated annually. We noted fire risk assessments were complete in 2013 and 2016.
- The provider did not store emergency medications in line with guidance such as Naloxone which is used to reverse the effects of an opioid overdose or an Epi Pen which is used to reverse an allergic reaction.
- Therapy staff did not complete mandatory training.
- Client risk assessments did not include risk management strategies.
- There were blanket restrictions in place. The provider expected clients to be in bed by 22:30. Clients were not able to lock their bedroom doors and did not have anywhere secure to store their valuables in their bedroom.
- We were not assured staff adhered to infection control principles when managing clinical waste. For example, we were told by staff once a urine test was complete the sample pot was emptied out in the staff toilet and the bottle was disposed of in the commercial bins.
- The safeguarding policy was out of date and did not contain detail how to protect clients from harassment and discrimination, including those with protected characteristics under the Equality Act.

However

- There was adequate space at the treatment centre for clients to attend one to one sessions, relax and engage with their peers

Summary of this inspection

whilst they had personal time. The accommodation houses were large and spacious. All clients had their own bedrooms. Some rooms were ensuite and some clients shared a communal bathroom.

- The three accommodation houses and treatment centre were visibly clean. It was the responsibility of staff and clients to clean to ensure the environment remained clean.
- Physical health monitoring equipment such as a blood pressure machine and a breathalyser were stored appropriately and calibrated in line with manufacture guidelines.
- Staff had access to individual alarms. Staff told us they were aware of personal safety procedures.
- The provider screened client's physical health observations on admission and regularly reviewed the client's physical health observation during detoxification in line with best practice guidance.
- Clients were given information regarding the service and the detoxification programme and the risks involved during the detoxification process. Clients spoken with confirmed this.
- There was a system in place for monitoring and ordering medications which included balance checking stock medications weekly.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- The provider did not have a supervision policy. Therapy staff did not receive supervision.
- The service did not have a Mental Capacity Act policy that staff could refer too.
- The equal opportunities policy did not refer to protected characteristics as set out in the Equality Act 2010.

However

- We reviewed six care and treatment records in depth and found evidence that clients were involved in the planning of their care. Clients set individual and group smart goals that were reviewed with their key worker.
- Clients had access to psychological and psychosocial therapies in line with the guidelines produced by the National Institute for Health and Care Excellence. For example, that clients have access to mutual aid support groups such as alcoholics anonymous which clients attended at a third-party location.

Summary of this inspection

- All client's folders were stored appropriately in a locked fire-retardant filing cabinet.
- The service promoted healthier lifestyles and supported clients to prepare healthy, well-balanced meals which accounted for cultural requirements, preferences, likes and dislikes.
- Staff conducted a daily handover meeting, which we observed. This meeting covered all areas of the client's needs such as, appointments, activities and any areas of concern.
- Recovery workers supported clients access to specialist advice such as, benefit advice, housing and debt management if required.
- Staff and clients completed discharge plans as part of their recovery planning.

Are services caring?

Good

We rated caring as good because:

- We observed staff interacting in a kind and respectful manner throughout the inspection.
- Clients told us that staff at the service were supportive. Generally, the staff knew their clients and were aware of their needs.
- There was evidence within the care and treatment records that staff supported clients to understand and manage their care and treatment plans.
- Staff gave examples to demonstrate how they kept client information confidential.
- Clients were given a satisfaction survey to complete when they had completed the programme and were ready for discharge. We reviewed the recent analysis of the satisfaction survey and it was positive.

However:

- Some clients told us they were unhappy because they were unable to lock their bedrooms.
- One client told us they felt the website was misleading. The pictures of the houses on the website did not reflect the house where they are staying.

Are services responsive?

Good

We rated responsive as good because:

- Clients told us they felt supported through the admission process and reported the pre-assessment was thorough.

Summary of this inspection

- An aftercare group was provided to all clients who used the service for up to one-year post treatment. Support offered was attending group and psychosocial support.
- There were adequate therapy rooms located throughout the treatment centre and the three accommodation houses. Clients also had access to the laundry facilities as required.
- The service had an activity time table that covered seven days per week and included evening activities for clients to participate in, for example, clients told us they could attend yoga and peer led groups.
- Out of area clients were given information regarding groups and services in their local area upon discharge.
- Clients told us they could access the treatment needed to meet their needs in a timely manner and treatment was never cancelled.
- Clients told us they knew how to raise a complaint within the service.

Are services well-led?

Inadequate

We rated well-led as inadequate because:

- The provider's arrangements of governance oversight were not robust. We reviewed 10 policies and procedures prior to the inspection, submitted as part of the provider information returns pack and examined the providers policy and procedure folder during the inspection and found the policies and procedures lacked detail, scope and purpose. We examined the provider's policy folder whilst on site and found a which
- The provider did not use key performance indicators to monitor operational and clinical performance. The provider did not use a risk register to robustly manage risks. Audits were not adequate and did not improve the quality of the service. The registered manager signed care files to evidence a file audit was complete however the manager did not use an auditing tool or standard template to ensure consistency.
- The provider submitted a health and safety audit after the inspection was conducted. The health and safety audit was complete by a third-party provider on the 08 February 2018. Not all high risk or medium risk items have been actioned.
- There was no evidence of learning from incidents. For example, we found an unreported Care Quality Commission notifiable

Summary of this inspection

incident were a client drank half a bottle of bleach and was taken to hospital by paramedics. During the inspection we found cleaning chemicals including bleach in the bathrooms and kitchens and were not stored securely.

- We were not assured staff knew and understood the vision and values of the service. We reviewed the vision and values which were honesty, integrity and caring. There was no description detailing what the values meant and how the provider will ensure staff apply them in their daily working.
- However
- The registered manager understood the services they managed. They could explain how the team were working to provide care for clients using the service.
- Staff and clients told us that both managers and the treatment director were visible and approachable if they wanted to speak to them.
- Staff reported good morale amongst the team. Staff spoken with told us they enjoyed coming to work and the team worked well together.
- All client information needed to deliver care was stored securely and available to staff, in an accessible form, when they needed it.

Detailed findings from this inspection

Mental Health Act responsibilities

The provider did not admit clients detained under the Mental Health Act as they were not registered to do so. However, the provider did provide Mental Health Act awareness training to all staff.

Mental Capacity Act and Deprivation of Liberty Safeguards

The provider did not have a Mental Capacity Act and Deprivation of Liberty Safeguarding policy in place. Care staff and Office staff received mental capacity training however the therapy staff were not expected to complete mandatory training.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Substance misuse/ detoxification	Requires improvement	Requires improvement	Good	Good	Inadequate	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Good	Inadequate	Requires improvement

Requires improvement

Substance misuse/detoxification

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Good
Well-led	Inadequate

Are substance misuse/detoxification services safe?

Requires improvement

Safe and clean environment

- The treatment centre had adequate space for staff to meet with clients. There was a small room where clients were seen on admission and received a physical health check. The service had access to an emergency defibrillation machine which was stored in the staff office and was calibrated and checked regularly.
- There was adequate space at the treatment centre for clients to attend one to one sessions, relax and engage with their peers whilst not attending group sessions. The accommodation houses were large and spacious. All clients had their own bedrooms. Some rooms were ensuite and some clients shared a communal bathroom.
- The three accommodation houses and treatment centre were visibly clean. It was the responsibility of staff and clients to clean to ensure the environment remained clean. All clients were allocated roles as part of their therapeutic recovery programme. We found the service did not have cleaning schedules that were complete after each task was complete, therefore it was difficult know who had completed the cleaning task.
- Managers failed to identify maintenance concerns at the three houses. There were splits in the laminate flooring in the hallways and broken kitchen floor tiles which were an infection control risk and also a risk of injury to clients.
- Cleaning chemicals were not stored in accordance with the Control of Substances Hazardous to Health Regulations 2002. There was evidence cleaning chemicals were stored in bathrooms and kitchens at the residential houses.
- Ligature risks were not adequately mitigated. We found the ligature risk assessment was generic for all locations and did not identify specific risks. Where risk where identified there were no control measures in place.
- Fire risk assessments were not updated annually. We noted fire risk assessments were last completed in 2013 and 2016. However, firefighting equipment was checked annually by a competent third-party person in line with best practice. There was evidence emergency lighting was reviewed by an external company.
- The residential houses did not have clinic rooms. Medications were stored in the staff room in a locked metal cupboard, there was evidence staff checked the room temperature regularly. Physical health observations were carried out in the staff room or the client's bedroom for privacy.
- We saw hand wash notices throughout the locations. Staff told us they understood infection control principles however we did not find an infection control policy in the policy folder. We were not assured staff adhered to infection control principles when managing clinical waste. For example, we were told by staff once a urine test was complete the bottle was emptied out in the staff toilet and the bottle was disposed of in the commercial bins.

Requires improvement

Substance misuse/detoxification

- Physical health monitoring equipment such as a blood pressure machine and a breathalyser were stored appropriately and calibrated in line with manufacturing guidelines.
- Staff had access to individual alarms. Staff told us they were aware of personal safety procedures. There had been one incident were staff were required to summon help in an emergency in the last 12 months prior to inspection which was managed appropriately.
- Mixed gender accommodation at the three accommodation houses was managed appropriately.

Safe staffing

- The registered manager had established the number of support workers and therapists required to meet the needs of the clients. At the time of inspection there were no staffing vacancies. Substantive staff worked together as a team to cover sickness and annual leave. The service reported no agency use over the last 12 months leading up to the inspection.
- The provider used a consultant psychiatrist to assess clients on admission and review clients during detox. However, we found the provider did not have a service level agreement or a contract in place with them. This was escalated to the registered manager who arranged a contract to be completed the following day.
- Therapy staff did not complete mandatory training which was not detailed in the providers policy. However, we found care staff and office staff were mostly up to date with mandatory training. Mandatory training included safeguarding, medication administration, first aid, Mental Capacity Act training and fire safety training.

Assessing and managing risk to patients and staff

- We examined six care and treatment records in depth and found all clients received an assessment on admission. Where necessary the provider used dependency scales for measuring level of dependency before admission in line with best practice.
- Client's risk assessments identified known risks such as physical health concerns, violence and same sex gender accommodation risks. We found all six records reviewed, clients had a risk assessment complete on admission however where a risk was identified the clients did not have a risk management strategy.
- The provider screened client's physical health observations on admission and regularly reviewed the client's physical health observation during detoxification in line with best practice guidance. Staff told us if they were concerned with a client's physical health they would speak to the psychiatrist or call 999 in an emergency.
- Clients were given information regarding their treatment options and the risks associated with treatment prior to admission to the service.
- We found all six records reviewed, clients had a risk assessment complete on admission however where a risk was identified the clients did not have a risk management strategy.
- There were blanket restrictions in place. The provider expected all clients to be in bed for 22:30. Clients were not able to lock their bedroom doors and did not had have anywhere secure to store their valuables in their bedroom. Staff were responsible for the safe keeping of client's mobile phones and laptops and clients could use the devices at agreed times.

Safeguarding

- Care staff and office staff received safeguarding adults and children training. Staff spoken with where able to describe the process and gave good examples when to raise a safeguarding concern.
- We found the safeguarding policy was last printed in 2013 and did not contain up to date key changes to safeguarding such as the Care Act 2014 which details how to protect clients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff access to essential information

- The provider used a paper based recording system which all staff had access too. Records were stored appropriately and in fire proof cabinets. Staff spoken with were aware of the clients right to see their care records upon request.
- Clients were given information regarding the service and the detoxification programme and the risks involved during the detoxification process. Clients spoken with confirmed this.

Medicines management

Requires improvement

Substance misuse/detoxification

- The provider's medication management policy was not robust. It did not reflect National Institute for Health and Care Excellence guidelines regarding: prescribing, detoxification, assessing people's tolerance to medication.
- There was a system in place for monitoring and ordering medications which included stock counting medications weekly. Controlled drugs were stored appropriately and the controlled drugs register was completed in full.
- The provider used local pharmacies to collect medications. Staff responsible for handling medication had complete medication administration training.
- We reviewed six medication cards and found they were mostly filled in correctly. However, we found an example of one medication recording form where the name of the medication was not at the top of the medication sheet which made it difficult to follow the medication card. This was escalated at the time of inspection.
- Staff completed withdrawal scales such as the severity of alcohol dependence questionnaire, clinical institute withdrawal assessment for alcohol and the clinical opiate withdrawal scale to monitor the severity of the client's withdrawal symptoms.

Track record on safety

- The service had not reported any serious incidents over the last 12 months prior to the inspection.

Reporting incidents and learning from when things go wrong

- We found evidence of an incident that was not reported to the Care Quality Commission as required by regulation. It is a legal requirement for providers to report specific incidents such where a patient has been harmed. This was escalated to the provider at the time of inspection.
- The providers incident policy did not include duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify clients (or other persons) of certain notifiable safety incidents and provide reasonable support to that person.

Are substance misuse/detoxification services effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- We reviewed six care and treatment records and found all clients received a comprehensive assessment on admission which included physical health assessment. There was evidence the provider used national dependency tools such as the severity of alcohol dependence questionnaire for measuring alcohol dependence in line with National Institute for Health and Care excellence guidelines.
- Clients were involved in the planning of their care. We saw evidence clients set individual and group smart goals that were reviewed with their key worker.
- Clients were able to register with the local GP if required. The service had an agreement in place with the consultant psychiatrist who assessed clients on admission and reviewed as required through the detox programme. There was no contract or service level agreement in place at the time of inspection. The registered manager provided a contract with the psychiatrist the day after the inspection.
- Care and treatment records were recovery focused and based on holistic, smart goals. clients completed life stories and a 12-step recovery booklet that included preparation for discharge. Life stories were discussed with therapy staff as part of the therapy programme.

Best practice in treatment and care

- The service promoted a total abstinence from mood altering substances and did not advocate harm minimisation.
- Clients had access to psychological and psychosocial therapies in line with the guidelines produced by the National Institute for Health and Care Excellence. For example, that clients have access to mutual aid support groups such as alcoholics anonymous which clients attended at a third-party location.

Requires improvement

Substance misuse/detoxification

- There was evidence in client's folders blood borne viruses were discussed at admission. The registered manager told us clients could access local specialist service for treatment if required.
- The service promoted healthier lifestyles and supported clients to prepare healthy well-balanced meals which accounted for cultural requirements, preferences, likes and dislikes.
- Staff used technology to support clients effectively for example. The service had a room available for clients to use skype to speak with members of their family if required.
- We were not assured appropriate good quality clinical audits were completed. For example, medications were stock checked and the care and treatment records were signed to say they were audited weekly. However, there was no recorded evidence of continuous improvement post audit. The registered manager did not use an auditing tool when checking client files.

Skilled staff to deliver care

- All care staff received an induction which included shadowing experienced staff and some training before they were deemed competent by the registered manager to work with clients independently.
- The provider did not ensure all staff completed mandatory training. We were told only care staff and office staff were required to renew mandatory training every three years. Therapy staff were not required to complete mandatory training. This was not detailed in the providers training policy.
- Where training was due to expire the registered manager booked staff on to the relevant training course.
- Staff had access to further specialist training such as the qualification and credit framework diploma level two and three which replaced the national vocational qualifications in health and social care.
- The service had a recruitment process in place. We reviewed six staff personnel files in depth and found they were not organised. Where there was a disclosure on the form, a risk assessment was completed by the registered manager.
- The registered manager provided supervision to care staff and office staff. At the time of inspection 100% of office and care staff had received supervision. We reviewed supervision records and found they were short and lacked detail.
- Therapy staff did not receive managerial supervision and were responsible for sourcing their own supervision from an external therapist. The provider did not have a supervision policy in place to reflect the supervision structure of the service. We were told therapy staff receive external clinical supervision however the provider did not track when therapy staff received clinical supervision.
- All relevant staff had an annual appraisal. The registered manager did not have an appraisal log however the manager completed appraisal at the same time each year.

Multi-disciplinary and inter-agency team work

- Staff conducted a daily handover meeting, which we observed. This meeting covered all areas of the client's needs such as, appointments, activities and any areas of concern.
- The therapy team met regularly where they discussed all clients, their outcomes and progress made for example during the morning handover and before group therapy.
- The service held regular staff team meetings and followed a set agenda.
- We were told the service had good working relationships with the local authority and other local health services.
- Staff had an awareness of local third-party services clients who were ready for discharge were informed of services such as local mutual aid groups.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

- The service did not admit clients to the service detained under the Mental Health Act.

Good practice in applying the Mental Capacity Act

- The service did not have a Mental Capacity Act policy that staff could refer too. Care and office staff completed

Requires improvement

Substance misuse/detoxification

Mental Capacity Act and Deprivation of Liberty Safeguards training every three years. However, therapy staff did not complete mandatory training which was not detailed in the providers policy.

- Client's capacity to consent to treatment was discussed during the admission process. Staff were able to demonstrate an understanding of the five statutory principles and the process they would take if they suspected a client lacked capacity.

Equality and human rights

- The provider had an equal opportunities policy in place however the policy did not refer to the Equality Act 2010. Staff told us they were aware of the equality act and were able to demonstrate an understanding of cultural differences and were able to meet the needs of culturally diverse clients.
- The service restricted patient access to their mobile phones during their treatment. Clients agreed set times with staff when they could access their phones. This was to ensure clients engaged in treatment whilst at the treatment centre. Plans were in place for named contacts to contact clients through the providers phone in case of an emergency.

Management of transition arrangements, referral and discharge

- The service had an admission criterion which staff were aware of. The registered manager screened all referrals and discussed them with the consultant psychiatrist to assess if they were able to meet the client's needs. If the provider was not able to admit a client due to their complex needs the provider was able to advise on other specialist services.
- Care staff supported clients' access to specialist advice such as, benefit advice, housing and debt management if required.
- Staff and clients completed discharge plans as part of their recovery planning. All clients were given a discharge summary upon the completion of their treatment which was complete by the registered manager.

Are substance misuse/detoxification services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

- We observed staff interacting in a kind and respectful manner through the day.
- Clients told us that staff at the service were supportive. Staff spoken with knew clients well and were aware of their needs. Clients told us they felt supported through the admission process and reported the pre-assessment was thorough.
- Some clients told us they were unhappy because they were unable to lock their bedrooms. One client told us they felt the website was misleading. The pictures of the houses on the website did not reflect the house where they are staying.
- Staff and clients told us they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes to clients without fear of the consequences.
- There was evidence within the care and treatment records staff supported clients to understand and manage their care, treatment plans
- Staff directed clients to other services when appropriate and, if required, supported them to access those services. For example, housing information and other peer support groups in their local areas.
- We were told clients used the staff toilet in the main reception area to provide a urine sample for testing. Staff complete the testing and tested the urine sample in the main foyer area which compromised the clients right to privacy and dignity.
- Staff were able to demonstrate that they understood how to keep client information confidential.

Involvement in care

- Staff gave all new clients a welcome pack which detailed what to expect, key staff and the facilities on offer. Clients were orientated to the service by their peers and key worker.

Requires improvement

Substance misuse/detoxification

- We saw evidence that clients were involved in developing and setting their care plan goals. Clients had a named key worker who they met with weekly. Clients spoken with confirmed this.
- Staff held weekly community meetings. Clients told us they could raise issues or concerns at the meetings and staff would address the issues raised.
- There were suitable areas for families, friends and carers to meet with their relatives whilst visiting.
- Clients were given a satisfaction survey to complete once they had completed the programme and were ready for discharge. The satisfaction survey included patient views on the programme and made suggestions how to improve the programme. We reviewed the recent analysis of the satisfaction survey and it was positive.

Involvement of families and carers

- Carers were able to access family therapy groups. The groups were facilitated at the weekend to account for people who work during the week.

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

Good

Access and discharge

- The service had an admission criteria and admission process. All clients received an assessment on admission which included physical observations. The registered manager told us if the service was unable to meet the needs of the client, the registered manager and consultant psychiatrist would inform the client of further treatment providers.
- Clients told us they felt supported through the admission process and reported the pre-assessment was thorough.
- Staff developed care plans and risk assessments on the day of admission. However, the risk assessments did not include a risk management strategy. Care plans and client goals were reviewed regularly during treatment.
- An aftercare group was provided to all clients who used the service for up to one-year post treatment. Support offered was attending group therapy and psychosocial support.
- Staff planned for client's discharge. Clients were given information regarding their local services such as alcoholic anonymous. We observed staff supporting clients during referrals and transfers between services – for example, if they were attending a hospital appointment.

The facilities promote recovery, comfort, dignity and confidentiality

- Clients had their own bedrooms and did not have to share their rooms. At the time of the inspection, the provider adequately managed mixed sex accommodation in line with national guidance.
- There were enough therapy rooms located throughout the treatment centre and the three accommodation houses. Clients also had access to the laundry facilities as required.
- The service had an activity time table that covered seven days per week and included evening activities for clients to participate in, for example, clients told us they could attend yoga, mindfulness and peer led groups.
- Clients spoken with told us they were able to make snacks and drinks through the day but felt they were not able to through the night.

Patients' engagement with the wider community

- Clients could access family therapy sessions if required. The focus of the family therapy sessions was to promote a positive relationship with their family members which was held on a Saturday to account for individuals who worked through the week.
- Clients were able to access the local community to access the gym and third-party services such as Alcohol and Narcotics Anonymous. Out of area clients were given information regarding groups and services in their local area upon discharge.

Meeting the needs of all people who use the service

Requires improvement

Substance misuse/detoxification

- The providers equal opportunities policy did not reflect current national guidance of best practice and did not detail potential issues faced by monitor groups such as the lesbian, gay and bisexual (LGBT) and black and ethnic (BAME) groups as well as older people.
- Clients spoken with could access the treatment needed to meet their needs in a timely manner and was rarely cancelled.

Listening to and learning from concerns and complaints

- The provider complaint policy was not robust. The policy did not provide contact deals for people responsible for managing the complaint, lacked detail regarding the right to appeal and did not explain the role of the ombudsman.
- There were two formal complaints raised over the last 12 months leading up to the inspection One complaint was partially upheld. We saw evidence the provider responded to the complaints in a timely manner.
- Staff told us they knew to how manage a complaint and that the registered manager would investigate complaints raised.
- Clients spoken with told us they knew how to raise a complaint within the service.

Are substance misuse/detoxification services well-led?

Inadequate

Leadership

- The registered manager had an understanding of the service they managed. They could explain how the team were working to provide care for clients using the service.
- The registered manager attended the morning handover meeting and was aware of daily incidents and client progress.
- Staff and clients spoken with told us the registered manager was visible and approachable if they wanted to speak to them.

Vision and strategy

- We were not assured staff knew and understood the vision and values of the service. We reviewed the vision and values which were honesty, integrity and caring. There was no description detailing what the values meant and how the provider ensured staff apply them in their daily working.
- We reviewed six staff files and found five staff had a job description. However, the consultant psychiatrist did not have a job description or a contract in place. The registered manager submitted evidence of a contract of employment the following day.
- Staff could contribute ideas towards the running of the service at team meetings.

Culture

- Staff told us they felt respected and valued by their peers and managers. Work related stress was manageable and did not impact on their roles.
- Staff reported good morale amongst the team. Staff spoken with told us they enjoyed coming to work and the team worked well together.
- All staff received an annual appraisal.
- There was no recorded evidence of bullying or harassment.
- Staff had access to support for their own physical and emotional health needs through the consultant psychiatrist.

Governance

- The provider's arrangements of governance oversight were not robust. We reviewed 10 policies and procedures prior to the inspection, submitted as part of the provider information returns pack and examined the providers policy and procedure folder during the inspection and found policies and procedures lacked detail, scope and purpose. For example, the safeguarding policy was last printed in 2013. The policy had been signed to suggest it was reviewed annually however, the policy did not contain up to date key changes to safeguarding such as modern-day slavery and female genital mutilation as set out in the Care Act 2014. Other policies we found to require review and amendment included infection control, fire, medicines management, duty of candour, supervision, Mental Capacity Act, Equality Act, mandatory training,

emergency and business continuity, the control of substances hazardous to health and the complaints policy. The lack of robust policies and procedures in place would impact on staff who were new to the service would not have a clear understanding of the governance process of the provider.

- The service held regular team meetings that followed a set agenda which included discussions about incidents and complaints. Staff spoken with were aware of the two complaints received over the last 12 months.
- The registered manager did not ensure therapy staff complete mandatory training. This was not reflected in the providers training policy.
- There was no evidence of learning from incidents. For example, we found an unreported Care Quality Commission notifiable incident were a client drank half a bottle of bleach and was taken to hospital by paramedics. During the inspection we found cleaning chemicals including bleach in the bathrooms and kitchens and were not stored securely. The provider did not have a policy for the control of substances hazardous to health.

Management of risk, issues and performance

- The provider did not use key performance indicators to monitor operational and clinical performance. Audits were not adequate and did not improve the quality of the service. The registered manager signed care files to evidence a file audit was complete however the manager did not use an auditing tool or standard template to ensure consistency.
- The provider submitted a health and safety audit after the inspection was conducted. The health and safety audit was completed by a third-party provider on 08 February 2018. Not all high risk or medium risk items were completed by the date set out in the audit findings.
- We were not assured the provider managed risk appropriately. The provider did not operate a corporate or local risk register.
- Emergency and business continuity plans lacked detail. For example, there was no detail of contractor contact information for staff to contact in an emergency such as loss of power or water.

Information management

- All client information needed to deliver care was stored securely and available to staff, in an accessible form, when they needed it. Client information was recorded on a paper based system in their individual personnel files. All files were stored in a lockable cupboard. Staff told us they had access to the files as and when required.
- There was evidence that confidentiality agreements were in place and staff requested client's permission before sharing personal information with their family. Staff spoken with could demonstrate the principles of confidently.

Engagement

- Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used – for example, through team meetings and information regarding the service welcome packs.
- Clients were given the opportunity to provide feedback during weekly community meetings and at the end of treatment clients were offered a satisfaction questionnaire.
- Families and carers were given the opportunity to provide feedback in the form of questionnaires, over the phone and face to face.

Learning, continuous improvement and innovation

- The service did not participate in any nationally recognised accreditation schemes.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure all cleaning chemicals are stored in accordance with the Control of Substances Hazardous to Health Regulations 2002.
- The provider must ensure all maintenance concerns are identified and repaired in a timely manner.
- The provider must ensure all staff receive regular supervision. Supervision records must be comprehensive.
- The provider must ensure the ligature risk assessment identifies all ligature risks and includes mitigating risks identified.
- The provider must ensure risk assessments have associated risk management strategies.
- The provider must ensure clients are able to lock their bedrooms with suitable locks.
- The provider must ensure all notifiable incidents are reported to the Care quality commission without delay.
- The provider must ensure governance systems are robust, including adequate self-audits and a risk register.
- The provider must ensure fire risk assessments are update annually and take action where areas of concern are identified.
- The provider must ensure all staff complete mandatory training.
- The provider must ensure staff adhere to the infection control principles when handling clinical waste.
- The provider must ensure clients urine testing is conducted in a private area to maintain client's privacy and dignity
- The provider must ensure all policies and procedures reflect current national best practice.
- The provider must implement a Mental Capacity Act policy.
- The provider must ensure all actions found through auditing are complete in line with recommended time scales based on risk.
- The provider must ensure they review blanket restrictions. Where blanket restrictions are in place all clients must have a personalised care plan and risk assessment.

Action the provider SHOULD take to improve

- The provider should ensure all staff are aware of the providers vision and values.
- The provider should ensure all medication cards are complete in full.
- The provider should ensure clients have access to outside space.
- The provider should ensure the business continuity plan has details of contractor contact information for staff to contact in an emergency such as loss of power or water.
- The provider should track therapy staff supervision to assure themselves that therapy staff access regular clinical supervision.
- Staff files should be organised and all information easily accessible.
- The provider should monitor client success post treatment.
- The provider should use cleaning schedules to track who completed specific housekeeping cleaning tasks.

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 9 HSCA (RA) Regulations 2014 Person-centred care Clients were not able to lock their bedrooms

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Urine tests were conducted in public areas.

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Ligature risk assessments were generic and did not identify specific risks Fire risk assessments were not up to date COSHH materials were not stored appropriately Staff did not manage clinical waste appropriately Not all maintenance issues were identified

This section is primarily information for the provider

Requirement notices

Not all high and medium risk actions identified through third party audits were complete

Risk assessments did not include risk management strategies

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 18 HSCA (RA) Regulations 2014 Staffing Not all staff completed mandatory training Not all staff received managerial supervision

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider's arrangements of governance oversight were not robust. We reviewed 10 policies and procedures prior to the inspection, submitted as part of the provider information returns pack and examined the providers policy and procedure folder during the inspection and found policies and procedures lacked detail, scope and purpose.