No 11

Quality Report

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

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

I am placing the service into special measures due to its failure to follow best practice for the safe detoxification of clients withdrawing from alcohol, its premises not being properly protected from the risk of fire and the lack of management oversight of safety and quality.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Professor Edward Baker
Chief Inspector of Hospitals

Overall summary

We rated the service **inadequate** overall because:

- The service provided medically monitored residential substance misuse detoxification treatment and psycho-social rehabilitation services. The service did not provide safe care for clients undergoing alcohol detoxification. The provider accepted clients for alcohol detoxification who had a history of alcohol withdrawal seizures and delirium tremens. This carried a level of medical risk that was not fully assessed prior to admission.
- We were concerned that the provider had not full taken account of a CQC briefing (supported by Public Health England) on the quality and safety of detoxification in residential substance misuse services. This was circulated to providers of all relevant services in 2017 and it remains on our website: https://www.cqc.org.uk/sites/default/files/20171130_briefing_sms_residential_detox.pdf
- Clients did not have a comprehensive assessment before commencing alcohol detoxification treatment. There was no record that clients had a physical examination, including for clients with a reported physical health problem. This included clients with possible or actual liver disease.
- Clients did not have a cognitive assessment. This meant clients were not screened for Wernicke's encephalopathy. Wernicke's encephalopathy can result in irreversible brain damage if left untreated.
- Clients were not asked about, or offered, screening for blood borne viruses, such as hepatitis and HIV.
- Clients' medical and mental health history was not always obtained from other healthcare professionals prior to detoxification treatment. This meant important information concerning clients' health was not always known. When clients refused to consent for the service to contact their GP, there was no record to show a clinician had reviewed the decision to make sure it was safe to provide treatment without this information.
- Environmental and health and safety risks were not managed. Actions recommended in a fire risk assessment dated March 2017 had not been actioned. Due to our concerns we requested an urgent visit from the fire safety officer from the London Fire Brigade. They carried out a visit on the 3 May 2019. They have told us they are taking further action.
- The service did not have effective systems for the appropriate and safe use of medicines, this put people

Summary of findings

at risk of receiving unsafe care and treatment. The service's medicine policy did not address all relevant areas. There were no prescribing protocols in place, doctors prescribed on an individual basis.

- One of the GPs prescribing for clients undergoing alcohol detoxification treatment had not had any specific training in treatment for substance misuse.
- Some staff had not completed, or updated, all of their mandatory training.
- At our last inspection, we recommended that the provider ensured that staff supervision continued for all staff and was recorded. At this inspection staff reported that they had regular supervision. However, staff supervision records were not available to confirm the frequency, quality and content of staff supervision.
- Staff team meeting minutes for 2018 were not available. Team meetings did not include any standing agenda items concerning safeguarding, referrals, incidents or complaints.
- The governance systems and processes in the service were not effective and did not keep people safe. They were not sufficient to assess, monitor and improve the safety and quality of the service. Risks were not appropriately identified, monitored and minimised.
- Managers lacked a clear understanding of regulatory requirements. Auditing processes were not robust and concerns were not always identified and acted upon. There was no system to ensure that best practice and national guidance was consistently followed.
- The provider did not have a proper process to make robust assessments to meet the fit and proper persons regulation (FPPR) (Regulation 5 of the Health and Social Care Act 2008).

However:

- At our last inspection, we identified that physical health monitoring equipment had not been regularly serviced and staff were not aware of their duty of candour. At this inspection, these matters had been resolved.
- People were cared for in a clean and comfortable environment and there were enough staff to meet the needs of the client group. Clients were supported and treated with dignity and respect and were involved as partners in their care. Clients were supported to understand and manage their care and treatment. The service offered family interventions and post discharge support groups.
- Clients were supported with their recovery journey. There was an extensive programme of individual and group activities that reflected patients' individual needs and preferences. Clients had clear and detailed plans in place in the event of their unexpected exit from treatment.
- Clients knew how to complain or raise concerns. Clients were able to give feedback on the quality of their experience. This was reviewed by the management team to make improvements to the service.
- Staff felt respected, supported, valued and were positive about working for the provider and their team.

We informed the provider of our serious concerns during and immediately after this inspection. We sent a letter of intent (notice of CQC's intention to take urgent action) to the provider about our concerns in relation to how assessment and treatment for clients' detoxification was being managed. The provider decided to stop providing alcohol detoxification treatment to clients with a history of alcohol withdrawal seizures or delirium tremens. The provider also sent an action plan to address our other immediate serious concerns. We have also taken other enforcement action concerning breaches of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. The details are found at the end of this report.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Residential substance misuse services	Inadequate 	

Summary of findings

Contents

Inadequate

No 11

Residential substance misuse services

Summary of this inspection

Background to No 11

No 11 is a three-bedded unit based in a mews house in Kensington. It is run by PROMIS clinics, which has two other services on the same street called No 12 and No 4. While the three are registered separately, they operate as one service with the same manager and the same staff covering the three locations. We completed one inspection which reviewed the three registered locations.

Clients in the three services use the same communal areas in No 11, including a kitchen and a living room. The clinic room for the three services is in No 11. There are some therapy rooms, which are used by clients across the services, in No 12.

At the time of our inspection, there were two clients in residence at No 11.

The service provides medically monitored alcohol and drug rehabilitation services including a psychological therapy programme.

The service is registered to provide the following regulated activities:

- Accommodation for persons who require treatment for substance misuse
- Treatment for disease, disorder and illness

No 11 was first registered with CQC in November 2012. We have inspected No 11, five times since 2012. Reports of these inspections were published between October 2013 and September 2017. All inspections of No 11 have been carried out simultaneously with an inspection of No 12. For the last inspection in August 2017, this also included No 4.

At the last inspection in August 2017, we followed up on the breach from the focused inspection in January 2017 in relation to Regulation 18 staffing, where nursing staff did not have access to clinical supervision. We found that whilst a new supervision schedule had been introduced it was not fully embedded within the service. As a result, we recommended that the provider continue to monitor and record supervision.

Our inspection team

The team that inspected the service comprised three CQC inspectors, one CQC pharmacy inspector and one specialist professional advisor with experience of working in the field of substance misuse as a nurse.

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 and to follow up on the recommendations from the last inspection in August 2017.

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. This inspection was unannounced, which meant the provider did not know we were coming.

During the inspection visit, the inspection team:

- visited the service and undertook an assessment of the quality of the environment and observed how staff were caring for clients
- spoke with three clients using the service
- spoke with the director of clinical treatment and service manager
- spoke with four other staff
- observed a multi-disciplinary team meeting
- looked at five client care and treatment records
- carried out a specific check of the medication management procedures and medication administration records
- looked at policies, procedures and other documents relating to the running of the service
- requested an urgent inspection by a fire safety officer from the London Fire Brigade.

What people who use the service say

We spoke with three clients who used the service.

All the clients we spoke with were happy with the service. Clients told us that they felt involved in decisions about their care and treatment. Clients said that staff were caring, supportive and helpful. Clients described staff as easy to approach, accessible and responsive to their needs. Clients reported that all the client areas and furnishings were well-maintained.

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?

Inadequate 

We rated safe as **inadequate** because:

- The service did not provide safe care for clients undergoing alcohol detoxification. The provider accepted clients for alcohol detoxification who had a history of alcohol withdrawal seizures and delirium tremens. This carried a level of medical risk that was not fully assessed prior to admission.
- Clients did not have a comprehensive assessment before commencing alcohol detoxification treatment. There was no record that clients had a physical examination, including for clients with a reported physical health problem.
- Clients did not have a cognitive assessment. This meant clients were not screened for Wernicke's encephalopathy. Wernicke's encephalopathy can result in irreversible brain damage if left untreated.
- Clients medical and mental health history was not always obtained from other healthcare professionals prior to detoxification treatment. This meant important information concerning clients health was not always known. When clients refused to consent for the service to contact their GP, there was no record that staff considered if it remained appropriate to provide treatment without this information.
- Environmental and health and safety risks were not managed. Actions identified in a fire risk assessment in March 2017 had not been addressed. Due to our concerns we requested an urgent visit from the fire safety officer from the London Fire Brigade. They carried out a visit on the 3 May 2019. They have told us they are taking further action.
- The service did not have effective systems for the appropriate and safe use of medicines, this put people at risk of receiving unsafe care and treatment. The service's medicine policy did not cover all relevant areas and it contained reference to out of date guidance. There were no prescribing protocols in place, doctors prescribed on an individual basis.
- At our last inspection we recommended that the provider ensured that clients were comprehensively risk assessed with risk management plans put in place prior to starting treatment.

Summary of this inspection

At this inspection, we found that whilst some risks to clients were identified, this did not amount to a full assessment of risks nor were they fully documented. This meant that full assessment information was not available to other staff.

However:

- People were cared for in a clean and comfortable environment and there were enough staff to meet the needs of the client group.
- At our last inspection, we identified that physical health monitoring equipment had not been regularly serviced and staff were not aware of their duty of candour. At this inspection, these matters had been resolved.

Are services effective?

Requires improvement

We rated effective as **requires improvement** because:

- Clients' needs were not compressively assessed, and care and treatment was not always delivered in line with current standards and evidence-based guidance.
- Clients were not asked about, or offered, screening for, blood borne viruses, such as hepatitis and HIV.
- Supervision records for all staff were not maintained. There were no staff team meeting minutes for meetings held in 2018. The team meetings did not include any standing agenda items concerning safeguarding, referrals, incidents or complaints. Regular team meetings did not take place.

However:

- Staff used the appropriate tools when assessing clients for alcohol detoxification treatment or opiate withdrawal. Psychological therapies and interventions followed guidance from the National Institute for Health and Care Excellence. Clients accessed individual and group therapy sessions.
- Staff sought clients' consent prior to them starting treatment.

Are services caring?

Good

We rated caring as **good** because:

- Clients were supported and treated with dignity and respect and were involved as partners in their care.

Summary of this inspection

- Staff were caring and demonstrated positive attitudes and behaviours towards clients. Clients were very happy with the service they received. Staff respected clients' personal, cultural, social and religious needs.
- Staff involved clients in understanding and managing their care and treatment. Clients felt their care and treatment plans reflected their personal preferences and discussed these regularly with staff.
- Clients felt involved and informed around their care and treatment. Clients were able to provide feedback individually and in group settings while in the service and/or at point of discharge.
- The service encouraged family contact and input into individual and group sessions with clients. Staff provided information and signposting to external services to support family members.

Are services responsive?

Good 

We rated responsive as **good** because:

- The needs and preferences of different clients were considered when delivering services.
- Each client could personalise their bedrooms and could keep their belongings secure. There were quiet areas clients could use for privacy.
- The food was of a high quality and reflected client preferences. Clients could access drinks and snacks at any time.
- The service encouraged and supported client engagement with the wider community. Clients were encouraged to develop and maintain valued relationships. Clients were supported to access external support groups and services.
- Clients knew how to give feedback about their experiences and could do so in a range of accessible ways, including how to raise any concerns or issues. Clients who used the service felt confident if they had to complain.

Are services well-led?

Inadequate 

We rated well-led as **inadequate** because:

- The service manager and lead nurse were unable to clarify who had responsibility for some of the safety issues we identified. Oversight of the service by the provider was not robust.

Summary of this inspection

- Systems and processes in the service were not effective, did not mitigate risks, or improve safety and quality. There was not a strong safety culture within the service.
- The frequency of governance meetings did not ensure the provider could assess, monitor and improve the quality and safety of the services provided in a timely manner.
- The service did not have appropriate systems in place for the safe management of medicines.
- Audit processes were not robust and did not identify areas for improvement.
- The service did not have a risk register. Risks in relation to medicines management, health and safety and not working within national guidance had not been identified. The provider did not have an accurate and current picture of the service.
- The provider did not have a proper process to make robust assessments to meet the fit and proper persons regulation (FPPR).

However:

- Staff felt respected, supported and valued, staff told us they were happy with their work within the service.
- The provider engaged with clients, staff and carers. They provided information to them through meetings and email. Comprehensive information was also available on the provider's website.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

Seventy eight per cent of staff had completed, and were up to date with, Mental Capacity Act training. Dates that staff had completed the training ranged between 2015 and 2019. This meant that in some cases, staff knowledge relating to the Mental Capacity Act had not been refreshed for four years.

However, staff understood mental capacity and were aware of how substance misuse may affect capacity. Staff reported that they only accepted clients who had capacity to consent to their care and treatment. Each client's consent was sought before staff contacted other healthcare professionals, such as the client's GP, for information.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Residential substance misuse services	Inadequate	Requires improvement	Good	Good	Inadequate	Inadequate
Overall	Inadequate	Requires improvement	Good	Good	Inadequate	Inadequate

Inadequate

Residential substance misuse services

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

Are residential substance misuse services safe?

Inadequate

Safe and clean environment

- Clients were placed at risk of receiving unsafe care because the provider did not have clear systems and processes to keep clients safe. Environmental risks were not managed. No environmental risk assessment had been carried out. Regular checks to ensure that the premises were safe and suitable were not undertaken. Audit information supplied by the provider indicated that weekly site walks were carried out to check for health and safety compliance. These had not been effective in identifying environmental risks. This meant that there was a risk that any hazards or maintenance issues would not be followed up promptly.
- Clients who used the premises were not appropriately protected from the risk of fire. The provider had not implemented the recommendations of a fire risk assessment they had commissioned in March 2017. We found fire doors wedged open. Doors to habitable rooms and the kitchen were not fire doors and did not have self-closing devices, strips and seals. We were sufficiently concerned to ask the London Fire Brigade to make their own inspection. They attended the premises on 3 May 2019 and they have informed us they are intending to take further action.

Safety of the facility layout

- There were enough meeting rooms to meet the needs of the clients. There was a kitchen available for clients and staff to access refreshments, including hot and cold drinks. The service was located in a mews house which was split over three floors. Staff were not able to easily observe people at all times. To mitigate this risk staff carried out two-hourly observations when clients were on the premises. Records of these observations were maintained.

Maintenance, cleanliness and infection control

- Areas clients had access to were visibly clean, comfortable and well-maintained.
- Staff followed infection control procedures to keep clients safe. Disposable gloves, aprons and liquid gel were available. Staff disposed of sharps appropriately. Arrangements were in place for the disposal of clinical waste and there was a spillage kit for body fluids. However, we found that infection control audits were not carried out.

Safe staffing

- The service had enough staff to meet the needs of the client group and could manage any unforeseen shortages in staff. Staff were able to book bank and agency staff to cover sickness, leave and any vacancies.
- There was a registered nurse working at the service at all times. The staff team consisted of registered nurses, healthcare assistants, therapy staff, housekeeping and a chef. The service had a registered manager for the three services in London.
- During the day one nurse,two support workers and two trained therapists were on duty. The therapists were

also trained to work as support workers when not carrying out therapy. At night, there was one nurse and one support worker. Staff on duty provided support to all three services.

- Clients attending the service for alcohol detoxification treatment were not always assessed by doctors trained in substance misuse treatment or alcohol detoxification. There was a risk of serious harm to clients due to the lack of knowledge and experience of doctors assessing clients and planning their alcohol detoxification treatment.
- Medical cover was provided by three GPs and two consultant psychiatrists. There was no onsite doctor available at all times. When a doctor was required, staff would contact one of the doctors to attend. There was a short delay in the doctor attending at times.
- Staff recruitment practices were safe. We reviewed four records for staff who worked for the service. All but one file contained the necessary information and documentation required. In the case of one member of staff, a full employment history and an explanation for any gaps in employment history were not available.
- Staff undertook mandatory training, including first aid, safeguarding, moving and handling, mental capacity, challenging behaviour, infection control and substance misuse. Dates that staff had completed mental capacity and safeguarding training ranged between 2015 and 2019. 79% of staff were up to date with safeguarding children training.

Assessing and managing risk to clients and staff

Assessment of client risk

- Clients requiring detoxification were placed at risk of receiving unsafe care and treatment. Comprehensive medical assessments of clients, including a physical health assessment, were not carried out prior to them commencing treatment. We reviewed the care records of two clients who had received alcohol detoxification treatment and had subsequently been discharged. In both cases, before commencing treatment, physical health problems had been reported. Treatment for alcohol detoxification, including medicines, may not have been tailored to clients' physical health needs. There was no written evidence that the decision to admit or the treatment plan had been reviewed by a clinician once the concerning information about the patients' physical health was known.
- Clients did not have their cognition assessed before alcohol detoxification treatment. This would help to identify Wernicke's encephalopathy. A cognitive assessment is recommended by the National Institute for Health and Care Excellence [NICE] (Alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence, 2011). Wernicke's encephalopathy can cause irreversible brain damage if untreated. NICE guidance recommends if Wernicke's encephalopathy cannot be excluded, clients should be prescribed pabrinex (an injectable form of vitamin B) for five days. The service did not routinely prescribe pabrinex for clients when Wernicke's encephalopathy could not be excluded. Not undertaking a cognitive assessment of clients and not prescribing pabrinex placed clients at risk of serious harm.
- The clinical director of the service reported that they were aware that the GPs used by the service refused to use the service's assessment documentation and did not undertake cognitive assessments of clients having alcohol detoxification treatment. This had been identified as an issue in the cross-clinic governance meeting held in May 2018. Subsequent meeting minutes did not detail whether this had been followed up.
- The provider's 'Admission policy and exclusion criteria' did not exclude clients who had a past history of seizures or delirium tremens from treatment at the service. A client's past history of alcohol withdrawal seizures or delirium tremens indicates they may be at high risk of such complications in treatment in the future. Alcohol withdrawal seizures and delirium tremens can result in death. To minimise the risk of this or other complications, comprehensive assessments of patients and a prompt medical response to any patient deterioration was required. We were not assured that both were consistently available.
- During assessment for the service, clients were not asked questions concerning blood borne viruses, including hepatitis.

Management of client risk

- At our last inspection we recommended that the provider ensured that clients had a comprehensive risk assessment and risk management plan in place prior to starting treatment. At this inspection, we found little improvement. We reviewed five clients' risk assessments and management plans. Three of these were for clients currently using the service. Clients' risk management plans varied in detail. For example, for one client the risk assessment had been completed but there was no plan on how to minimise risks. For another client, whilst there was a risk management plan within the care plan, but not all the identified risks had been minimised. For a further client, there was a detailed and comprehensive risk management plan in place. Risk and individual plans were discussed with the individual client, updated and reviewed regularly, but parts were missing for some clients. A lack of full documentation and full assessment information was not available for all clients. This meant that all staff may not be aware of potential client risks and how to minimise these.
- Clients were made aware of the risks of continued substance misuse, and harm minimisation safety planning was an integral part of recovery plans. For example, a client reported that they better understood their risk and risk triggers in relation to their addiction behaviour.
- When clients first attended the service, staff discussed with them the risks of the treatment they would be undertaking. They discussed the signs and symptoms to look out for as well as what action to take if they experienced any of the symptoms. Information was also provided in the client information pack given to each person when they were admitted to the service.
- Staff identified and responded to changing risks to, or posed by, clients. For example, a client's mental health had deteriorated during treatment. Staff facilitated a transfer of the client to a mental health hospital.
- The service had implemented a smoke free policy. Clients could only smoke outside of the service.

Use of restrictive interventions

- Staff searched clients' luggage and clothes during the admission process. Clients were required to hand in any prescription and non-prescription medicines to nursing staff for safe keeping. This was part of the contract clients consented to when accepting treatment at the service.

Safeguarding

- Seventy eight percent of staff had undertaken safeguarding adults training and 79% had undertaken safeguarding children training. Some staff had previously undertaken safeguarding training, but had not undertaken refresher training within three years as the provider required.
- Staff could give examples of how to raise safeguarding concerns within the service and how to raise alerts to local authority safeguarding teams.

Staff access to essential information

- The service used a mixture of paper and electronic records. We experienced difficulties in locating and following the information in the records of the clients using the service as there was no coherent system for recording. It was not clear what the patient journey through treatment looked like. When patients were discharged all paper records were uploaded to the electronic system.

Medicines management

- The service did not have appropriate systems in place for the safe management of medicines. This placed clients at risk of unsafe care and treatment. The service policy 'Management and administration of medicines' did not cover dispensing medicines to clients on leave or on discharge, medicines disposal, alerts or patient group directions. Medicines policies referred to out of date guidance. There was no process for staff to follow for dispensing medicines when clients went on leave, including the length of the prescription to be supplied.
- The service had no prescribing protocols for alcohol detoxification in place. Doctors assessing clients, prescribed on an individual basis. The doctors had varying degrees of experience and qualifications and there was no process as to which client saw which doctor. The service had not commissioned any prescribing support or clinical oversight from the supplying pharmacy.

Inadequate

Residential substance misuse services

- Staff did not fully adhere to medicines management procedures. We observed medicine pre-dispensed and stored in the locked medicines cabinet. This practice increased the risk of a medicines error that could lead to client harm. The medicines keys were stored in a lockable box which was found to be unlocked. The office door was not kept locked and this was next to a client bedroom.
- We reviewed medicine administration records for five clients. For one client staff were using a 'sliding scale', however the use of this form had not been recorded on the drug prescription chart which also prescribed the same medicine. On another chart the 'sliding scale' medicines had been prescribed incorrectly**.**These practices placed the clients at risk of an inadvertent overdose.
- The service had a Patient Group Direction (PGD) for the administration of Buccal Midazolam. This is an emergency medicine given to clients who may experience seizures during withdrawal. The PGD stated that, if used, staff should prepare to assist with ventilation. The service did not have the ability to assist clients with ventilation. The PGD was signed by two doctors, indicating a fundamental misunderstanding of the purpose of a PGD. The PGD stated that the staff authorised to administer Midazolam by the PGD were registered nurses employed and authorised by PROMIS. On the first day of our inspection an agency registered nurse was working the day shift. There was no record of a risk assessment to assess and minimise risks when a registered nurse employed by the service was not on duty.
- Medicines were disposed of safely and a disposal log was maintained by the service. The temperatures of medicines refrigerators and the clinic room were monitored and recorded daily.
- The service had a contract with a pharmacy company. A pharmacist from this company carried out a monthly medicines audit.
- Staff working at the service were trained to administer medicines. The majority of medicines were administered by nurses. Some therapy staff had also been trained to administer medicines. Medicines competency assessments were carried out for staff.
- Equipment in the clinic room was visibly clean. Emergency medicines, oxygen cylinders and the defibrillator were checked weekly to ensure the medicines were in date and equipment was working. At our last inspection we identified that the alcometer and blood pressure machine, had not been regularly serviced by staff. At this inspection, both pieces of equipment had been calibrated to ensure they gave a correct reading.

Track record on safety

- The service had reported no serious incidents in the 12 months leading up to our inspection.

Reporting incidents and learning from when things go wrong

- Staff knew what incidents to report and how to report them using the service's reporting procedures. Staff told us all incidents were escalated to the manager and clinical director.
- At our last inspection we found that staff were not aware of their responsibilities relating to the duty of candour. At this inspection staff understood the duty of candour. Staff told us when things went wrong they were open, honest, transparent, apologised and gave clients a full explanation and suitable support.

Are residential substance misuse services effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- Clients' needs were not compressively assessed, and care and treatment was not always delivered in line with current standards and evidence-based guidance. We reviewed five care and treatment records. Two of these were for previous clients who had alcohol detoxification treatment. Clients had an initial pre-assessment by telephone with the service. This pre-assessment was not detailed and did not identify if further information was required about clients' medical or mental health history prior to them attending for an assessment at the service.

- Clients were assessed by staff in the service before commencing treatment. Assessment information was brief and did not provide a detailed history of clients' substance misuse history, physical health, mental health or social circumstances. Clients were not asked about blood-borne viruses and testing, such as for hepatitis or HIV. The service did not ensure that adequate information was obtained pre-admission for safe and effective alcohol detoxification.
- There was no medical review by a doctor during alcohol detoxification. Staff could contact a doctor if required, but there was no consistent practice for doctors to undertake a review.
- The assessment of clients for alcohol detoxification treatment did, however, include te use of the severity of alcohol dependence questionnaire (SADQ). This followed best practice guidance (NICE, 2011).
- Clients' care plans were personalised and recovery orientated. Staff developed care plans that met the needs identified during the assessment. All three clients we spoke with confirmed the staff worked collaboratively with them in developing their care plans and that they had a named key worker.
- Individual care plans were regularly reviewed. Staff and clients told us that care plans, risk assessments and risk management plans were reviewed and updated at least weekly, or sooner if the clients' risk levels or needs changed. Clients did this collaboratively with staff. However, care records showed that gaps were not consistently identified or addressed.
- Clients had plans in place in the event of their unexpected exit from treatment. Each client had an individual plan which detailed relapse prevention and unplanned exit from the service and how staff were to try to re-engage with the client. However, we found that the documentation had not been completed fully in every case. When staff were concerned about the safety of a client who had left the service the police were called to carry out a welfare check.

Best practice in treatment and care

- Rating scales were used to assess clients during detoxification treatment. The clinical institute withdrawal assessment for alcohol (CIWA-Ar) was completed for clients having alcohol detoxification treatment. This followed best practice guidance (NICE, 2011). For clients having opioid detoxification, staff used the clinical opiate withdrawal scale (COWS). This was best practice.
- Psychological therapies and interventions were provided following best practice guidance. Clients accessed individual and group therapy sessions. The group sessions included process and psychoeducation groups, art therapy and drama therapy. Individual therapy sessions included cognitive behavioural therapy (CBT), dialectical behavioural therapy (DBT) and eye movement desensitisation and reprocessing therapy (EMDR).
- The service also provided several wellbeing and recovery-focused groups. For example, clients accessed a planning recovery group, as well as yoga, tai chi and acupuncture. Staff and clients reported that groups were well attended and were available every day of the week.
- Staff supported clients to live healthier lives. Clients told us that they were supported to access the local health and leisure facilities to use the gym and swim. Staff supported clients to the point where they could use these facilities independently.
- Staff routinely checked clients' physical health at least once a day by taking their temperature, blood pressure and pulse. These checks were increased if the staff had concerns that the person's physical health may be deteriorating. Staff had completed regular urine drug screenings for clients in each of the records we reviewed.
- The provider had a schedule of audits, which contained 24 areas of audit to be undertaken at various frequencies. These included audits of weekly environmental checks, care plans, risk assessments 1:1 sessions and documentation on discharge. However, several of these audits involved reviewing one client's care record every month. This was insufficient to monitor the quality of care. There were no standards for staff to refer to when undertaking audits. This meant staff may use different criteria when auditing, based on their own knowledge. Improvement plans were not developed from audits.

Skilled staff to deliver care

- The service provided all staff with a local induction, including bank staff. Staff stated that this included a tour of the premises, orientation to the service and time to review policies and procedures and client documents.
- At our last inspection, we recommended that the provider ensured that staff supervision continued for all staff and was recorded. At this inspection staff reported that they had regular supervision. We were provided with a clinical supervision matrix, this was used to record when supervision took place. However, there were no dates recorded for 2018 and the matrix detailed that supervision was 'on-going'. Dates had been recorded for 2019. Supervision records were not available to confirm the frequency, quality and content of staff supervision. Therapists received external supervision monthly, however the service had no details of the areas this covered so again, there was no assurance about the quality of the supervision provided. The previous service manager received quarterly operational supervision from the clinical director. The current manager of the service had not received any formal supervision since starting the post in February 2019. We were unable to assess the quality of the supervision received by staff. We were not assured that the supervision the staff received ensured that they were able to carry out their roles and responsibilities safely and effectively.
- One of the GPs assessing clients for detoxification treatment had not undertaken any specialist training on substance misuse. Following the inspection, the provider agreed that this GP would no longer undertake the assessment of clients. The two psychiatrists and two other GPs had specialist training or experience. The two psychiatrists provided assessment and treatment for clients who also had mental health problems.
- All staff received performance and development appraisals. However, the service was not meeting its own target of staff receiving performance and development appraisal each quarter. As there were no records of supervision for staff, the performance and development appraisals were not fully effective. The majority of staff had received one appraisal within the last calendar year.
- We were told the service held monthly team meetings for staff. However, staff were not able to confirm this. Information from the provider showed that there were no minutes for staff team meetings in the service in 2018. There had been only one team meeting in 2019. The minutes of the team meeting did not include any standing agenda items concerning safeguarding, referrals, incidents or complaints. The lack of regular team meetings meant there was no formal space for staff to discuss service and client- specific issues such as risk concerns, lessons learnt from incidents or near misses, and service strategy and development.

Multi-disciplinary and inter-agency team work

- The service had regular multi-disciplinary team meetings, where clients' progress, care and treatment was reviewed. This included a review of each client's risk management, safeguarding concerns, therapy engagement, recovery, relapse planning and after care arrangements. Medical staff were not always present at multi-disciplinary team meetings and this affected the ability of the team to consider all aspects of clients' care and treatment.
- The service did not regularly communicate with GPs. In some cases, when clients consented, the service did contact GPs for information. However, when clients were having alcohol detoxification treatment, the service did not consistently contact GPs for information concerning clients' health. The service continued to provide alcohol detoxification treatment when clients did not provide consent to contact with their GP. There was no record that staff had considered if it was possible to provide safe and effective treatment without information from clients' GPs.
- Handover meetings took place when staff started their shift. All the staff team could contribute to the handover. An allocation sheet was completed and staff used this to plan the day and ensure tasks were carried out.
- Recovery plans included clear care pathways to other supporting services, such as community mental health teams, support networks and self-help groups. Clients confirmed that staff supported them to access support groups as part of their discharge plan.

Good practice in applying the MCA

- Seventy eight per cent of staff had completed, and were up to date with, Mental Capacity Act training. Dates that staff had completed the training ranged between 2015

and 2019. This meant that in some cases, staff knowledge relating to the Mental Capacity Act had not been refreshed for four years. The provider had set three years as the timescale for updates.

- However, staff understood mental capacity and were aware of how substance misuse can affect capacity. Staff reported that they only accepted clients who had capacity to consent to their care and treatment. Staff sought clients' consent to contact other healthcare professionals, such as their GP, for information.

Are residential substance misuse services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

- We observed staff displaying positive attitudes and behaviours when interacting with clients. We observed one to one interactions and a therapeutic group where staff demonstrated compassion and respect when supporting clients. Staff provided responsive, practical and emotional support.
- We spoke with three clients who told us staff were very supportive and helpful. They said they were very happy with the service they received. Clients described staff as easy to approach and always available to help when they needed support. Clients stated that staff took a personal approach towards the care and support they provided, and clients valued this. This was supported from data from previous clients' exit surveys.
- Staff respected clients' personal, cultural, social and religious needs. Staff told us that they supported clients to attend places of worship, such as the local mosque and church. Clients stated that the service adapted the menu to meet their dietary requirements.
- Staff supported clients to understand and manage their care and treatment. Clients told us that staff helped them to develop insight into their individual needs and to take ownership of their recovery process. Clients said that staff helped them to develop coping mechanisms.
- Staff directed clients to other services when appropriate and, if required, supported them to access those services. For example, staff told us about a previous client whose needs became too complex to be managed within the service. Staff were able to liaise with the client and another provider to facilitate that client's admission to a more suitable setting.
- Clients stated that staff supported them to access additional community based addiction services to further aid recovery.
- Staff maintained confidentiality. The service had clear confidentiality policies in place that were understood and adhered to by staff. Staff provided information to clients about confidentiality and explained and discussed the importance of client confidentiality. Staff sought client consent to share information with family members and other agencies such as GPs.

Involvement in care

Involvement of clients

- Staff communicated with clients so that they understood their care and treatment. Clients said that they received service information via email and an accompanying letter once they agreed to come into the service. The service provided an online welcome pack before admission. Clients told us that they discussed their care and treatment plans at least once a week with staff.
- Staff were aware of the service's advocacy support, and advocacy information was given to clients in the service if requested.
- Each client who used the service had a recovery plan and risk management plan in place that demonstrated their preferences. Clients said they discussed their associated risks daily with staff.
- Staff engaged with clients using the service, and, where appropriate, their families. This ensured staff could develop responses that met clients' needs and clients had the information needed to make informed decisions about their care.
- Staff engaged clients using the service in planning their care and treatment. Clients told us that they felt informed and involved in their care planning and treatment decisions. They stated that they openly discussed their care with staff.

- Clients reported that they were able to provide feedback via the client community meetings and during group sessions. Clients stated that they felt comfortable in providing feedback directly to individual staff. The service provided clients with an exit survey at the point of discharge as another means of gathering client feedback. The service manager and clinical director reviewed this information and acted on feedback.

Involvement of families and carers

- Staff encouraged and supported family contact. Where appropriate, staff encouraged family members to attend therapeutic sessions and groups with clients.
- Staff supported family members with information regarding addiction and other issues clients might be challenged with. Family members were signposted to external substance misuse support services for concerned relatives. Clients also told us that that family members had attended external support groups with them.

Are residential substance misuse services responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

- Most clients self-referred to the service. At the time of the inspection there were four clients in the service. The service did not have a waiting list and rarely had one due to the service capacity. When clients contacted the service, the admissions team sent out a patient handbook for the services in London. All referrals were screened by a clinical admissions officer who also carried out a pre-admission telephone assessment. Once potential admission had been agreed, the client was assessed at the service.
- The service had clearly documented admission and exclusion criteria, but it did not exclude people who may be at risk of complications during withdrawal. There was evidence that they signposted people with needs they could not meet to other services.
- Clients said they were introduced to, and oriented to the service by, staff onsite at the time of admission. Clients said if they arrived late for their assessment appointment, a doctor would assess them in the evening.

Discharge and transfers of care

- Staff began planning for discharge when clients first entered the service. Staff worked with clients to develop a continued recovery plan which included areas such as physical health, mental health, relationships, support services, social activities employment and education. Staff liaised with clients' GPs if they consented, as well as community mental health services where appropriate.
- Staff escorted and supported clients who required transferring to another service. For example, when clients required transfer to a hospital setting.

The facilities promote recovery, comfort, dignity and confidentiality

- Clients had their own bedrooms. Clients could personalise their bedrooms.
- Clients told us they could store their possessions securely in their rooms. Clients could lock their bedroom doors if they wished.
- Clients and staff had access to a range of rooms to support care and treatment, including lounges, a dining area, kitchen spaces and rooms that could be used for individual and group sessions or for seeing visitors.
- The food was of a high quality. The menu reflected client preferences, as well as cultural and dietary needs. Clients said that they could request individual tailored meals if they wanted. Clients could always access drinks and snacks.

Clients' engagement with the wider community

- Staff encouraged clients to develop and maintain relationships with people that mattered to them. Staff supported clients in managing family relationships. Staff facilitated and mediated family meetings.
- Staff used technology to support clients to access online self-help groups, forums and message boards. The provider reminded clients not to share their personal information online, so that they remained safe.

- Staff supported clients to access external support services as Alcoholics Anonymous and Narcotics Anonymous. Staff encouraged clients to access local community services. Clients were supported to attend the local gym and leisure facilitates.
- Staff supported clients to manage their return to employment by offering treatment and group and individual sessions around work commitments. Clients said they had the choice to pursue educational opportunities if they wanted.

Meeting the needs of all people who use the service

- Staff demonstrated knowledge of protected characteristics and vulnerabilities, such as the potential needs of clients identifying as black and ethnic minority or lesbian, gay, bisexual or transgender.
- The service accepted clients of all faiths and those without religious beliefs. Staff supported and encouraged clients to maintain their religious practices.
- Staff had access to external translation services. Staff had the autonomy to request translation services as required, without management authorisation.
- The service accommodation and treatment facilities were located across three buildings each with several floors. The buildings were not suitable for clients with mobility needs or wheelchair users. Potential clients were directed to the provider's Kent services when the service was unable to meet clients' mobility needs.
- Clients told us that care and treatment was never cancelled or delayed.

Listening to and learning from concerns and complaints

- The service had a total of four complaints over the 12 months leading up to the inspection. One complaint was partially upheld.
- The service had a complaints system to record how complaints were managed. Complaint records demonstrated that individual complaints had been responded to in accordance with the service's complaints policy. Complaints were investigated and responses were comprehensive. Complainants could appeal if they were concerned about the way their complaint was investigated or they were unhappy with the outcome and this was explained in the letter they received.
- Complaint responses were reviewed by the director of clinical treatment before being sent to complainants.
- Clients reported that they knew how to raise informal and formal complaints. Clients also stated that they felt comfortable in raising complaints if they needed to. The service protected clients who raised concerns or complaints from discrimination and harassment.

Are residential substance misuse services well-led?

Inadequate

Leadership

- A new service manager joined the service in February 2019. The service also had a lead nurse. They were not clear what their roles and responsibilities were in relation to safety and quality in respect of the day-to-day running of the service. They were unable to tell us what the current risks were and where to find some pertinent information relevant to the operation of the service. There was no single person in a day to day leadership role who had oversight of the whole service.
- Leaders were approachable for patients and staff. The director of clinical treatment was responsible for providing clinical leadership. They attended the service weekly or more often if required. Staff could also contact them by telephone.

Vision and strategy

- Staff told us that they were proud of the caring ethos within the service. Staff emphasised the importance of supporting people as individuals to reduce their substance misuse and to increase their wellbeing.

Culture

- There was an absence of a safety culture within the service, both in terms of oversight of medical risks during detoxification and in regard to environmental health and safety.

- Staff felt respected, supported and valued, staff told us they were happy working within the service.
- Staff reported they felt positive and satisfied with the way the team worked well together. Staff felt their views were taken into account to help develop the service.
- Staff appraisals included discussions regarding development and learning needs, and opportunities for career development.
- There were no reported cases of bullying or harassment.
- Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for development, for example, through attending training.

Governance

- The systems and processes in the service were not effective and did not help to keep people safe. They did not adequately assess, monitor and improve the safety and quality of the service. Risks were not appropriately identified, monitored and mitigated.
- Environmental and health and safety risks were not managed. There was no environmental risk assessment. Regular checks to ensure that the premises were safe and suitable were not effective. There were long-standing fire risks which had not been addressed following the risk assessment commissioned by the provider in 2017.
- Policies and practices which involved the prescribing and administration of medicines were not appropriate. Professional guidance and national clinical guidance were not followed. This increased the risk to patients. Clients' needs were not fully assessed prior to starting treatment. People's care and treatment did not always reflect current evidence-based guidance and standards.
- There were no staff supervision records.
- The provider did not have a clear framework of what had to be discussed at team meetings to ensure essential information was shared amongst the staff. Team meeting minutes were not available for meetings held throughout 2018. Regular team meetings did not take place.
- The audits carried out by the provider had not identified the areas of non-compliance with Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identified by CQC during this inspection.
- There were two governance meetings for the service, in January and July each year. We reviewed the minutes of the meetings held in 2018 and 2019. There was no clear record that areas of concern identified at each meeting had been followed up or actioned. The frequency of governance meetings did not ensure the provider could assess, monitor and improve the quality and safety of the services provided in a timely manner.
- We requested further information regarding the fire risk assessment for this service following the inspection. This was not provided.
- The provider did not have a proper process to make robust assessments to meet the fit and proper persons regulation (FPPR). The provider was unable to show us that appropriate fit and proper persons checks were carried out to make sure that directors were suitable for their role. These are checks that are carried out for people who have director-level responsibility for the quality and safety of care, treatment and support provided to people using the service.

Management of risk, issues and performance

- There was no clarity around processes for managing risks, issues and performance. The service did not have a risk register or other system in place which would have helped leaders to have an oversight of risk areas. Risks in relation to medicines management, health and safety and not working within national guidance had not been identified. The system of audits did not proactively identify areas of risk.

Information management

- Staff made notifications to external bodies as needed. The service notified the Care Quality Commission of notifiable incidents, including incidents involving the police.

Engagement

- Clients, staff and carers had access to up-to-date information about the work of the provider through meetings and email. The provider had a website which clients could access. This detailed news and events that were taking place within the service.
- Clients had opportunities to give feedback on the service they received in a manner that reflected their individual needs via an exit survey. Clients completed a 31-item questionnaire on the service and 10 item review of their individual therapist on leaving the service. Data from the exit surveys were reviewed by the director of clinical treatment director and the service manager with learning points and outcomes recorded.
- Clients told us they felt able to speak with senior managers at any time.

Learning, continuous improvement and innovation

- The director of clinical treatment reviewed all incidents and complaints. Themes or trends were identified, but they did not always systematically inform practice.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that health and safety, environmental risks and fire safety are managed to ensure that clients and staff are kept safe.
- The provider must ensure that all aspects of care and treatment for patients undergoing alcohol detoxification follow national guidance. This includes all clients having a comprehensive assessment, including physical health examination and mental health history, cognitive assessment and offer of blood borne virus screening, prior to commencing detoxification treatment.
- The provider must ensure that all clients have a comprehensive risk assessment and risk management plan in place prior to starting treatment.
- The provider must ensure that medicines policies and practice follow national and professional guidance.
- The provider must ensure that comprehensive and effective clinical audits and service audits are undertaken on a regular basis and follow up actions are taken when necessary.
- The provider must ensure that supervision records for all staff working at the service are maintained and that supervision sessions cover relevant quality and safety topics.
- The provider must ensure there is a clear framework detailing what must be discussed at each level of the organisation to ensure that essential information is shared with relevant directors and staff members. This may include a framework of regular meetings with standard agenda items.
- The provider must ensure that effective systems are in place to assess, monitor and improve the quality of service. This may include benchmarking so staff engaged in audits know the standards required.
- The provider must have a process in place to make robust assessments to meet the fit and proper persons regulation (FPPR).

Action the provider SHOULD take to improve

- The provider should ensure that staff regularly complete mandatory training to make sure that their skills and knowledge are up-to-date.
- The provider should ensure that potential risks to any children clients may have contact with are explored to assess if a safeguarding children referral is required.
- The provider should ensure that there is consistent practice in place for medical reviews by doctors during alcohol detoxification.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Fire safety arrangements were not robust. Fire drills, fire checks and fire assessments were not carried out. Risk mitigation plans were not in place for all identified client risks. This was a breach of Regulation 12 (1) (2) (b)(d)

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff supervision records were not completed or available and there was no assurance that relevant topics were covered, such as those related to quality and safety. This was a breach of Regulation 18(1) (2) (a)

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Treatment of disease, disorder or injury	Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors The provider did not have a proper process to make robust assessments to meet the fit and proper persons regulation (FPPR). The provider was unable to show us that appropriate fit and proper persons checks were carried out to make sure that directors are suitable for their role.

This section is primarily information for the provider

Requirement notices

This was a breach of Regulation 5 (1)(2)(5)

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider accepted people who had a history of alcohol withdrawal seizures and delirium tremens to the service, but comprehensive medical and cognitive assessments were not carried out prior to people commencing alcohol detoxification treatment. The service did not follow best practice guidance. Full medical information and medical history was not obtained before a client was admitted to the service to commence treatment. Clients needs were not fully assessed prior to starting treatment. Clients were not asked questions concerning blood borne viruses, including hepatitis. The provider did not carry out the proper and safe management of medicines. This was a breach of regulation 12 (1)(2)(a)(b)(g)

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

The provider did not ensure systems and processes were established and operated effectively to assess, monitor and improve the quality and safety of the services provided or to assess, monitor and mitigate the risks to the health, safety and welfare of service users or others.

There were no infection control audits, environmental risk assessments or a risk register for the service.

Auditing processes were not robust. They did not identify issues and concerns. There were no standards to which staff could refer when undertaking audits.

Governance meetings were held twice a year. The frequency of the governance meetings did not ensure the provider could assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk in a timely manner.

There were no minutes for staff team meetings in the service in 2018. Team meetings did not include any standing agenda items concerning safeguarding, referrals, incidents or complaints.

The provider did not have a clear framework of what must be discussed in team meetings to ensure that essential information is shared with staff.

This was a breach of Regulation 17(1)(2)(a)(b)