Broadreach

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

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

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

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

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

Overall summary

We do not currently rate independent standalone substance misuse services.

Broadreach has been inspected twice previously, in 2013 and 2016. The comprehensive inspection in September 2016 did not fully comply with CQC policy and guidelines for inspection activity. Consequently the report was not published.

We will undertake a further comprehensive inspection in the near future.

In July 2017 we carried out an unannounced, focussed inspection of this location to check on a number of issues that had come to our attention through the information we hold about the provider.

At this inspection we found the following areas of good practice:

- All medicines were stored safely and administered by staff apart from those required for immediate relief of symptoms such as asthma inhalers.

Summary of findings

- There were systems in place to ensure the repair of faulty equipment in a timely manner; there was a schedule for safety testing of equipment and staff now carried personal alarms.
- Medication risk management plans were in place to give staff permission to manage and administer medicines. This included some disease specific risk assessments. For example, diabetes plans which detailed triggers and symptoms and what actions to take if the client's health deteriorated.
- The provider had reviewed its policy on locking bedroom doors. Bedroom doors did not lock but this was for the safety and wellbeing of clients. We talked to clients about this policy and they were in agreement with it.
- Physical health checks were carried out on admission and clearly documented.
- Risk assessments were clearly documented in client's files.
- There was a programme of audits in place to ensure required improvements in the services were identified and actioned in a timely manner and the vision and values of the provider were clearly displayed on a noticeboard.

Summary of findings

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Background to Broadreach

Broadreach offers detoxification and first stage treatment, along with a specialist 12 week programme for clients who, in addition to issues with the misuse of substances also have serious physical or mental health issues. The programmes at Broadreach are available to both men and women and there are 31 beds available.

Clients are referred to the service by their GP, a care manager, or are able to self-refer and self-fund.

Broadreach was initially registered in 2010 for accommodation for persons who require treatment for substance misuse, diagnostic and screening procedures and for the treatment of disease, disorder or injury.

There is a registered manager in post.

Broadreach has been inspected twice previously, in 2013 and 2016. The comprehensive inspection in September 2016 did not fully comply with CQC policy and guidelines for inspection activity. Consequently the report was not published.

Our inspection team

The team that inspected the service comprised, Michelle Mcleavy (inspection lead), two inspectors, and a pharmacist.

Why we carried out this inspection

In July 2017 we carried out an unannounced, focussed inspection of this location to check on a number of issues that had come to our attention through the information we held about the provider.

During the same week as the inspection at Broadreach House we inspected two other locations (Closereach and Longreach) which are registered under this provider. Separate reports have been published for Closereach and Longreach.

How we carried out this inspection

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

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

However, as this was a focussed inspection we looked at specific areas of care in response to information we held about this provider.

During the inspection visit, the inspection team:

- visited the location, looked at the quality of the physical environment, and observed how staff were caring for clients
- spoke with 13 clients
- spoke with the registered manager
- spoke with five other staff members employed by the service provider, including nurses and support workers
- attended and observed a multidisciplinary meeting, and a daily meeting for clients
- looked at eight care and treatment records, including medicines records, for clients
- observed medicines administration
- looked at policies, procedures and other documents relating to the running of the service

Summary of this inspection

What people who use the service say

- Clients were positive about staff. They said that staff were caring, empathic, kind, friendly, professional, and approachable and that they check on client's wellbeing.
- Clients said they were getting what they needed from the service. A nurse was on duty 24 hours per day and they could offer support if needed.
- Clients said the food was good.
- One client told us the brochure changed and they were expecting to be offered massage as this was in the brochure, however this was not available to them during their stay.
- Clients were not allowed to have their mobile phones during their stay because it could jeopardise their recovery. One client said they were not aware before they came that they could not have their mobile phone.
- Some clients shared rooms but none of them described this being an issue for them.
- Clients told us they would like to have lockable storage in their rooms, as they did not have this at the time of the inspection.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Portable appliance testing (PAT) of electrical equipment to ensure electrical appliances were safe to use was up to date.
- With the exception of medicines required for immediate symptomatic relief such as asthma inhalers, clients did not self-administer their medication. Clients said they preferred staff to administer their medication at set times.
- The multi-disciplinary team meeting discussed the needs and risks of all potential new clients to the service, and included information sharing with other agencies as required to ensure the safety of the client. Clients who were considered to be too high risk for admission to the service, due to ill-health, were referred to other agencies for support.
- There were robust medicines management systems in place.

However:

- Clients did not all have individual guidance on the risks of relapse and unplanned discharge.

Are services effective?

We found the following areas of good practice:

- Staff used psychological interventions with clients that were based on cognitive behavioural therapy which is recommended for substance misuse.
- The provider followed National Institute for Health and Care Excellence (NICE) guidance in prescribing. Clients were supported through the detoxification process by using recommended withdrawal measurement tools to ensure that the severity of withdrawal symptoms were understood and medication could be appropriately prescribed and administered in order to safely alleviate the symptoms.

Are services caring?

We found the following areas of good practice:

- Staff spoke to clients politely and discussion of clients in the multi-disciplinary team meeting (MDT) was respectful and showed concern for the welfare of the individual clients.

Summary of this inspection

- Clients told us that staff treated them with respect and that staff were approachable when they needed support.

Are services responsive?

We found the following areas of good practice:

- All admissions were risk assessed and a multidisciplinary team decision was made to determine if the service could safely meet the needs of the client.
- There was a wide range of activities available to clients, this included art classes, yoga and auricular acupuncture.
- The provider had privacy screens in shared bedrooms and all clients were made aware prior to admission that they may have to share a bedroom during their stay.

However:

- There were no facilities for clients to safely store their personal belongings which they could access 24 hours a day.

Are services well-led?

We found the following areas of good practice:

- There were clear systems in place to ensure that clients who should not receive a service, as this might compromise their safety, were refused and offered alternative advice.
- There were systems in place for regular audits and the outcomes were used to inform improvements.
- The provider had a mission statement and quality statement which included information about privacy and dignity. The quality statement described what clients could expect upon admission.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

All staff had been trained in the Mental Capacity Act and Deprivation of Liberty Safeguards. The training was mandatory and repeated every three years. All staff were up to date with their training.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

- Records showed all appliances were portable appliance tested (PAT) annually. The estates manager carried out PAT testing on equipment brought in by clients before they used it in the service. The deputy manager carried out weekly maintenance checks.
- The estates manager completed fire alarm checks every week in all locations and organised for a fire company to carry out external checks every 6 months. Fire extinguisher inspections were up to date and the fire safety certificates were in date.
- The estates manager had carried out a house surveillance questionnaire for all staff which gathered feedback about their opinions on health, safety and their welfare. The estate manager had not documented the results formally but had gathered feedback, responded to staff verbally and documented who needed specific learning or support with a date when this was completed.
- The deputy manager carried out audits on the environment, including room checks, health and safety and infection control.
- During our inspection clients complained that the smoking area was dirty. The tables were unclean and there were cigarette butts on the floor.
- Walkie-talkies had been replaced by personal alarms. The deputy manager carried out weekly checks on personal alarms. When activated the alarm connected directly to the nurses' office phone. If there was no answer, it would go through to the on call mobile. If there was no mobile response, the call would go through to the deputy manager. This cycle would then repeat until the call was answered.

Safe staffing

- One client told us they could go for a walk but only if three clients wanted to go together due to shortages of staff. However, clients said it was unusual for the service to be short staffed. The provider told us counsellors and support staff took clients out to help them adjust to the outside world if, for example, the client had a history of social isolation and high anxiety.
- Staff were on duty 24 hours per day and included night support staff and a qualified nurse on duty overnight. There was an on call counsellor and management rota system for staff to access additional support if required.
- There was a medical officer who oversaw prescribing and attended the multi-disciplinary team (MDT); this was a local GP who worked with the nursing team to ensure that prescribing was safe and in line with NICE guidance. The medical officer had full input into the safety of admissions and engaged in the pre-screening of prospective clients prior to admission as part of the MDT.

Assessing and managing risk to clients and staff

- Clients' risk assessments were completed by nurses during their induction to the service. The referring agency would send all the relevant paperwork to the service, which was then discussed during weekly multidisciplinary team (MDT) meetings. Staff would then meet with the client and ask specific questions; for example, if there was any history of self-harm or any underlying mental health issues, and decide what, if any, level of risk there was to other people on the unit.
- We reviewed eight care records. Seven care plans had the clients detoxification and medical risk management plans completed. One client had been in the service for two days and although their opiate and detoxification and medical risk assessment had not been completed a

doctor had completed a treatment plan. The nurses on duty confirmed that detoxification and medical risk assessments were completed within a few days of arrival at the service.

- Risk assessments were completed on a standard form. Counsellors completed risk assessments for all their clients and updated them on admission, on discharge and every three months or sooner if risk escalated or changed.
- Seven care plans had documentation around unplanned discharge, although only one care plan reviewed had a detailed risk assessment relating to discharge. The other six just contained the address of the next of kin. There was no evidence of relapse prevention discussions taking place when considering early discharge or unplanned exit from the service.
- All inhalers were labelled with clients' names. If a client arrived with an unlabelled inhaler, the pharmacist would replace it upon admission. Clients could self-administer inhalers, topical creams and angina sprays.
- Clients had medication risk management plans. All care records reviewed held a list of medication on the front page with the dose, frequency and the client's diagnosis. One client said they had good control over the medicines they took and could ask the nurse for them when they wanted them.
- Controlled drugs were prescribed and managed in line with National Institute for Health and Care Excellence (NICE) guidance and the provider's policy. Two staff signed off the dispensing of controlled drugs.
- Staff reported any medication errors by following a drug error protocol, which was kept in the office. We reviewed the drug error records file. Staff were required to complete a form and detailed what the response was. Staff kept the record for six months. The deputy manager audited the medical records produced by the nursing team. This included audits of prescribing sheets every week for every client. There was a storage of medicines audit for general stock areas, including the checking/recording of fridge temperatures, with a space to record concerns and any action required. Included in the medical records check was a controlled drugs audit. The deputy manager followed an NHS medicines management checklist audit, which was completed once a month.

Track record on safety

- The provider had not experienced any serious incidents.

Duty of candour

- The provider had a policy about duty of candour and all staff understood the need to be open and transparent with clients when the service had made errors or not fulfilled all of their responsibilities.

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

Assessment of needs and planning of care

- All clients had a physical health check on admission, this included a detailed history of their substance misuse and associated health needs. Clients could contribute to their health management plans and staff talked clients through their medication, how it would be prescribed and informed them who they could talk to and when they would see the doctor.
- Staff explained that before a client was admitted they would look at a combination of physical and mental health issues and discuss this in the multi-disciplinary team meeting. Staff held conversations with outside agencies such as human immunodeficiency virus (HIV) specialists and the GP. Staff prescribed medicines in line with National Institute for Health and Care Excellence guidance.
- Physical health information was located in the clients' initial assessment document. One client had an epilepsy medical risk assessment plan. One treatment plan included goals and action planning for the management of chronic obstructive pulmonary disease. Another client had an asthma management plan and a psychosis medical management plan. A member of staff described how they had developed pain management and medical plans for a client with pancreatitis.
- Clients had access to a copy of their care plans. Staff used standardised care plans as the clients were only with them for a relatively short amount of time, but the conversation was always recorded on these notes. This

included creating specific, measurable, achievable, time framed (SMART) goals where clients set targets for themselves that they could achieve within the timeframe available to them.

Best practice in treatment and care

- Staff used psychological interventions with clients that were based on cognitive behavioural therapy which is nationally recommended good practice for substance misuse.
- Dependency tools recommended by National Institute for Health and Care Excellence such as the Severity of Alcohol Dependence Questionnaire were not used to detail a clients' history as these had already been completed by the referring service. However, we did not see evidence of this when we reviewed clients' files. The multi-disciplinary team meeting considered all new referrals and the substance use history and the health of the client was assessed. Staff told us that they used cognitive screening, depression scales, and Asperger's screening although we did not see this documented.
- Withdrawal tools, recommended by NICE such as the Clinical Institute Withdrawal Assessment for Alcohol and the Clinical Opiate Withdrawal Scale were used. These tools enable the prescriber to identify the severity of the withdrawal symptoms from a non-subjective perspective and to inform the prescribing regime required to alleviate the withdrawal symptoms.
- Clients had a treatment outcomes profile completed at the beginning and end of treatment and also in the middle depending on how long they were being treated in the service. The treatment outcomes profile provided a measure of improvement in their substance misuse and general functioning. Clients all completed a client self-evaluation at induction, midterm if they were in the service for six weeks or more and discharge. This enabled the counsellor to create a graph to show the client their progress.
- We attended a multi-disciplinary team meeting where a client who wished to be prescribed medicines outside of NICE guidance was discussed; as there was no medical reason for the preferred detoxification the team agreed to advise the client that this approach would not be acceptable and a NICE recommended detoxification could be offered instead.

Skilled staff to deliver care

- There were a range of staff disciplines within the service, this included, a psychiatrist, trainee psychiatrists, qualified counsellors, nurses and support workers.
- Staff had access to training opportunities.
- The consultant psychiatrist carried out staff training around psychosis and risk.

Multidisciplinary and inter-agency team work

- In addition to MDT meetings there were also multi-agency meetings. These meetings included service commissioners and community mental health teams and other professionals supporting the clients with their ongoing care.

Good practice in applying the MCA

- Staff understood the principles of the Mental Capacity Act and were able to describe that sometimes clients may be incapacitated due to the influence of substance misuse. In these instances staff told us that they would discuss issues with clients when they were not under the influence of substances.

Are substance misuse services caring?

Kindness, dignity, respect and support

- Staff spoke to clients politely and discussion of clients in the multi-disciplinary team meeting (MDT) was respectful and showed concern for the welfare of the individual clients.
- Clients told us that staff treated them with respect and that staff were approachable when they needed support.

The involvement of clients in the care they receive

- Clients we spoke with told us they were actively involved in developing their risk and care plans.

Are substance misuse services responsive to people's needs?

(for example, to feedback?)

Access and discharge

- All admissions were discussed at the multi-disciplinary team meeting, some referrals would be refused admission if their risks and needs were considered to be too high for the provider to meet. For example, if a client

had a history of arson or sexual offences, or was outside the age range then they would not be admitted to the service. However, the provider would offer a placement to a client requiring a high level of care and support if for example, the client had experienced alcohol related seizures, as they were able to offer a medically managed detoxification.

The facilities promote recovery, comfort, dignity and confidentiality

- There were no facilities for clients to safely store their personal belongings which they could access 24 hours a day; there were no locks on bedroom doors. Some clients we spoke with said they were aware of clients' belongings going missing and this had led to tension. Two clients said they would like locks on their bedroom doors. However, there were facilities for clients to store items safely in the reception area. On admission, clients were asked if they had any valuables such as identification documents or money. They could then choose to hand these over to staff or keep them. However, if they stored their items in reception they would not necessarily have immediate access to them if the office was closed. Clients were made aware, before admission, that they would not have individual safes in their rooms. Three clients said they would like their own safe.

- Male and female bedrooms were on the same corridors and the need for some clients to share rooms could compromise clients' dignity and privacy and may put vulnerable clients at risk. The MDT had reviewed the processes to keep male and female areas safe as bedrooms were all on the same corridors. The team had agreed that clients should be reminded about the need to dress appropriately when using the bathrooms. The MDT had also discussed the benefits of sharing rooms and what staff could do to protect the privacy and dignity of the individuals in the shared rooms; for example, using screens appropriately. Staff told us that the service was not in a position to guarantee single rooms. Information about rooms was detailed in the service pre-admissions paperwork so clients were aware of this before they entered the service. The service had 19 single rooms; these were given to clients the team agreed most needed them and those that were staying longest.

- The provider had a mission statement and quality statement which detailed information about privacy and dignity. The quality statement described what clients could expect upon admission.

- New staff were made aware of privacy and dignity standards during their induction, when they read the policy.

- The service successfully accommodated clients with disabilities requiring adjustments.

Listening to and learning from concerns and complaints

- There had been one formal complaint in the 12 months prior to our inspection, this had been investigated and the complainant had received a full and open response. Clients also had the opportunity to provide feedback in a comments book in the reception area. The manager and deputy manager had responded to clients' comments which were recorded in the book.

Are substance misuse services well-led?

Vision and values

- Staff had different interpretations of the organisations vision but they were all focussed on supporting clients to recover.

- The provider had a mission statement, philosophy of care and a quality statement specific to the service. This was held in a policy manual and there were versions for the clients on the communal notice board. New staff went through this document during their induction and every member of staff received their own copy of the policy manual.

- The visions and values were displayed on the client notice board in a communal area.

Good governance

- The manager followed a quality framework document which detailed the audits taking place and when they were due and these were all being completed within the identified timescales. Audits such as health and safety were a standing item on the weekly staff meeting agenda. The manager reported quarterly to the board on any findings, including the number of accidents and safeguarding alerts.

Substance misuse services

Leadership, morale and staff engagement

- Staff said that managers at all levels were supportive, including the chief executive. Staff gave examples of support they had received from their managers. Staff described an open culture when it came to talking about any errors they had made and were able to talk to their manager regularly. Staff described their supervision as open and honest.
- Staff all said the staff team was supportive of one another. They said they could approach each other for advice. The team was described as happy, warm and cohesive.
- Staff explained that their morale varied at times but in general morale was positive.

Commitment to quality improvement and innovation

- One member of staff had won a competition and had been awarded funding to research the use of virtual reality in relapse prevention. This method would enable clients to safely be exposed to situations that potentially could trigger a relapse in order to help them cope with the types of situations following discharge.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that it documents the actions it will take, for each individual client, in the event that the client decides to leave treatment early, this should include providing clients with information about the risks of re-using substances once detoxed.
- The provider should review its pre-admissions documents and other information provided to clients to ensure that it is up to date and provides clients with full details of the facilities available and the restrictions that may be placed upon them during their detoxification placement.
- The provider should consider providing lockable, safe storage facilities in client rooms to enable them to have access to their valuables 24 hours a day.