No 4

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 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.
- At the time of inspection there were no clients resident within this property, although it was still accessed by staff. Therefore, we could not gather sufficient evidence to answer three of the key questions.
- 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
- 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 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.

Summary of findings

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 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).

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 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 agreed not to admit any clients to No. 4 until the fire safety concerns had been addressed. 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 4

Services we looked at:

Residential substance misuse services

Summary of this inspection

Background to No 4

No 4 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 11 and No 12. 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 no clients at No 4, but as the same managemement, systems and processes in use at No 11 and No 12 apply to No 4, we were still able to form a judgement about safety and leadership.

The service provides medically supervised 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 4 was first registered with CQC in June 2016.

We have inspected No 4 once in June 2017. The last inspection of No 4 was carried out simultaneously with an inspection of No 11 and No 12. At that inspection we made a number of recommendations to improve areas of the service.

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?
- Is it well-led?

Summary of this inspection

As there were no clients in residence we could only inspect the safe and well-led questions. We were able to do this because systems and processes were the same for No 4 as for No 11 and No 12 where there were clients present.

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 (who were accommodated in the other houses)
- 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 across the service
- looked at policies, procedures and other documents relating to the running of the service
- requested an urgent inspection from a fire safety officer from the London Fire Brigade.

What people who use the service say

There were no clients in residence at the time of the inspection, although clients accommodated in other parts of the service gave positive feedback about the staff, support and facilities. The staff, support and some of the facilities were the same as those in place for clients when No 4 was occupied.

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:

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.
- The care records did not contain evidence that a doctor had undertaken a comprehensive assessment of clients before they commenced alcohol detoxification treatment. There was no record that clients had a physical examination, including clients with a reported physical health problem.
- 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. At this inspection, we found that whilst some risks to clients had been identified, this did not amount to a full assessment of risks nor were they fully documented. For example, there was no record that doctors had undertaken a cognitive assessment. This meant that clients were not screened systematically 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

Summary of this inspection

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.

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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 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.
- 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:

Summary of this inspection

- 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

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Residential substance misuse services	Inadequate	N/A	N/A	N/A	Inadequate	Inadequate
Overall	Inadequate	N/A	N/A	N/A	Inadequate	Inadequate

Inadequate

Residential substance misuse services

Safe	Inadequate
Well-led	Inadequate

Are residential substance misuse services safe?

Inadequate

Safe and clean environment

- The property was not safe. There were no clients residing in the property during the inspection, but we saw records which confirmed that they had been accommodated there despite the inadequate fire safety precautions. 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.
- The property comprised three floors. In common with many mews-style houses, a built-in garage was located on the ground floor. It housed an industrial iron for bed linen which generated heat when in use. However, there was no heat or smoke detector or carbon monoxide detector in the garage.
- There was an open plan lounge and kitchen. In the kitchen area there was an electric oven, a gas hob and a washer/drier. A fire blanket in the kitchen had a label to show it was last checked in 2017. The carbon monoxide detector indicated the battery needed replacing. There was no smoke or heat detector in the kitchen area or lounge.
- The only fire escape route from the upper floors was via the kitchen/lounge area, but the cooking appliances, which were potential sources of fire, were not separated from the escape route in any way so it was not fire protected.
- In a first floor bedroom, the smoke alarm was without a cover and had been disconnected. In both bedrooms on the second floor, intumescent strips in the door frames, designed to expand in the event of a fire, had been painted over and may not have worked as designed. Some were completely missing. Also, on the second floor, one bedroom did not have a fire door or door closer. These factors meant that bedroom doors could not be relied on to work as fire doors.
- We reviewed the fire documentation associated with the premises. A fire risk assessment, undertaken by an external company had been completed for the property in March 2017. We were advised by the director of clinical treatment that this was the most recent fire risk assessment. The March 2017 fire risk assessment recommended a review date of March 2018.
- The 2017 fire risk assessment recommended carbon monoxide detection in the garage. It stated that the only means of escape in a fire was 'compromised' and that the 'deficiencies in automatic fire detection' and 'fire separation' on the ground floor affected the escape route. These issues had not been addressed.
- The fire risk assessment stated the travelling distance for occupants to escape in the event of fire was 'not within recommended guidelines'. It also indicated that the type of doors / door closures along the fire escape route were not sufficient to protect people. These issues had not been addressed.
- The fire risk assessment stated the hazard from fire was moderate and the consequences for life safety was extreme harm. The overall risk to life at No 4 was assessed to be substantial by the specialist company brought in to complete the assessment.
- We looked at fire testing documentation for the property. There had been no weekly tests from Dec 2018 until the date of the inspection. Records showed that, although there were no clients resident in no.4 on the date of inspection, at least six clients had been accommodated there since December 2018.
- We found no evidence of fire safety improvements having been carried out since the provider was warned of the substantial risk to life in 2017. The safety

equipment that was in place had not been maintained, regular fire alarm testing and fire drills had not taken place and there was scant regard to clients' physical safety.

- The property was visually clean at the time of inspection, but no client bedrooms were in use.

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. At night, there was one nurse and one support worker. The therapists were also trained to work as support workers when not carrying out therapy. 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.

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 director of clinical treatment 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.
- 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.

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

Inadequate

Residential substance misuse services

- 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 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, such as fire alarm testing and maintenance of safety equipment. 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.
- 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.
- 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 and 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. However, staff supervision records were not available to confirm the frequency, quality and content of staff supervision.
- 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 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).

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 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. 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 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

This section is primarily information for the provider

Requirement notices

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 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 15 HSCA (RA) Regulations 2014 Premises and equipment The provider did not ensure that the premises were kept safe for people using the service. We found no evidence of fire safety improvements having been carried out since the provider was warned of the substantial risk to life in 2017. The safety equipment that was in place had not been maintained, regular fire alarm testing and fire drills had not taken place. This was a breach of Regulation 15(1)(2)(c)(e)