

Cranstoun - City Road

Quality Report

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Date of inspection visit: 10, 11 & 27 November 2015

Date of publication: 14/06/2016

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

Overall summary

- Cranstoun City Road provides a residential detoxification, crisis intervention and stabilisation service for up to 21 people with drug and alcohol dependency.
- The environment was clean. A number of rooms for therapy were available, but the building was not accessible by wheelchairs. The provider had used capital funding to make the ground floor bedrooms more accessible to disabled people.
- People received holistic assessments, and had a medical assessment within 24 hours of being admitted to the service. There were good examples of staff working together, within the service and in the community to ensure people who use services needs were fully met. The service had a clear policy around access, discharge, and unplanned exits from treatment.
- Staff considered guidance around best practice when prescribing medication.
- Staffing levels were sufficient for the needs of people who use services. The provider had a mix of counsellors, nurses and doctors.
- There was a wide range of training and staff could request specialist training. The provider regularly provided staff with supervision and appraisals.
- Staff treated people who used services with kindness and respect. We saw that staff understood individual needs and were aware of individual's preferences. People who used services said they felt safe when using the services.
- Staff reported that morale was low and they noticed levels of stress amongst their colleagues.

Summary of findings

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Summary of this inspection

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Cranstoun City Road

Services we looked at:

Substance misuse/detoxification

Summary of this inspection

Background to Cranstoun - City Road

Cranstoun City Road is a residential detoxification, crisis intervention and stabilisation service in north London providing care, treatment and support for up to 21 people with drug and alcohol dependency.

Cranstoun City Road is registered to provide:

accommodation for persons who require nursing or personal care; and treatment of disease, disorder or injury.

There was no registered manager at the service. The new manager was applying for registration at the time of the inspection. The service received referrals from various organisations inside and outside of London. We have inspected Cranstoun City Road three times since 2010, most recently in August 2013. At the August 2013 inspection, the service met essential standards, now known as fundamental standards.

Our inspection team

The team that inspected the service comprised three Care Quality Commission (CQC) inspectors, a CQC pharmacist inspector and a specialist adviser. The specialist adviser was a psychiatrist with experience of

working in a substance misuse service. The inspection team also included an expert by experience. This is someone who has used, or cared for someone using, a similar service.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive substance misuse service inspection programme.

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?

Before the inspection visit, we reviewed information that we held about the location, asked a range of other organisations for information and sought feedback from people who used the service.

During the inspection visit, the inspection team:

- visited the service, looked at the quality of the environment and observed how staff interacted with people who used the services
- spoke with five people who were using the service
- spoke with four members of the management team
- spoke with 12 staff members; including members of the social care team, doctors, nurses, administrators and catering team
- reviewed 25 incident forms
- looked at nine staff personnel files
- looked at five care and treatment records of people who use services
- carried out a specific check of the medication management in the service, and
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this inspection

What people who use the service say

We spoke with five people. People using the service said they felt safe. They felt staff treated them with respect and genuinely cared about their wellbeing. People using the service reported they could always find a member of staff when they needed one and staff were approachable and supportive.

People using the service felt fully involved in their treatment and were aware of the contents of their treatment plans.

People using the service knew how to complain, and were provided with this information upon admission. They felt listened to and said staff were responsive if they felt they were struggling.

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 rate specialist services but found that:

- there were sufficient staff on all shifts.
- the provider had robust systems to manage incidents and used the learning to improve the service.

However,

- staff had omitted security checks, which meant that the premises might not have been secure and safe for people using the service and staff.
- some staff were unclear regarding safeguarding procedures.

Are services effective?

We do not rate specialist services but found that:

- comprehensive assessments took place within 24 hours of an individual's admission for treatment and included a full medical assessment.
- staff had a positive working relationship with other teams outside of the organisation.
- the provider considered best practice guidance when prescribing medication for detoxification and stabilisation. There was a good range of alternative therapies offered.
- all people using the service had key-working sessions, these sessions gave individuals the opportunity to discuss their treatment, any concerns and make plans for discharge.
- the provider had skilled staff to support individuals undergoing treatment.
- all staff had received an appraisal.
- people using the service were able to attend recovery groups such as Narcotics Anonymous.
- the service had consistent access to a doctors five times a week. There was management cover and an on call doctor out of hours.

However,

- The provider did not offer mental capacity act training even though staff undertook assessments of capacity.
- The provider did not consider prescribing naloxone to people who had used the service and had been discharged. This was not in accordance with national guidance or recommended best practice.

Summary of this inspection

Are services caring?

We do not rate specialist services but found that:

- people using the service were involved them in their care planning and knew about their treatment goals
- people using the service could give feedback on the service
- there was evidence of changes being made to the group work programme after people using the service had made suggestions.

Are services responsive?

We do not rate specialist services but found that:

- people using the service had access to activities throughout the week, including weekends.
- staff supported people using the service to access their spiritual needs in the local community.
- the provider had links with the local sexual health clinic and made referrals when necessary.
- people using the service felt safe and said they received all the information they needed to understand what to expect from treatment
- people using the service expressed high rates of satisfaction with the service

However,

- some staff were unclear how to arrange an interpreter for people who used the service who were unable to speak English.

Are services well-led?

We do not rate specialist services but found that:

- The provider had values, which included, innovation, compassion, integrity and ambition. The staff modelled these values in the work they undertook with people who used the service.
- staff were open and transparent with people who used the service and informed them when things went wrong.
- development days for staff took place regularly.

However,

- there was low morale amongst a number of members of staff.They described high levels of stress and concerns around losing their job if they challenged management.
- The service was undergoing changes and some staff did not feel supported.

Detailed findings from this inspection

Substance misuse/detoxification

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse/detoxification services safe?

Safe and clean environment

- Cranstoun - City Road provided a service from four converted, listed buildings. The layout of the building meant that staff could not easily observe all parts of the building. There was no closed circuit television (CCTV) on the premises. However, the provider had recently installed an alarm system. This enabled staff to summon assistance if necessary. At the time of the inspection, there were not enough alarms for all the staff on duty because the provider had not ordered enough. The provider was ordering extra alarms. Until then, staff that had direct contact with people using the service carried alarms.
- Staff carried out security checks on the building every 12 hours. Checks had not taken place on 12 occasions in October 2015. Between 1 and 22 November 2015, the checks were missed on six occasions. This meant that the provider was not following its own procedures. There was no assurance that the premises were secure and safe for people using the service and staff at all times.
- The service complied with guidance on same sex accommodation. The bedrooms and bathrooms for male and female people using the service were on separate corridors. There were house rules in place for people using the service. Males were prevented from going onto the female corridor. The premises did not have a female only lounge.
- The furnishings throughout the service were clean and well maintained.
- The clinic room was well equipped with a range of emergency equipment. Staff checked the equipment weekly. Staff knew where the service kept the emergency medicines and equipment bag. However,

the staff had not labelled the bag clearly. This could have posed difficulty in identification for a staff member who was unfamiliar with the service, such as an agency nurse.

- The resuscitation equipment was stored in a bag, but this was not neatly organised. This meant that it might be difficult to find the correct equipment. The manager told us that they would obtain a more suitable bag, so that equipment could be more easily located. Medicines were stored securely in a separate medical room. Only authorised staff that checked and administered medicines were able to get into the room.
- The nurse manager investigated all medicine errors. There had been one significant error in 2015. An investigation had taken place. The provider had changed its' medicines management procedure after the incident.
- The provider had purchased a large stock of routine medication, which was not needed for detoxification. The quantity of medicines stored had the potential to cause difficulties with how the service managed its' medicines. The provider stated that they would take action to return the unused medicines to the pharmacy after the inspection.
- There was no written procedure or risk assessment for the security of medicines in transit to and from the service.

Safe staffing

- The service operated 24 hours a day. There were 35 staff employed at the service. The service had 11 volunteers. There were two vacancies for nurses. The provider used both bank and agency nurses to cover shifts when permanent staff were absent. To ensure that there was minimal impact on people using the service, they only

Substance misuse/detoxification

used nurses who had substance misuse experience. The service also attempted to book the same nurses each time for consistency. There were three staff on long-term sickness absence.

- In the previous twelve months, the provider had used agency and bank nursing staff to cover 113 shifts. No shifts were left uncovered.
- The provider was able to increase staffing levels when there were more than 17 individuals in the service. This was to ensure that there was enough staff to meet the needs of people using the service.
- The provider had a minimum of two nurses on a shift during the day. Additionally there were a range of social care workers and volunteers available during the shift. During the night, there was one nurse on shift and a social care worker.
- There was a doctor available Tuesday to Friday each week. A psychiatrist was available on a Monday, this meant that there was medical cover during the working week. There was management cover and an on call doctor out of hours.
- There were enough staff for individuals to have one to one sessions with staff. These sessions gave people using the service the opportunity to discuss any concerns.
- All staff undertook a period of induction before working in the service. This included new staff observing the way experienced staff worked.
- Staff had completed their mandatory training.
- The provider had undertaken all of the required pre-employment checks on all staff and volunteers. However, some staff members' disclosure and barring service (criminal records) checks were very old. Two of the checks were over seven years old. The provider had a policy that required staff members to inform them regarding any pending criminal prosecutions and convictions. The service did not have any other methods to ensure that staff working at the service were still a fit and proper person to work at the service.

Assessing and managing risk to clients and staff

- We reviewed five care plans. Three of the care plans and risk management plans were comprehensive and personalised. Two of the care plans had identified risks, however, there was no clear risk management plan. This meant that staff and people using the service might not be fully aware of the strategies that could mitigate the risks posed by and to the client.

- People using the service were subject to some blanket restrictions. These were rules, which applied to all individuals. People using the service were required to store their mobile phones and aftershave in the staff office. These restrictions were appropriate to ensure alcohol or illicit substances did not come into the service. Staff agreed these restrictions with people using the service as part of the admission process.
- Three staff out of 12 seemed unclear regarding procedures to safeguard adults and children, even though they had received training. This meant they might not be able to identify when those individuals were at risk of harm. Although children did not visit the service, staff in key working sessions reviewed the needs of people using the service and the individual's social network. Failing to provide staff with basic knowledge of safeguarding children meant that they might not identify the risk posed to children that people using the service came into contact with.
- Staff said they would report safeguarding concerns to the safeguarding lead within the service.
- All medicines were stored safely in a clean, well-ordered, alarmed, clinical room. There were regular checks on the temperatures of fridges where medicines were stored and on emergency equipment. Staff were able to explain what the medicine processes were. There was no written procedure for transporting medicines to and from the service. Staff did not have a locked bag to transport medicines from the pharmacy back to the service. We discussed this with the nurse manager who stated that they would take action to update the procedures after our inspection.
- When individuals were admitted to the service, staff sent a fax to the individual's general practitioner (GP). The GP provided the service with an up-to-date list of the individual's medicines. This ensured that people using the service continued to receive their current medicines.
- The medical team prescribed medication for individuals after a thorough assessment. There were procedures in place for verbal orders to prescribe medication for people using the service in an emergency. The doctor confirmed and signed off the verbal orders within 24 hours. Only nursing staff took the verbal orders. Verbal orders were not used to initiate detoxification. Medicines for detoxification were only prescribed after a face-to-face assessment with a doctor. We noted that out of four verbal order forms in place on the day of the inspection, two of the four forms had been not been

Substance misuse/detoxification

completed in full, to confirm that the service doctor had verified the change within 24 hours. The error was due to the use of two different verbal order forms. We discussed this with the manager on the day of the inspection and this was rectified.

- All visits from family and friends were pre-planned. A member of staff observed visits to ensure safety

Track record on safety

- There was a designated “incident lead” manager and incidents were reported to them in the first instance. There had been seven serious incidents at the service in the previous six months.
- The service had made changes because of learning from incidents. The service had changed their risk assessments so they included an assessment of the risk of domestic violence. The service now trained all staff on domestic violence. The service also had a nominated domestic violence lead. The provider had made changes to their discharge planning so that people using the service were safeguarded from domestic violence once discharged into the community.

Reporting incidents and learning from when things go wrong

- Local incident review meetings took place with the clinical lead, psychosocial lead and service manager. The local management team discussed incidents and looked at the learning from incidents and how they could improve the service.
- Incidents were not a regular agenda item at the staff meeting. Some staff were aware of recent incidents. However, two members of staff we spoke with were not aware of the current policy related to reporting incidents.
- There was a medicines error log. The nurse manager investigated errors. Four incidents were medicine errors. Following these incidents, the service had investigated the incidents. The management had shared the information with staff and implemented new procedures to minimise the risk of future incidents.

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

Assessment of needs and planning of care

- Planned admissions took place. This meant that individuals arrived at the service with both a care and discharge plan in place. There was some scope to take crisis admissions. The admissions team based at the service was responsible for receiving the individual’s referral. The team made contact with the general practitioner (GP) and conducted the initial interview with individuals. The service could not offer safe detoxification to people who had a history of seizures, as these individual’s needs were too complex. These individuals were signposted to alternative facilities, which were better suited to manage their complex needs.
- Members of the medical team assessed individuals on admission to the service. The assessments were comprehensive and looked at the various needs of the person using the service. The tests included an assessment of mental health needs, physical health and social circumstances. There was ongoing monitoring of physical health needs during detoxification and stabilisation. The provider had links with the local sexual health clinic and made referrals when necessary. The staff consulted people using the service regarding their treatment regime. The provider was able to prescribe methadone or buprenorphine to people who had used heroin. The case files of people using the service contained relevant information and this was accessible to relevant staff.
- People using the service with physical health needs had medicines prescribed for them. There were clearly completed prescription charts, including allergy information. There were no gaps in recording.
- All people using the service had care plans. We reviewed five care records in detail. Information of high importance was colour coded for easier identification.
- The staff did not prescribe naloxone for people using the service following opioid detoxification. This medicine is used to prevent death if a client relapses and uses drugs. This was not in accordance with national best practice guidance (Drug misuse and dependence: guidelines on clinical management, Department of Health [DH], 2007). People using the service were given advice about the dangers of overdose post opioid detoxification and information was included in their discharge plan, which was also shared with their community based keyworker and care co-ordinator. Staff prescribed acamprosate for people who were undergoing alcohol detoxification.

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- The provider used recognised tools including opiate withdrawal scales and severity of alcohol dependence questionnaire (SADQ) to measure the severity of withdrawal from alcohol and opiates. There was timely identification of people who were becoming acutely unwell as a result.
- The service manager was developing new training packages. The manager had undertaken an analysis of training needs of staff. They had commissioned a range of training to upskill their staff. This included motivational interviewing, and working with self-harm. .

Best practice in treatment and care

- The medicines prescribed for detoxification were in accordance with current national guidance (National Institute for Health and Care Excellence NICE). Staff prescribed medicines to minimise the risk of complications from alcohol withdrawal. There were detailed local protocols concerning the prescription of medicines for detoxification.
- The social care team provided people who were using the service with a range of groups, including psychosocial interventions. The service also offered a variety of holistic therapies such as Indian head massage and reflexology.
- The psychosocial team led the group work programme. Staff spoke positively about the programme and impact it had on people using the service. Television was allowed only in the evenings and staff felt that this had a positive effect on people using the service, as they felt more motivated to become involved in group activities that promoted recovery.
- A “recovery themed” film was shown whilst people using the service waited for their medicines. This helped to distract people using the service from talking about drugs and alcohol while they were waiting.
- Staff referred people using the service to specialist doctors where there was an identified need. For example, people using the service who had mental health difficulties were referred the psychiatrist. A mobile tuberculosis (TB) unit visited the service to x-ray people using the service.
- A symptom-triggered detoxification regime was used by the service (NICE, CG100, 2010). The service used the Clinical Institute Withdrawal Assessment – Alcohol,

revised (CIWA–Ar) scale to measure the withdrawal symptoms of people using the service. The use of this scale was in accordance with NICE guidance. The service also used a clinical opiate withdrawal scale (COWS).

- The provider had undertaken one clinical review in the last 12 months to assess the quality of care and treatment provided. An independent nurse consultant had led this. The service had not shared the recommendations at the point of inspection.

Skilled staff to deliver care

- The service had a service manager, a clinical lead and a psychosocial lead. The assessment team were also based on site and worked for all of the providers’ services.
- All staff employed by the provider had experience of working in a substance misuse service. Social care staff had, or were working towards, an NVQ3 in social care.
- All the doctors attached to the service had been revalidated. This meant that they had demonstrated their fitness and ability to provide a good level of care. The doctors had undertaken Royal College of General Practitioners training parts 1 & 2 in the management of drug use.
- The provider employed sessional staff to deliver alternative therapies. For example, Indian head massage. The staff had up to date qualifications and insurance certificates. An application form was completed and employment checks made prior to their employment in the service.
- Staff received management and clinical supervision. This provided them with the opportunity to discuss practice issues. There was an expectation that staff would receive supervision every four to six weeks. The provider had appraised staff annually. All staff had an appraisal.
- Nurses had received training in blood borne viruses, overdose prevention and delirium tremens. Social care workers had not received this training, as the monitoring of these issues was a core task of the nurses, rather than social workers.
- One social care worker had requested additional training. The provider had paid for specialist training including motivational interviewing skills.
- The service used volunteers to offer additional opportunities for people using the service to access the community. There was an induction checklist for volunteers.

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- Weekly staff meetings took place. The day of the staff meeting changed on a weekly basis so that different members of staff would be able to attend. The provider displayed the minutes from the staff meeting on the client's noticeboard. This meant that people using the service were aware of what staff were discussing.

Multi-disciplinary and inter-agency team work

- The staff team had built links with some London local authorities. Staff consulted with and provided additional support and information to, locally based teams on work around substance misuse. The service supported local teams to work more effectively with people before they were referred the service.
- Staff had handover meetings at the start of each shift. All of the staff team could contribute to the handover. During the handover meetings, staff discussed people using the service and identified what support they required.
- Three mutual aid organisations (Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous) attended the service weekly to support people using the service. The service had a good relationship with the local pharmacist.

Good practice in applying the Mental Capacity Act 2005.

- The provider did not provide training to the staff on the mental capacity. This training was not mandatory. The provider assumed capacity unless the client was too intoxicated or experiencing withdrawal symptoms, to give consent to admission and treatment. The provider did not begin treatment until the client was able to sign and give consent.

Are substance misuse/detoxification services caring?

Kindness, dignity, respect and support

- All people using the service were very positive about the service. People using the service described staff as 'caring', 'responsive' and 'knowledgeable'. They always had time to listen to individual's concerns.
- Staff understood individual needs and were aware of their preferences.

- People using the service said they felt safe. They said they received all of the information they needed and understood what to expect from treatment.

The involvement of people in the care they receive

- The individuals we spoke with were aware of the contents of their care and treatment plans and had contributed their views. However, people using the service had not signed their care plans.
- Newly admitted individuals were "buddied up" with an individual who was more "established" and further along in their treatment. The service had introduced this in response to client feedback. People using the service had requested a buddy system as a way of helping newly admitted individuals settle into the service.
- The service collected feedback in a number of ways. Daily community meetings were available for people using the service to provide feedback. A person who had completed their drug detoxification some years ago volunteered at the service regularly. They collated feedback from people who were currently undergoing detoxification. People using the service completed feedback questionnaires about the service. We reviewed 47 questionnaires. The majority of people using the service were very satisfied with the service they had received. Some people using the service had asked for additional therapeutic groups. The service had organised these and they were taking place.
- The provider had made links with a number of advocacy services, which could support people using the service. The noticeboard in the service had advocacy information displayed on it.

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

Access and discharge

- The provider admitted individuals from across the London area. Planned admissions took place in the majority of cases. Individuals had a telephone assessment prior to admission. This meant that they had a good understanding of what care and treatment they would receive. Admission for individuals in crisis took place within 24 hours.

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- The provider had a target of 15 people using the service per night. Information provided indicated that they had lower bed numbers in the weeks prior to inspection.
- The provider had a “did not attend” (DNA) procedure. Individuals who failed to turn up for their due admission date were given three opportunities to attend. The provider communicated directly with the individual and the community referrer. This communication was intended to motivate the individual to attend for detoxification.
- There were 25 DNA’s in the 12 months prior to inspection. The provider had discharged 373 individuals back to the community. There were clear plans for discharge at the end of treatment. There were also contingency plans for those individuals who left the service before treatment was completed. Discharge from the service took place between Monday and Friday whenever possible. This was to ensure that there was co-ordination with community substance misuse services in their home area. The community based substance misuse services provided individuals with care and treatment post discharge.
- The service was not wheelchair user friendly. The provider could not admit individuals who used wheelchairs. However, the provider had adapted some of the ground floor bedrooms. This was to make them more accessible for people using the service who had impaired hearing and sight. There was a designated bedroom, which was accessible for people using the service with mobility difficulties. Individuals using this room could have additional support from staff.
- Some staff could not clearly describe how they supported individuals whose first language was not English. One member of staff told us that people using the service ‘managed’ to speak enough English. Another member of staff said that they did not have easy access to interpreters
- Information was available in some languages. However, the provider did not keep this information at the service. Information was not specific to the service.
- The provider supported individuals from differing faiths and would accompany them to places of worship if required. There was also a quiet space for people using the service if they wished to pray. If individuals were unable to go outside the provider could organise for a faith leader to attend the project.
- The catering team at the service provided food that was specific to people using the service’s cultural and religious needs.
- The service had made provisions for transgender people using the service. The service accommodated individuals in a bedroom that related to the gender they identified themselves with.
- The service had recently recruited a female volunteer to run female only groups for the female people using the service.
- Information on local services and harm minimisation was available to people using the service.

The facilities promote recovery, comfort, dignity and confidentiality

- A range of rooms was available so that people using the service could have privacy whilst receiving treatment.
- People using the service had access to activities and therapies every day, these included activities that promoted health and fitness, such as walking.
- There was a ban on people using the service having mobile phones. Staff made individuals aware of this before admission. The provider had a pay phone that people using the service could use to make calls.
- People using the service had access to the garden where they could smoke. The provider offered smoking cessation sessions to people using the service who wanted this.
- A volunteer accompanied people using the service if they wished to go for a walk or shopping.
- People using the service could store their belongings securely. Items of value could be stored in the provider’s safe.
- Facilities were available so that people using the service could make a drink when they wanted to.

Meeting the needs of all people who use the service

Listening to and learning from concerns and complaints

- People using the service knew how to make a complaint. This information was part of the induction pack information.
- The provider received two complaints in the last 12 months. Neither complaint was upheld. The provider had a three-stage complaints process with clear time frames for responses.

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- There were clear systems in place to ensure discussions took place with staff around feedback or lessons learnt following a complaint. Complaints were monitored in the management team meetings. The outcome of complaints was discussed in team meetings.
- The provider had no method for collecting compliments. They were looking at starting a system to collate these.
- The “annual service user survey” undertaken in 2014-15 indicated that the service performed better in 14 areas out of 19 in comparison to the providers’ other locations. The project had made changes to their evening programme because of feedback. The changes included more activities and better conflict resolution strategies for people using the service to enable to deal with disputes in a more positive manner.

Are substance misuse/detoxification services well-led?

Vision and values

- The provider’s vision was to support people using the service to make changes in their lives and to help them make a new start. The provider had values, which included innovation, compassion, integrity and ambition. The service objectives and work undertaken by staff fully reflected the organisations’ vision and values.
- Staff knew who the senior managers in the organisation were and these managers had visited the project.

Good governance

- The service was in the process of transition. The service had commissioned a consultant who was a nurse with experience in similar settings. They provided guidance with introducing more robust clinical governance systems. They also ensured that the current clinical lead had appropriate professional supervision from another nurse.
- Senior staff discussed incidents and learning took place at the monthly provider governance meeting. The deputy director provided feedback to the service
- There were a number of key performance indicators used by the provider to monitor the quality of care and

performance of the service. The project had clear improvement targets for 2015-16. Examples included retaining 90% of staff and increasing the number of successful completions of treatment to 60%.

- The service had a comprehensive service risk register and had clear plans to mitigate the risks identified. The service had identified that the loss of key staff through resignation was a risk to service delivery and the management were considering improving the remuneration package and improving development opportunities for staff. The manager shared these plans in team meetings,
- The provider had a three-stage process for investigating incidents with clear timeframes. The Cranstoun incident review group (CIRG) met monthly and reviewed all incidents. The CIRG implemented and monitored improvement actions plans for the service.

Leadership, morale and staff engagement

- There had been a change in leadership within the provider at a local level. A new manager had started with the provider in June 2015.
- The senior management team told us that the service was in a process of change and that they were aware of the challenges because of this. The service had weekly staff meetings, which enabled staff to discuss service specific issues.
- The service had been running quarterly development days. Staff were able to use these days to give feedback information about the service. The provider held an annual staff conference.
- The manager was undertaking a leadership course, which he said had helped improve his knowledge and skills.
- Staff were open and transparent and explained to people using the service when things went wrong.
- The service had a specific incident review group meeting which took place monthly. The provider also had monthly senior management team meetings.
- There was one bullying and harassment case raised by a member of staff, which was ongoing at the time of the inspection.
- Most staff told us that they felt they could raise concerns with their managers. Some staff talked about positive recent changes with the more structured daytime plans and the change in the availability of television to people using the service. However, three members of staff told us that some changes had been more difficult. They

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reported that this had an impact on staff morale. One member of staff stated that they felt unable to challenge some of the management instructions, as they feared “losing their job”.

- Senior management were aware of the concerns, but action to manage the immediate concerns and stress of staff was unclear

Commitment to quality improvement and innovation

The provider did not participate in any national accreditation schemes

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **MUST** take to improve

- The provider must ensure staff complete training in safeguarding children
- The provider must ensure they have systems to monitor staff to ensure they meet the fit and proper persons employed requirement throughout the period of employment.

Action the provider **SHOULD** take to improve

- The provider should review the policy around the safe transportation of medicines.

- The provider should consider prescribing naloxone for people using the service who are being discharged from the service.
- The provider should ensure that all staff are provided with panic alarms whilst on shift and that the security checks on the building are undertaken in line with local procedures.
- The provider should train staff in the Mental Capacity Act. The provider currently expects staff to undertake capacity assessment on people using the service without training.

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 nursing or personal care	<p>Regulation 18 HSCA (RA) Regulations 2014 Staffing</p> <p>Not all staff had received appropriate training to enable them to carry out the duties they were employed to perform.</p> <p>The service had not provided staff with training on safeguarding children.</p> <p>This was a breach of regulation 18(2)(a)</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed</p> <p>The provider did not have robust ongoing monitoring systems to ensure the fitness of staff.</p> <p>The provider requested a criminal records check when staff were newly employed and did not repeat this process at routine intervals. Some criminal record checks were several years old. The service did not have any other robust methods to ensure that staff working at the service were still a fit and proper person to work at the service.</p> <p>This was a breach of regulation 19 (5)</p>