We Can Recover CIC

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Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Requires Improvement
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Inadequate

Summary of findings

Overall summary

We Can Recover is a Community Interest Company located in West Liverpool. It has been registered with the Care Quality Commission since June 2021 to provide accommodation for persons who require treatment for substance misuse and treatment of disease, disorder or injury.

Following this inspection, we took urgent action and served a Notice of Decision which placed conditions on the service's registration. The Notice of Decision prevented the provider from admitting any further clients to We Can Recover CIC. We were concerned about the unsafe care and treatment of the clients and the lack of good governance.

Due to the seriousness of the concerns identified in this report, the Care Quality Commission (CQC) was also due to issue other enforcement action and a Notice of Proposal to deregister the service.

However, on 12 June 2023 the CQC received an application from We Can Recover to deregister. We were informed that there were no clients at the service receiving a regulated activity.

Therefore, the Notice of Proposal to deregister the service and other enforcement action was not issued.

Our rating of this location stayed the same. We rated it as inadequate because:

- The service did not provide safe care. There was no monitoring of the cleaning processes and ligature risks were not mitigated.
- There were gaps in the fire safety procedures and there was no observation policy. Medicine management was not safe.
- The clinic room lacked the appropriate equipment and emergency medicines.
- The service did not have enough staff with the correct skills, experience and training.
- The service did not have access to the full range of specialists required to meet the needs of clients under their care. The doctor was not specialised in substance misuse detoxification. None of the managers or registered nurses had any experience of managing a substance misuse detoxification service. Managers failed to ensure that staff received training and supervision. Staff did not work well together as a multidisciplinary team or with any relevant services outside the organisation.
- Staff did not assess and manage risk well or follow good practice with respect to safeguarding.
- Staff did not develop holistic recovery plans that were informed by a comprehensive assessment. The admission process was not safe or robust. Staff did not engage in clinical audit to evaluate the quality of care they provided.
- Staff lacked an understanding of the individual needs of clients. Incidents were not reported.
- Staff did not plan and manage discharge well. Clients did not have discharge plans or unexpected exit from treatment plans. Clients near to discharge did not have information outlining the post-discharge process.
- The service was not well led. The governance processes failed to ensure that its procedures ran smoothly. The service lacked an audit system. Managers were not aware of the failings of the service. There were large gaps in employment checks.

However:

- There had been limited improvements, the clinical premises were well maintained with a repairs log in place. Sexual safety in terms of the environment had been rectified. There were now separate sleeping areas for males and females.

Summary of findings

- Staff treated clients with compassion and kindness. Clients reported the group therapy sessions to be beneficial and that the food was of good quality.

Summary of findings

Our judgements about each of the main services

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

Summary of findings

Contents

Summary of this inspection

Background to We Can Recover CIC

We Can Recover is a Community Interest Company located in West Liverpool. It has been registered with the Care Quality Commission since June 2021 to provide accommodation for persons who require treatment for substance misuse and treatment of disease, disorder or injury. The service was dormant, meaning not in use, until 4 October 2022 when We Can Recover started to admit clients for treatment. The service is not funded through the NHS, all clients pay private fees for treatment or are admitted free of charge.

The service had a registered manager who was also the nominated individual. Registered managers have a legal responsibility for compliance with the requirements of the Health and Social Care Act 2008 and associated regulations and must be able to influence compliance with the essential standards. A nominated individual supervises the management of a regulated activity across an organisation.

This is the fourth inspection of the service.

We conducted a focussed inspection in November 2022 and rated the service inadequate in safe and well led. We also issued an urgent Notice of Decision to suspend the service immediately. Warning notices were also issued.

The service was inspected again in January 2023 and focussed on safe and well-led, and the inadequate rating remained, and the suspension extended until February 2023.

The service was inspected again in February 2023 with some improvement, but the ratings and warning notices remained in place.

The provider appealed the suspension, and this was lifted on 17 March 2023.

We Can Recover was registered to provide inpatient care and detoxification for up to 24 clients with non-opiate addictions such as alcohol or cocaine in their residential rehabilitation facility. Clients must adhere to the house rules which include compulsory in-house groups and 12 step meetings. There were nine clients admitted to the service during this inspection.

What people who use the service say

Clients stated that the service lacked activities, especially at weekends when it felt “boring”.

Clients remarked that they were concerned about not knowing where they were due to move to next and the lack of discharge planning. This included being unsure about how mental health needs would be met once discharged and how they would access mental health medication if needed.

One client could not recall their admission or consenting to being at the service. They were upset about not being able to speak to their usual doctor in relation to medication decisions.

All clients reported that the therapy sessions were excellent and that they held them in high regard. Clients were also very complimentary about the quality of the food provided and that staff were always polite and approachable.

Summary of this inspection

How we carried out this inspection

Prior to and following the inspection visit, we reviewed information that we held about the location, and asked other organisations, including the local authority, for information.

During the inspection visit, the inspection team:

- reviewed the quality of the environment and observed how staff were caring for clients.
- spoke with five clients who were using the service.
- spoke with the registered manager, operational manager and clinical lead.
- spoke with four other staff members: including two support workers, a registered nurse and a doctor.
- reviewed seven care and treatment records of clients including risk assessments.
- reviewed client prescription cards.
- reviewed a range of policies, procedures and other documents relating to the running of the service.

This inspection was an unannounced comprehensive inspection that focused on all key questions Safe, Effective, Caring, Responsive and Well Led.

The inspection team was two CQC inspectors, two medicines inspector and one specialist advisor.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The service must ensure that staff have access to a ligature risk assessment and that the ligature risk assessment clearly identifies ligature risks and mitigation. (Reg 17 (2) (b))
- The service must ensure that there are effective systems in place to monitor the cleanliness of the service. (Reg 17 (2) (a))
- The service must ensure that fire safety procedures are carried out in line with the provider's policy and fire risk assessment documents. (Reg 17 (2) (b))
- The service must develop an observation policy that ensures clients and areas of the environment are observed to mitigate any risks to clients. (Reg 17 (2) (b))
- The service must ensure that there is appropriate clinical equipment and emergency medicines available to meet the needs of client. Medicines must be managed safely. (Reg 12 (2) (d))
- The service must ensure that staff are suitably trained, experienced and qualified to meet the needs of the service. The staff induction must cover all necessary modules staff require prior to starting direct work with clients. Staff must be compliant with mandatory training modules and receive regular supervision. Staff must understand the needs of the clients and any associated risk. (Reg 12 (2) (c))

Summary of this inspection

- The service must ensure that there is suitable medical input to ensure clients are appropriately prescribed medicines in a timely and safe way. (Reg 17 (2) (b))
- The service must ensure that pre-employment checks are carried out prior to staff starting work. Staff must have disclosure and barring service checks completed. (Reg 17 (2) (b))
- The service must ensure that risk assessments must contain detailed information about client risk and include concise information about how risk will be managed. (Reg 12 (2) (a))
- The service must ensure that there is a clear admission process and criteria. Staff must understand the admission process and criteria and be able to follow it. The admission criteria should correspond to the level of risk the service is able to manage. (Reg 12 (2) (a))
- The service must ensure that the safeguarding policies are robust and up to date. Staff must understand safeguarding incidents and know how to report safeguarding concerns. (Reg 13)
- The service must ensure that all incidents are reported. (Reg 17 (2) (b))
- The service must ensure that client assessments and recovery plans are detailed and comprehensive. The service must develop discharge plans and unexpected exit from treatment plans. (Reg 9 (3) (a) (b))
- The service must ensure that there are effective systems and processes in place to identify any shortfalls in the quality of the service. Governance structures must be able to promptly highlight any failings within the service. Managers must be able to rectify any issues in a timely way. (Reg 17 (1) (2) (a) (b))
- The service must ensure that client care records are stored in line with policy and General Data Protection Regulations. Personnel records must also be stored in line with GDPR. (Reg 17 (2) (c)

Action the service SHOULD take to improve:

- The service should ensure there are enough activities for clients to minimise lethargy.

Our findings

Overview of ratings

Our ratings for this location are:

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

Inadequate

Residential substance misuse services

Safe	Inadequate
Effective	Inadequate
Caring	Requires Improvement
Responsive	Requires Improvement
Well-led	Inadequate

Is the service safe?

Inadequate

Our rating of safe stayed the same. We rated it as inadequate.

Safe and clean care environments

All clinical premises where clients received care were not always safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Safety of the facility layout

Staff did not complete and regularly update thorough risk assessments of all areas and remove or reduce any risks they identified. During the onsite inspection, staff were unable to demonstrate that there was a ligature risk assessment in place and available to staff to refer to.

There were potential ligature anchor points in the service which staff were unaware of. Therefore, there was limited mitigation in place to keep clients safe. During the onsite inspection we found several strong ligature anchor points in the basement laundry room, boiler room and bedroom six. The anchor points ranged from between four and six feet in height. Staff told us that clients were not allowed to enter the basement without staff supervision. However, the entrance to the basement was unlocked. Bedroom six was unoccupied and this room was also left unlocked.

A ligature risk assessment was provided following the inspection which was incomplete and inaccurate. For example, the ligature risk assessment did not identify ligatures we noted in the basement laundry room, boiler room and bedroom six. There were also no actions to minimise risk within the ligature risk assessment document.

Staff completed a daily walk around which identified if any repairs or cleaning were required.

There was an environmental risk assessment in place dated January 2023. This was not available during the onsite inspection and provided following the inspection.

There was a fire risk assessment in place dated September 2022 which now referred to the service as a substance misuse detoxification service. However, we found that many fire safety processes were not being followed. For example,

there were still two fire logbooks but only one in use. There were a number of weekly fire safety checks that had not been completed each week such as weekly fire escape check, weekly fire alarm check and weekly fire door check. These had only been completed between three and four weeks out of six. The fire risk assessment stated clients who were detoxing required a personal emergency evacuation plan. These had not been completed and staff did not know what a personal emergency evacuation plan was.

Staff did not observe clients in all areas of the service. There was no observation policy in place for staff to follow regarding observing clients or observing higher risk areas of the building. There were no regular checks of areas such as the laundry room (other than the once-a-day daily walk around) and no regular check on clients at set intervals throughout the day. This meant that clients with mental health or physical health risks were not closely monitored.

The service now managed risk and client safety better where there was mixed sex accommodation. At previous inspections, the service had not considered risks associated with male and female shared accommodation. There was now separate sleeping areas and separate bathrooms for both males and females. There was a male only staircase, leading to the male bedrooms and bathrooms and a female only staircase leading to female only bedrooms and bathrooms.

Staff did not have easy access to alarms and clients also did not have easy access to call systems. The service did not have any nurse call alarms or panic buttons available to staff or clients.

Maintenance, cleanliness and infection control

All areas appeared clean, well maintained, well furnished and fit for purpose. The service employed maintenance staff who could carry out repairs and maintenance to the building. Within the previous inspection reports, there were outstanding repairs that required attention. These had mostly been rectified with the exception of the uneven floor in the corridor near the kitchen which remained. The laundry stairs were steep and difficult to navigate. A light switch was now in place at the top of the stairs.

There was previously no clear process to ensure repairs were completed in a timely manner. However, there was now a maintenance log which demonstrated repairs that had been identified and a completion date.

Furniture appeared new and in good order.

Staff did not make sure cleaning records were up-to-date therefore it was not clear how the provider was not assured the premises were clean. There were no cleaning records available to demonstrate that the building had been cleaned thoroughly. There was no longer a cleaner employed. Staff stated that cleaning tasks were completed by other staff members. However, this was not documented. There was a mattress in bedroom 15 with a stain that appeared to be blood. Staff advised that new mattress protectors had been ordered. There were also no female sanitary bins.

It was not clear if staff were following the infection control policy There was evidence of staff using the correct colour coded mop for the kitchen area. Most staff had been trained in the Control of Substances Hazardous to Health Regulations 2002 which was 83% compliant. Most staff had also been trained in how to manage COVID-19 outbreaks which was 79% compliant.

There was an infection control policy in place dated April 2023. Staff were unable to locate this document during our onsite inspection visit. However, when provided following the inspection, the policy was a generic document and contained references to PEG feeding and tracheostomies which were irrelevant to this service.

There were appropriate handwashing facilities in place.

Clinic room and equipment

Clinic rooms were not fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. There was still no couch in the clinic room. At the previous inspection the registered manager had confirmed this would be in place prior to the service re-opening. There was no fridge, oxygen or emergency medicines other than over the counter medicines. There were no pregnancy tests available. There was still no medicines cupboard. At the previous inspection it was confirmed a medicines cupboard would be in place prior to the service reopening. Medicines were still stored in a locked filling cabinet. Staff explained a medicines cupboard had been ordered. We did not see any evidence of this purchase.

However, there was a defibrillator and other equipment such as a blood pressure monitor, thermometer, a height chart and weighing scales. There was a controlled drugs cupboard in place.

Staff had not fully checked, maintained, and cleaned equipment. There were no visible stickers to demonstrate that the equipment had been checked and calibrated. There was a carpet in the clinic room which meant that the cleaning of the clinic room was difficult. The clinic room and equipment were cleaned regularly.

Safe staffing

The service did not always have enough nursing and medical staff, who knew the clients and received basic training to keep people safe from avoidable harm.

Nursing staff

The service did not have enough nursing and support staff to keep clients safe. At the previousprevious inspection in February 2023, we were concerned that registered nurses had been employed but we were unsure how effectively they would be deployed over a 24-hour period. At this inspection the staffing establishment consisted of:

- One registered manager, one operations manager and one clinical manager (registered nurse)
- Three registered nurses
- Eight support workers
- One therapist
- One GP doctor
- Three pre-admission team staff (working from home)
- Four maintenance staff

Managers confirmed that the registered nurses would be deployed to work between 8am and 8pm, 7 days a week. Managers also confirmed that the staffing ratio had been calculated to estimate that one support worker would be required to be on shift per every five clients admitted. Managers also stated that the service did not permit lone working and that there would always be two staff in the building or supporting clients in the community. We found that the staffing rota did not reflect that enough staff had been deployed. There were many gaps on the rota:

- 30 March 2023 Registered manager worked night shift alone
- 1 April 2023 Clinical lead worked night shift alone
- 8 April 2023 Registered manager night shift alone

- 16 April 2023 no managers on shift and no nurses on shift

The nurses that had been recruited were not from a substance misuse background. The clinical lead had no prior experience of substance misuse. Two of the nurses also had no prior experience of substance misuse detoxification services. There was one registered nurse who was a registered mental health nurse.

The service had no vacancies. The operations manager stated that staffing would be increased as more clients were admitted.

The service did not use bank or agency staff. Managers stated any gaps in the rota would be filled by staff already employed by the service to complete extra shifts to cover for annual leave and sickness.

The service had a high turnover of staff. Following the services suspension on 1 December 2022, most staff were dismissed from their employment. When the service was due to re-open, new staff were recruited. Most of the staff we spoke to during the onsite inspection were new in post.

Managers supported staff who needed time off for ill health.

Levels of sickness were low.

The manager could adjust staffing levels according to the needs of the clients. Managers could increase staffing levels, but they were reliant on the goodwill of staff to complete extra hours. We saw evidence of staff working excessive hours. The registered manager was not aware of employment law such as the working time directive. There was evidence of staff breaching this requirement. Evidence of excessive hours worked included:

- On week commencing 27 March 2023, the registered manager worked 70 hours. This consisted almost 41 consecutive hours with four hours break. The staffing rota stated the registered manager worked on 30 March 2023, 9am to 5pm and 8pm to 8am. On 31 March the registered manager worked 9am to 5pm.
- On week commencing 17 April 2023, the registered manager worked 60 hours. This consisted almost 20 consecutive hours with three hours break. The staffing rota stated the registered manager worked on 21 April 2023, 9am to 5pm and 8pm to 8am.
- On week commencing 1 May 2023, the registered manager worked 97 hours. This consisted almost 47 consecutive hours with four hours break. The staffing rota stated the registered manager worked on 5 May 2023, 9am to 8pm and 8pm to 8am. On 6 May 2023 the registered manager worked 9am to 5pm and 8pm to 8am.

Clients had regular one to one sessions with their named nurse.

Staff stated that they did not carry out any physical interventions with clients. We were sent a copy of a restraint policy dated May 2023. The quality of this policy was very poor. The policy was mostly a list of definitions and statements about the use of restraint. Managers and staff told us they would never use restraint and if required they would call for police attendance. This document did not outline this process.

Staff did not share key information to keep clients safe when handing over their care to others. We could not find evidence that, with consent, relevant information was shared with other healthcare providers involved in client care. Policies did not describe how or if, with consent, information would be shared with the person's regular GP on discharge from the service.

Medical staff

Inadequate

Residential substance misuse services

At previous inspections there had been concerns regarding the level of medical leadership and input into the service.

At this inspection, we found that a GP doctor had been employed to oversee the suitability of admissions and to recommend a prescribing regime for clients who required that level of care. The GP was not a substance misuse specialist but did have a Royal College General Practitioner substance misuse certificate. The GP's input into the service was only via remote video or telephone calls to assess clients prior to admission which is not in line with guidance and best practice.

The GP did not offer any leadership to the service. The GP was not listed as an attendee at any of the senior management or clinical leadership meetings. The GP was available to offer telephone guidance to staff. The role of the GP was very limited and would not constitute any leadership for the service.

There was no alternative cover if the GP was unavailable. If the GP had annual leave arranged, the service would not admit any clients during that period. It was unclear how episodes of unplanned leave or sickness would be managed. There was no locum cover arrangement in place. The service therefore did not have enough daytime and night-time medical cover and a doctor available to go to the service quickly in an emergency. In the event of a medical emergency staff said they would utilise accident and emergency provision at the local NHS hospital.

Mandatory training

Staff had not completed and kept up-to-date with all mandatory training. The mandatory training data was difficult to assess. Some training modules were identified as mandatory for some staff but not others of the same discipline. This made mandatory training compliance difficult to understand.

Mandatory training compliance rates were acceptable for the following modules:

- Health and Safety 95%
- Manual Handling 100%
- Risk assessment awareness 90%
- Fire safety awareness 100%
- Fire Marshall 100%
- Fire extinguisher 100%
- Display screen equipment 94%
- Basic food safety awareness 89%
- Stress in the workplace 86%
- Control of substances hazardous to health 95%
- Bullying and harassment 77%
- General data protection regulations 77%
- Personal protective equipment 95%
- The Equality Act 86%
- Lone working 95%
- Mental health awareness 76%
- Reportable injuries, diseases and dangerous occurrences regulations 95%
- CPR awareness 91%
- Modern slavery 91%
- Infection control 86%
- COVID-19 77%

However, the following mandatory training modules were below the expected level:

- Medication management 20% (only three staff had completed this training)
- Safe administration of medication 40%
- Bribery Act 63%
- Basic life support 53%
- Induction training (including CIWA) 68%

The providers safeguarding training compliance data demonstrated there were gaps in the training delivered.

Although fire training compliance was good at the time of the inspection, we found examples of staff completing shifts with clients prior to completing fire training. Fire training was not completed as part of the induction process. Staff were expected to complete this once starting shifts. This meant some staff were working without fire training: in total we found that four staff completed approximately 40 shifts without the appropriate fire training.

The training matrix also showed that the three nurses listed had not completed medicines management training. One out of the three nurses had not completed administration of medicines training. The deputy manager told us support staff could administer medicines at night and there was always someone on shift who was trained. The training matrix showed only three staff had completed medication management training, and only six staff had completed safe administration of medicines. The staff rota showed on 29 and 30 April staff working on the night shift had not completed either relevant medicines training and there were no medicines trained staff available.

There was evidence of one staff member commencing shifts without having completed the induction training modules. The clinical lead stated that there was further inhouse training due to commence on week beginning 15 May 2023 which included first aid, CPR, ligature, seizures and observation.

The training included within the induction model did not equip staff with the necessary skills to commence safe working with clients. There was no mitigation in place to ensure staff without the appropriate training were always supported by other fully trained staff.

The registered manager had access to a mandatory training matrix. However, it was unclear how this was being used to ensure staff on shift had the correct training.

Assessing and managing risk to clients and staff

The screening of clients before admission was poor. This meant clients who were at risk of poor physical and mental health were admitted unsafely. Staff did not assess and manage risks to clients and themselves well. They did not respond promptly to sudden deterioration in clients' physical health.

Assessment of client risk

Staff completed risk assessments for each client on admission, but these were of poor quality. A recognised tool was not used.

Prior to admission clients were assessed by the pre-admission team who completed a pre-admission assessment form. This considered risk information such as:

- Liver damage
- Withdrawal symptoms
- Issues with mobility, hearing and sight
- Self-harm/suicide/psychosis
- Seizures
- Injecting history
- Offending history

However, the information contained in the document was very limited. We saw examples of pre-admission staff not understanding Hepatitis C. "Client had Hepatitis C when they were in prison, but they had all three jabs." The three injections are for Hepatitis B not C meaning the client was potentially still at risk of Hepatitis C complications.

Staff did not consult with any other health professionals to validate the information given or seek further detail to support the pre-admission assessment process.

None of the documents used to assess risk were based on a recognised tool.

Following the pre-admission form being completed, the client was then assessed over the telephone by the GP doctor. Information again was solely based on what the client disclosed. The assessments did not contain full detail of risks. For example, one client's assessment noted that the client was increasingly depressed and suicidal previous year. There was no detail around this such as triggers or what type of suicide was considered or what protective factors the client had.

We saw examples of clients being admitted without satisfactory test results such as liver function tests. Liver function tests should be examined in order to further assess the health of the client and whether any additional support was required whilst they were underdoing a detoxification. One client's liver function test was three years out of date and no longer relevant. Another client had never had a liver function test completed and did not consent to GP contact. Another client did not know who their GP was. Therefore, a liver function test was not obtained for these clients. Staff explained they don't routinely ask for a liver function test prior to admission or at any time.

GP summaries were not routinely requested to support the assessment of risk prior to admission. We spoke with managers of the service who confirmed that clients were expected to bring GP summaries with them when they are admitted to the service. However, this frequently did not happen. For example, one client did not have a GP summary as they were unsure who their GP was as noted in the pre-admission assessment form. Another client did not consent for their GP to be contacted and therefore did not have a GP summary. Their recovery plan stated that the service user was "unsure if [they] is depressed or is experiencing cocaine withdrawal". There is no history from the GP to provide supporting information regarding risks to this service user's mental health. Another client did not have a GP summary, but self-reported experiencing seizures in 2021 and had stopped all their medication four weeks earlier when they relapsed to alcohol. Another client did not have a GP summary despite suffering with asthma which had noticeably deteriorated, according to their care records. There was no GP summary to provide information about prescribing or risk of seizures. Information from GP's and others was not used as part of the decision-making process to admit service users or to manage any ongoing risks.

The service did not have a clear admission criteria. The policy named "Pre-admission and Admission policy and procedure" dated April 2023 did not clearly state an admission criteria or who would be deemed inappropriate to be admitted. Clear admission criteria ensures that service users can be safely managed based on their individual risk and need and the level of care and expertise available. The clinical lead stated that service users who were a risk of seizures, violence or complex mental health risks such as suicidality would not be admitted to the service. In the doctor's terms of contract document, it states that, "A service user would not be suitable for our facility if:

- "They had experienced previous seizures during detox (this would effectively mean the risk is too high as we can't guarantee a seizure would be avoidable in our facility)
- Pregnancy
- They have an extensive history of self-harm or suicidal attempts that have warranted crisis intervention or detention under the Mental Health Act
- Uncontrolled or untreated chronic illnesses that may include heart disease, diabetes mellitus, hypertension, epilepsy, asthma or COPD
- History of complicated or polydrug usage
- Extensive history of eating disorders
- Allergies that require epipen provision
- History of violence
- History of complicated alcoholic hepatitis or cirrhosis"

However, we saw records of service users that had been admitted who would fall into the type of service user that the clinical lead told us would not be admitted, or the type of service user that the doctor's terms of contract stated would not be suitable for the facility.

One client's pre-admission assessment form stated they had a history of seizures three years previously. Another client also had a history of suicide and self-harm previous year and had overdosed on tablets several years ago. The client was also charged with domestic violence and common assault in 2008. Another client was noted to have attempted suicide by hanging in 2020 and had a history of seizures. Another client was documented to have had four seizures whilst self-detoxing, the previous one being in 2021. Another client was diagnosed with asthma that was not under control.

From this information it was clear that the service did not have a clear admissions criterion that they were adhering to. There was a risk that the service did not have staff with the appropriate competence to care for service users with multiple comorbidities.

One client had complex mental health needs and was not taking their prescribed mental health medication. Their notes stated that their diagnosis was generalized anxiety disorder alongside either borderline personality disorder or bipolar affective disorder. The clients' notes stated they were confused on admission and unsure if they had been compliant with their medication or not. The clinical lead informed us during our inspection process that the doctor had told staff not to give the client their mental health medications. However, during the onsite visit, staff were unable to demonstrate who externally had been liaised with to confirm this decision was safe.

We reviewed seven clients' admission paperwork. We found that:

- Only one client had been assessed appropriately in relation to their drug use.
- Only one client had been assessed appropriately in relation to their injecting history.
- Two clients had been assessed appropriately in relation to their previous access to treatment.
- No clients had been assessed using tools such as alcohol use disorders identification test and severity of alcohol dependence questionnaire.
- No clients had been appropriately assessed in relation to blood born virus.
- Three clients had assessed appropriately in relation to harm reduction advice.
- Only one client had been assessed appropriately in relation to their motivation to change.

The admission process was further hampered due to failures to prescribe promptly. The GP prescribed for clients remotely. Written confirmation of instructions on how to administer the prescribed medicine were not promptly sent to the service. Copies of some prescriptions were sent to the service during the inspection at our request. However, there was no written information from the prescriber to confirm each client's Chlordiazepoxide regime. Assessments referred to attached dosing sheet – but these were 'ticked' for each dose by staff in the service.

Management of client risk

Staff did not know the full extent of any risks to each client and were therefore unable to act to prevent or reduce risks.

Risks to the health and safety of service users after they were admitted were not assessed effectively. There were nine service users at the time of the inspection. We reviewed seven risk assessment documents and six were of poor quality. For example, one client was noted to have attempted suicide by hanging in 2020. Risk assessments state this risk to be managed by observations. However, no timescales or frequency of observations were specified.

The content of the risk assessments was vague and lacked detail. For example, one client was noted to have self-harmed and attempted suicide in 2022. The same client had also taken an overdose about one year previously. There was no detail as to what type of suicide attempt, what type of self-harm, the severity of the overdose or what treatment was required.

A client was also noted to have been charged with common assault and domestic violence. The risk assessment did not state whether they received a prison sentence for this offence. Also, the mitigation did not explain any potential risks now they were sharing accommodation with others.

Risk assessments now contain a scoring matrix.

The GP solely based his judgements of clients on the information provided by clients and staff. He did not have extra information from GP's or from any care records. The GP did not look at any care plans or risk assessments.

Nurses were not inputting into risk assessments or care plans.

Staff did not identify and respond to any changes in risks to, or posed by, clients. For one client, there was no care plan for their asthma. Care records demonstrated that the client was struggling with their asthma which was deteriorating. The service did not seek any GP support or a review of the client's treatment. The client's Fostair inhaler was not listed on their Medication Administration Record chart. The service had not requested a GP summary or a copy of their recent discharge from hospital to clarify that the medicine prescribed was correct and complete. There was no evidence to demonstrate that the inhaler was being administered as prescribed. A GP summary was obtained at our request during the inspection. It was noted that this client should have been prescribed two inhalers. The service failed to escalate increasing physical health risks or to confirm the correct treatment was being administered.

Staff did not follow procedures to minimise risks where they could not easily observe clients. There was no observation policy in place for staff to follow in regard to observing clients or observing higher risk areas of the building. There were no regular checks of areas such as the laundry room (other than the once-a-day daily walk around) and no regular check on clients at set intervals throughout the day. This meant that clients with mental health or physical health risks were not closely monitored.

Staff followed policies and procedures when they needed to search clients or their bedrooms to keep them safe from harm. The service had a search policy. This was not dated and did not have a date for review. Some of the content of the policy was not relevant and referred to the searching of staff.

Use of restrictive interventions

Staff stated that they did not use any restrictive interventions. However, the service had a restraint policy dated May 2023. This policy was of very poor quality. The document was a list of definitions and statements about the use of restraint. Managers and staff told us they would never use restraint and if required they would call for police attendance. This document did not outline this principle.

Staff were not trained in restraint. Staff explained they would use de-escalation techniques to support clients if they were distressed and to keep the client and others safe.

Safeguarding

Staff did not understand how to protect clients from abuse and the service did not work well with other agencies to do so. Staff had received limited training on how to recognise and report abuse and lacked knowledge of how to apply it.

Staff had received limited training on how to recognise and report abuse, appropriate for their role.

The provider's safeguarding training compliance data was difficult to assess as some safeguarding courses were classed as not applicable to staff of the same discipline who had completed the same level. For example, out of 22 staff:

- 12 staff completed safeguarding adults, level two.
- Three staff completed safeguarding adults, level three.
- No staff completed safeguarding adults, level five.
- Four staff completed safeguarding children level two.
- One staff completed safeguarding children level three.

Also, six staff had received no safeguarding training at all. This consisted of four support workers and two maintenance staff. There was only one nurse who had completed safeguarding children level 3.

No staff had received safeguarding adults or children level four training.

The operations manager was the service safeguarding lead. However, the only safeguarding training they had completed was safeguarding adults, level two.

Most staff were new in post since the service re-opened on 31 March 2023 and therefore were not due to renew their safeguarding training.

Staff could give clear examples of how to protect clients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Inadequate

Residential substance misuse services

Staff did not know how to recognise adults and children at risk of or suffering harm and did not work with other agencies to protect them. Staff did not know how to make a safeguarding referral and who to inform if they had concerns. We saw evidence of a client disclosing to staff that they had historically been a victim of sexual abuse. However, this was not reported as an incident internally nor raised as a safeguarding alert to the local authority.

There was a safeguarding policy in place that had been reviewed in April 2023. However, the document did not include any safeguarding children information. The safeguarding lead was not listed in the document and an ex-employee was named as the safeguarding lead.

Managers did not take part in serious case reviews or make changes based on the outcomes. Managers did not have any links with similar organisations to share learning or good practice.

Staff access to essential information

Staff did not have easy access to clinical information, and it was not easy for them to maintain high quality clinical records – whether paper-based or electronic.

Client notes were not comprehensive, and all staff could not access them easily. Clients care record documentation was poor and lacked specific detail. Information was missing prior to admission that would have supported risk assessment and recovery planning. Telephone calls about clients were not documented in the client notes. These were stored electronically. Staff were unable to access these during our inspection visit. Telephone calls were also not labelled appropriately. This meant staff needed to listen to the telephone call recording to ascertain which client it related to.

Records were not stored securely. Client records were mostly held in paper files within a locked office. Other aspects of client records were held electronically. We noted that staff laptops had the passwords labelled to them making access not secure. The staff office also had a notice board that had confidential client details clearly written on it. Clients also accessed this office and could see the information about themselves and others.

Medicines management

The service did not fully use systems and processes to safely prescribe, administer, record and store medicines. Symptoms of alcohol withdrawal were not consistently monitored in line with the providers own guidance.

Staff did not follow systems and processes to prescribe and administer medicines safely.

A private GP spoke with clients via video link or telephone before commencing a detoxification regime. A medical and drug history was obtained from the client. However, blood results to check whether it was safe to prescribe a detoxification regime were not always obtained by the service. We saw examples of liver function tests not being obtained by the service. The GP assessment explored alcohol intake and there was evidence of tailoring fixed dose regimes to support withdrawal, but severity of dependence was not clearly documented using a formal assessment tool. The GP prescribed for clients remotely, written confirmation of instructions on how to administer the prescribed medicines were not promptly sent to the service. No written record of the GP advice was available at the service to confirm the dosing instructions for each client's alcohol withdrawal prescribing regimen.

The service had contracted a private GP contactable by the service throughout the detox process. Staff told us that clients who were not admitted for detox would be supported to access their own GP, or to register temporarily with a local GP if needed.

Staff did not complete medicines records accurately and kept them up to date.

Medicines administration records were poorly completed and did not always evidence the safe administration of clients' medicines.

Staff did not store and manage all medicines and prescribing documents safely. Medicines were securely stored but contrary to the services own policy there was no medicine fridge, should any medicines require refrigerated storage. Prescribing records for alcohol detoxification were not clearly maintained and easily accessible. There was no written confirmation of the individual alcohol detox regime prescribed for each client.

Staff did not follow national practice to check patients had the correct medicines when they were admitted, or they moved between services. We could not find evidence that, with consent, relevant information was shared with other healthcare providers involved in clients' care. Policies did not describe how or if, with consent, information would be shared with the client's regular GP on discharge from the service.

Staff did not review the effects of each patient's medicines on their physical health according to NICE guidance. Staff did not always record CIWA-Ar scores at the frequency described in the service's own protocol. Guidance about use of 'when required' doses of medicine was unclear because the instructions on each clients CIWA-Ar form differed from those on their detoxification regimen form.

Track record on safety

The service did not have a good track record on safety.

Reporting incidents and learning from when things go wrong

The service did not manage client safety incidents well. Staff did not recognise incidents and report them appropriately. Managers therefore did not investigate incidents and share lessons learned with the whole team and the wider service.

Staff did not know what incidents to report and how to report them. Staff we spoke with said they were aware of how to raise incidents and described incidents they would class as needing to be reported. However, in practice we saw examples of this not happening.

We spoke to all leaders within the service, who all confirmed no incidents had occurred and therefore there was nothing reported.

However, we noted medicines errors that had not been reported. One client also disclosed historical sexual abuse which was not reported as an incident or as a safeguarding concern.

Managers said there was an incident form to complete.

Inadequate

Residential substance misuse services

Staff did not raise concerns and report incidents and near misses in line with provider policy. The service had a serious incident policy and an accident and incident reporting policy. Both policies were not dated nor had a review date. Staff had not reported an incident in line with these policies.

At the time of the inspection, the service had only been re-opened for approximately six weeks. There had not been any serious incidents.

The service had no never events.

Staff understood the duty of candour.

Managers did not investigate incidents thoroughly as we saw evidence of incidents not being reported. Clients and their families were therefore not involved in these investigations.

Is the service effective?

Inadequate

We have not previously inspected the effective key question. We rated it as inadequate.

Assessment of needs and planning of care

Staff did not complete comprehensive assessments with clients on admission to the service. They worked with clients to develop individual care plans and updated them as needed. However, care plans were vague and lacked specific detail.

Staff did not complete a comprehensive substance misuse assessment of each client either on admission or soon after. Prior to admission clients were assessed by the pre-admission team who completed a pre-admission assessment form. However, the information contained in the document was very limited.

Staff explained they do not routinely ask for liver function tests or GP summaries prior to admission or at any time. The assessments completed by the doctor were vague and lacked specific detail. This meant assessments were completed with significant gaps in information.

All clients had their physical health observations completed soon after admission. However, staff did not have a GP summary to support their knowledge and understanding of the client's physical health needs. Therefore, it was not possible to respond to physical health needs that had not been known or disclosed by the client. We saw an example of one client with deteriorating asthma for whom the service had not sought any extra support.

Staff did not develop a comprehensive recovery plan for each client that met their substance misuse, mental health and physical health needs. We reviewed seven client records in respect of their recovery plans. Only four clients had recovery plans completed. Three clients did not have a recovery plan. Recovery plans were not recovery orientated and lacked detailed information about the client's care. One client with complex mental health needs did not have a robust recovery plan in relation to her mental health medication. Other recovery plans were very brief and did not contain measurable goals.

Staff did not regularly review and updated care plans when clients' needs changed. We noted that the client whose asthma had deteriorated had not had their recovery plan updated to reflect this change in circumstance.

Recovery plans were personalised, but not holistic or recovery orientated.

Best practice in treatment and care

Clients did not have good access to physical healthcare but staff did support clients to live healthier lives. Staff did not use recognised rating scales to assess and record severity and outcomes. They also did not participate in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the clients in the service. Clients on average spent three hours a day receiving group therapy. The day was structured to include opportunities to engage in yoga, group walks and individual sessions with staff.

Staff did not always identify clients' physical health needs and mental health needs and recorded them in their recovery plans. We noted one client with physical health issues relating to asthma. This was not well documented in their recovery plan. Another client with complex mental health needs, did not have this documented clearly in their recovery plan.

Staff did not always make sure clients had access to physical health care, including specialists as required. For one client with asthma, staff did not seek any external support from any primary or secondary care services. This meant that it was likely the clients physical health would deteriorate further putting the client's health at risk.

Staff met clients' dietary needs and assessed those needing specialist care for nutrition and hydration. Clients were asked about any dietary needs as part of the pre-admission assessment process.

Staff helped clients live healthier lives by supporting them to take part in programmes or giving advice. Clients engaged in a daily programme of activities aimed at supporting them to have more structured and meaningful lives. The structured routine began at 8am and finished at 11pm. Clients were expected to participate in walking groups, yoga, meditation, art classes, and breadmaking sessions. Clients were also expected to join external online support groups to support them in the longer term and following discharge.

Staff did not use recognised rating scales to assess and record the severity of clients' conditions and care and treatment outcomes. However, the service had developed an inhouse tool based on the Recovery STAR model.

Staff did not take part in clinical audits, benchmarking or quality improvement initiatives. The service was not auditing any aspect of the service. Although the service had only been re-opened for approximately six weeks, there was not a programme of audits in place ready to be implemented. The service had not benchmarked itself with a similar service.

Managers were therefore unable to use results from audits to make improvements.

Skilled staff to deliver care

Inadequate

Residential substance misuse services

The teams did not have access to the full range of specialists required to meet the needs of clients under their care. Managers failed to make sure that staff had the range of skills needed to provide high quality care. Staff were not receiving supervision. Managers provided an induction programme for staff. However, the induction programme lacked all necessary modules required for staff to begin work safely.

The service did not have access to a full range of specialists to meet the needs of the clients in the service. Managers did not ensure staff had the right skills, qualifications, and experience to meet the needs of the clients in their care. At previous inspections we were not assured that staff had the skills and experience to ensure safe care was delivered.

At this inspection we found that the GP doctor responsible for assessing potential admissions, prescribing and addressing any ongoing concerns was not a specialist in substance misuse. The GP doctor had a Royal College General Practitioner substance misuse certificate only. He had no experience of working in a substance misuse detoxification service. The nursing team were also not experienced in substance misuse. The clinical nurse lead had never worked with substance misuse clients. Other nurses included two registered general nurses and one registered mental health nurse were also not from a substance misuse background. We spoke with a registered nurse who confirmed their role was to focus on medication. They did not input into recovery plans or risk assessments these were completed by the support worker staff. The service employed a therapist. On the day of our inspection the therapist was on sick leave. None of the leaders we spoke to had any experience of managing a substance misuse detoxification service. We also spoke to two support workers who confirmed that only one of them had experience of substance misuse.

Managers did not give all staff a full induction to the service before they started work. Only 68% of staff had completed the induction training.

The induction training included inhouse training on the following topics:

- Emergency protocol
- Operations manual
- Values and aims of the service
- Professional boundaries
- Risk assessments and psychological risk assessments
- Capacity to consent
- Support plans
- Medicines policy (incident reports, medication errors, MAR charts and CIWA)
- Case notes
- Whistleblower policy
- Safeguarding
- On-call response
- Feedback form

There was evidence of one staff member commencing shifts without having completed the induction training modules.

The training included within the induction model did not equip staff with the necessary skills to commence safe working with clients.

There was no mitigation in place to ensure staff without the appropriate training were always supported by other fully trained staff.

Managers did not support staff through regular, constructive clinical supervision of their work. We spoke to the clinical lead who stated that supervision was not part of their role to deliver or monitor compliance regarding clinical supervision. We were told that supervision was the responsibility of the operational manager. The operational manager confirmed that they had delivered managerial supervision to three members of staff, the clinical lead, a registered nurse and a senior support worker. There was no overarching plan regarding how supervision would be delivered to all other staff or to include clinical supervision.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Team meetings had taken place. We reviewed the team meeting minutes and confirmed meetings had taken place. We requested minutes of the senior management meetings. One was supplied for March 2023. We requested team meeting minutes and one was supplied for April 2023 with only four staff in attendance. This meeting highlighted GP summaries not being available.

There was evidence of meetings taking place. However, there was no set agenda such as incidents to discuss or safeguarding issues. Set agenda help support information flowing from staff to senior leaders. Staff informed us that meeting minutes were also emailed to them.

Managers had not yet identified any extra training needs for their staff. The service had only been re-opened for approximately six weeks. During the inspection visit staff remained focussed on completing mandatory training modules. No further training had been considered at this stage.

Managers had not made sure staff received any specialist training for their role. None of the staff employed by the service had any previous experience of working in a medically assisted substance misuse detoxification service.

Managers recognised poor performance, could identify the reasons and dealt with these. Managers were able to identify staff who had failed to complete training modules in a timely manner and were dismissed from their post.

Multi-disciplinary and interagency teamwork

Staff from different disciplines did not work together as a team to benefit clients. The team did not have effective working relationships with other relevant services outside the organisation.

Staff did not hold regular multidisciplinary meetings to discuss clients and improve their care. Staff did not have effective working relationships with external teams and organisations. We did not see any record of any multidisciplinary meetings being held in respect of individual client care. Staff told us that telephone discussions were held between the operational manager and the GP doctor in respect to agreeing new admissions. However, we could find no record of these discussions within the care record system. Staff told us these discussions via telephone were recorded and stored within a separate electronic system. On reviewing these telephone calls with the registered manager, it was not possible to clearly identify which recording related to which client or the nature of the discussion. The calls recorded were not clearly labelled.

We noted an example of a client who prior to admission was prescribed multiple mental health medications. This medication was stopped on the client's admission to the service. We could not find any evidence to confirm how the decision to stop all the mental health medication was reached. We could not find evidence that relevant information

was shared with other healthcare providers involved in the patients care. The prescriber did not share information with other healthcare professionals before prescribing and the assessment did not demonstrate that the risks of not sharing information had been explained to the client. There was no multi-disciplinary meeting recorded regarding this client's complex care.

Staff made sure they shared clear information about clients and any changes in their care, including during handover meetings. We sampled a number of handover documents. There was clear information regarding client wellbeing and progress.

Good practice in applying the Mental Capacity Act

Staff did not support clients to make decisions on their care for themselves well.

Staff had not received training in the Mental Capacity Act and therefore their understanding was limited. No staff had completed training in the Mental Capacity Act. The service had access to an online training module in the Mental Capacity Act but no staff had completed it. It was not listed as mandatory. Some staff had received training in capacity to consent. Capacity to consent training was included as part of the induction programme. However, not all staff had received the induction. At the time of the inspection the compliance with this was 68%.

We were concerned regarding the admission and capacity of one client. A client disclosed to us that they did not recall their admission to the service. Admission paperwork was completed which described the client as "totally confused" and that they were unsure whether they had been compliant with their mental health medication.

There were no deprivations of liberty safeguards applications made in the previous 12 months.

The service did have a Mental Capacity Act policy for staff to refer to.

Staff did not know where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards. No staff had received training in the Mental Capacity Act.

It was not known whether staff gave clients all possible support to make specific decisions for themselves before deciding a client did not have the capacity to do so. The service had only been re-opened for approximately six weeks. One client was admitted whilst appearing confused. There was no capacity assessment for this client.

Staff assessed and recorded capacity to consent clearly each time a client needed to make an important decision. We noted that staff had documented evidence of mental capacity during the admission process for three clients. Three other clients did not have their capacity to consent to admission clearly stated in their notes.

It was unclear if staff assessed clients as not having capacity, they would be able to make decisions in the best interest of clients and consider the client's wishes, feelings, culture and history. As staff had not received training in the Mental Capacity Act, it was likely that staff would not understand the best interests' process.

The service did not monitor how well it followed the Mental Capacity Act or make changes to practice when necessary.

Staff did not audit how they applied the Mental Capacity Act or identify and act when they needed to make changes to improve.

Inadequate

Residential substance misuse services

Is the service caring?

Is the service caring?

Requires Improvement

We have not previously inspected the caring key question. We rated it as requires improvement.

Kindness, privacy, dignity, respect, compassion and support

Staff treated clients with compassion and kindness. However, they lacked understanding in relation to respecting clients' privacy and dignity. Staff also lacked an understanding of the individual needs of clients and were therefore unable to support them to understand and manage their care, treatment or condition.

Staff were not always discreet, respectful, and responsive when caring for clients. We witnessed a staff member beginning a one-to-one session with a client in a room full of staff and external visitors. Staff also did not respond appropriately and in a timely way for a client whose physical health was deteriorating.

Staff gave clients help, emotional support and advice when they needed it. Clients reported that staff were available to them when needed.

Staff were not fully able to support clients to understand and manage their own care treatment or condition. Staff were not experienced in working in a medically managed substance misuse detoxification service. There was no specialist training provided to mitigate this gap in staff's knowledge.

Staff did not always direct clients to other services and supported them to access those services if they needed help. Clients did not have unexpected exit plans or discharge plans. Staff were not directed to other sources of support in their home areas. Staff were not aware of any local advocacy services that would be useful to clients.

Clients said staff treated them well and behaved kindly. Clients reported that staff spoke to them in a polite manner.

Staff lacked an understanding around the individual needs of each client. Staff were not experienced or well trained in the understanding of medically managed substance misuse detox. This lack of understanding of needs was highlighted in the poor care plans that we reviewed.

Staff felt that they could raise concerns about disrespectful, discriminatory, or abusive behaviour or attitudes towards clients.

Staff did not follow policy to keep client information confidential. We noted that three laptops that held confidential client information had labels attached to them clearly stating the password to access them. Confidential telephone calls with clients or about clients were recorded and stored electronically. Each call was not labelled clearly. Staff would need to listen to calls to differentiate which client it related to. We were not assured that the electronic storage of telephone calls was safe and not easily accessible to others.

Involvement in care

Inadequate

Residential substance misuse services

Staff did not always involve clients in care planning. However, staff did actively seek client feedback on the quality of care provided. Staff did not always ensure that clients had easy access to additional support.

Involvement of clients

Staff introduced clients to the service as part of their admission. On admission clients were given a tour of the building. Daily routines were explained to clients such as mealtimes and therapy times. Clients were given an activity planner for their reference. A nurse completed a list of physical observations.

Staff did not always involve clients or give them access to their recovery plans. We reviewed seven recovery plans. Four were personalised and referenced client views. Three were not personalised and did not include client views. Recovery plans had been offered to only three clients.

Staff did not always make sure clients understood their care and treatment. We spoke to clients who were concerned about their imminent discharge but did not know what their discharge plans were. The service had not completed any discharge or unexpected exit from treatment plans for any clients that we could find.

We did not see any evidence of staff involved clients in decisions about the service.

Clients could give feedback on the service and their treatment and staff supported them to do this. Clients were contacted following their discharge and asked to complete a questionnaire regarding their recent admission. The service had received five feedback questionnaires. The service also had a comments box for clients to post feedback. Clients also kept daily diaries which contained client reflections on their admission experiences.

Staff did not make sure clients could access advocacy services. The service had not made any links with any local or national advocacy service. Staff were unable to direct clients for advocacy support as this provision had not been considered by the service.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Staff stated that with client consent they contacted families and carers when needed. Clients were asked on admission whether they consented to carer contact. Families and carers were not permitted to visit the service. The service were considering having family visits every Sunday. No date for this commencing had been set.

Staff did not help families to give feedback on the service. There was no provision for families to give feedback other than the complaints process.

Staff did not give carers information on how to find the carer's assessment. We saw no evidence of staff signposting carers to organisations that could support the completion of a carers assessment.

Is the service responsive?

Inadequate

Residential substance misuse services

Requires Improvement

We have not previously inspected the effective key question. We rated it as requires improvement.

Access and discharge

The service was easy to access. However, staff did not plan or manage discharge well. The service did not have alternative care pathways or referral systems for people whose needs it could not meet.

Bed management

Managers made sure bed occupancy did not go above 85%. At the time of the inspection bed occupancy was 38%. There were only nine clients. Managers we spoke to stated that they planned to steadily increase their occupancy and staffing levels at a pace that was manageable.

Managers regularly reviewed length of stay for clients to ensure they did not stay longer than they needed to. Clients were only permitted to stay for the length of time agreed prior to admission.

Clients were admitted from all different areas of the country.

Managers and staff worked to make sure they did not discharge clients before they were ready. Clients were encouraged to remain in the service until their treatment had finished. However, no clients had discharge plans or unexpected exit from treatment plans. This meant that clients wishing to self-discharge earlier than planned did not have a plan of how to manage this.

Staff did not move or discharge clients at night or very early in the morning. We saw no evidence of discharges occurring at inappropriate times.

Discharge and transfers of care

The service had not experienced any delayed discharges. The service had access to a step-down provision of supported accommodation in the local area. If clients were unable to access housing from their home area, they were offered supported accommodation. This could be on a temporary or longer-term basis.

Staff did not carefully plan clients' discharge. They did not work with external agencies to make sure this went well. We reviewed seven client discharge plans. No clients had completed discharge plans.

Staff did not always support clients when they were referred or transferred between services. A client whose physical health was deteriorating was not referred to primary care or specialist care to have their health concerns reviewed. The service had not completed discharge plans or unexpected exit from treatment plans to support any transition for clients to return home or to access other services.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported clients' treatment, privacy and dignity. Each client had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy.

Bedrooms were a mixture of twin and single rooms. Clients could choose a single or twin room dependant on the fee charged. At the time of the inspection, each client had their own bedroom as there were only nine clients admitted to the service. Clients could personalise their rooms with photographs or other belongings. Clients were not permitted to put pictures on the wall due to bedrooms being recently redecorated.

Clients had a secure place to store personal possessions. All money and mobile phones were handed in to staff for safekeeping. Clients could access money on request.

The service had a full range of rooms and equipment to support treatment and care. Staff and clients could access the rooms. The service had a clinic room, a dining room and kitchen and two lounges. There was no female only lounge.

The service had quiet areas which were the two lounges. The service did not have a room where clients could meet with visitors in private. Visitors were not permitted.

Clients could make phone calls in private. Clients were given their mobile phones to contact family and friends each evening between 6pm and 7.30pm. Clients were permitted to use their phones in their bedrooms for privacy. Mobile phones were handed back into staff each day after usage.

The service had an outside space that clients could access easily. The service had access to an outdoor area that was paved and tidy. Clients could access this area directly from the dining room.

Clients could make their own hot drinks and snacks and were not dependent on staff. Hot drinks and snacks were available for clients to access in the kitchen/dining room. These were available at any time.

The service offered a variety of good quality food. Clients reported that the food was of excellent quality. Clients stated the meals were varied and healthy. The service employed a chef Monday to Friday. Staff cooked meals at weekends that had been prepared by the chef.

Meeting the needs of all people who use the service

The service had limited ability to support and make adjustments for disabled people and those with communication needs or other specific needs. The service did not have lift access. Clients were asked about their mobility prior to admission. Clients who were unable to manage stairs were not admitted to the service. There was no hearing loop to support deaf people. Clients were also asked about issues relating to hearing, sight, and literacy prior to admission.

The service did not have information leaflets available in languages spoken by the clients and local community. There were no leaflets on display anywhere in the building.

Managers did not make sure staff and clients could get help from interpreters or signers when needed. The registered manager had considered using translators for clients who did not speak English or were deaf. However, they concluded this was too expensive to be feasible. Clients were asked about their hearing, sight and ability to read and write prior to admission.

The service provided a variety of food to meet the dietary and cultural needs of individual clients. Clients were asked about any specific allergies and dietary needs of clients prior to admission. The registered manager stated they were unable to cater for any clients with severe allergies. However, the chef was able to adapt meals to meet other dietary requirements.

Clients had limited access to spiritual, religious and cultural support. The service was unable to facilitate clients who wanted to attend religious services outside of the building. The service had not developed any links with any local religious organisations. If necessary, clients would be allowed a religious leader to visit the service. The service had not yet had a client with any religious or cultural needs.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Clients knew how to complain or raise concerns. Clients were made aware of how to complain by various methods. This included within client community meetings, informal discussions with staff and in the welcome pack sent to clients prior to admission.

Information about how to complain was not clearly disclosed to relatives and carers.

The service had no clearly displayed information about how to raise a concern in client areas. There were no leaflets or posters on display relating to complaints.

Staff understood the policy on complaints and knew how to handle them. There was a complaints procedure in place for staff to follow. This policy was not dated and did not have a review date.

The registered manager stated the service had not received any complaints. Following this inspection, we were made aware that the service had received several complaints in December 2022. The registered manager did not disclose this or demonstrate any learning from these complaints.

Staff knew how to acknowledge complaints. This was explained within the complaint's procedure. It was unclear whether clients received feedback from managers after the investigation into their complaint as this information was not shared with us.

We did not see any evidence of the service using compliments to learn, celebrate success and improve the quality of care.

Is the service well-led

Is the service well-led?

Inadequate

Our rating of well-led stayed the same. We rated it as inadequate.

Inadequate

Residential substance misuse services

Leadership

Leaders lacked the skills, knowledge and experience to perform their roles. They did not have a good understanding of the services they managed. However, they were visible in the service and approachable for clients and staff.

At the previous inspections, we were concerned that managers were not experienced in the running of a medically managed substance misuse detoxification service.

At this inspection we continued to be concerned about the lack of skill and experience held by managers. There were two managers with lived experience of substance misuse detoxification and rehabilitation but they did have and qualifications or experience of managing such a service.

In more recent months, the service had also appointed a clinical lead. However, they had no qualifications or experience specific to substance misuse detoxification. Although, they were a registered nurse, they were not familiar with the requirements of the service. They were unable to answer many of the questions asked of them during the inspection process. They were unable to offer a clinical leadership role to other staff members. They stated that they did not deliver or take responsibility for areas such as staff supervision.

Leaders continued to have a lack of understanding of the service they managed. Management tasks were still delegated out among the three members of the leadership team and there was no oversight of each other's roles. For example, in the absence of the registered manager, other managers were unable to locate documents such as the ligature risk assessment and electronic personnel files. They were unsure whether the maintenance log was accurate or how often the training matrix was reviewed. Client care record documentation was still completed by support workers. Nurses stated that this was not their role. Leaders had failed to ensure clinical input into recovery plans and risk assessments.

The service also had a GP doctor employed to oversee admissions and prescribing to clients. However, the GP doctor did not offer any leadership into the running of the service.

Leaders continued to fail to implement safe systems and processes to provide safe and good quality care to clients paying for the service. There was no process to observe clients or to regularly check areas of the building that contained significant ligature risks.

Managers were visible in the service and mostly approachable for clients and staff.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

At the previous inspections, we were concerned that the service did not have any vision or values. Provider vision and values help staff to understand the purpose of the organisation and the core values on which it is governed. They help a provider to set priorities, allocate resources, and ensure that everyone is working towards common goals and objectives.

At this inspection we were assured that the vision and values of the service had improved. Vision and values were discussed as part of the services staff induction. We spoke to three staff who confirmed they had received information about vision and values during their induction process. Staff also stated they had a written copy for reference.

The service was yet to develop a mission statement. The registered manager stated this was still being worked on.

Culture

Staff felt respected, supported and valued. They said the service promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff felt valued and positive in their roles. Staff described a happy and content staff team who felt respected. The staff we spoke with had only been employed for a few weeks and did not raise any concerns about their managers or the running of the service.

There had been no cases of bullying or harassment reported within the service.

Staff were aware of the whistleblowing process. The whistleblowing process was covered as part of the induction programme.

All staff we spoke with confirmed they felt confident to raise concerns to managers without fear of retribution or victimisation.

The service had not developed any clear staff development opportunities or career progression pathways.

Governance

Our findings from the other key questions demonstrated that governance processes operated ineffectively, and that performance and risk were not managed well.

At the previous inspection, we were concerned that the service was poorly managed and that there were no systems or processes in place to notify leaders of service failures. This meant there was no opportunity to make improvements or to be assured that clients were safe.

At this inspection, there remained issues with the premises not being cleaned properly and well equipped. Staff still had not completed and regularly updated thorough risk assessments of all the areas and removed or reduced any risks they identified. There were gaps in the completion of fire safety checks.

Clinic rooms were again not fully equipped and emergency drugs available.

The service did not have enough skilled and experienced nursing, medical staff, and leaders, who knew the clients and received relevant basic training to keep people safe from avoidable harm. Managers had not made sure all staff had a full induction and understood the service before starting their shift. Mandatory training compliance in the most important and relevant modules were low.

Staff completed ineffective risk assessments for each client prior to admission and on arrival. The service did not use a recognised risk assessment tool and risk management plans were of poor quality and did not address risks identified. There continued to be gaps in the assessment and admission process. Staff did not have access to a full GP summary before commencing detoxification regimes.

Inadequate

Residential substance misuse services

Safeguarding adult training and safeguarding children training compliance figures were low and haphazard. It was not clear which level of training was required for staff of different disciplines. The provider did not raise safeguarding concerns with the local authority when incidents occurred. The service did not ensure that they kept high-quality, secure clinical records – whether paper-based or electronic, that all staff contributed to. Client and staff records did not meet data protection regulations.

Staff did not follow systems and processes to prescribe and administer medicines safely. Staff did not complete medicines records accurately and kept them up to date. Staff did not store and manage all medicines and prescribing documents safely. Staff did not follow national practice to check patients had the correct medicines when they were admitted, or they moved between services. Staff did not review the effects of each patient's medicines on their physical health according to NICE guidance.

The service did not manage client safety incidents well. Most staff did not recognise incidents and report them appropriately. Managers were unable to investigate incidents or share lessons learned with the whole team due to the lack of reporting.

Recovery plans and associated documents did not contain all pertinent information required to deliver safe care and treatment. Basic elements were missing or were too brief to be of value. This included the management of physical and mental health concerns.

Staff supervision was in its infancy. Only three staff had received managerial supervision. The clinical lead was not able to explain how clinical supervision would be offered to staff.

There was a lack of external liaison with other agencies to ensure clients received the correct treatment in a safe way.

No staff had received training in the Mental Capacity Act

No clients had discharge plans or unexpected exit from treatment plans. Clients were unsure of their next steps causing confusion and distress.

The service was unable to facilitate onsite or offsite family visits.

The service had received complaints in December 2022. The registered manager did not disclose these complaints. It is not known whether the complaints were resolved or whether any learning was gained from following the complaints process.

Leaders did not have the skills, knowledge, and experience to perform their roles. They did not have a good understanding of the service they managed. Managers did not complete audits to review the quality of care provided. Individual management tasks were delegated out among the three members of the leadership team and there was no oversight of each other's roles. Policies did not reflect the service provided. Managers did not ensure all staff had all the appropriate pre-employment checks in place prior to starting in their roles.

There were no audits in place or scheduled to take place in relation to care records, DBS checks or professional registration. The registered manager informed me there was a folder in the office which contained audits. However, it only contained the daily walkaround checklist and list of attendees at a fire drill.

A key performance indicator tracker was submitted to us following the inspection which listed whether clients had a risk assessment and care plan. However, the information was not accurate and did not match what we found on site. For example, one client was listed as having a care plan but during the onsite visit this was not completed. The client did have a brief support plan. This client was on day six of their admission and due to be discharged the following day. The tracker did not date the information so there was no way to tell if documents were completed in a timely way.

However, there had been limited improvement in some areas such as the furnishings were well maintained and fit for purpose. There was now a system to manage maintenance issues. The environment now had bedrooms which were allocated with consideration for environmental risks and banister rails had been fitted. The service now considered risks from mixed sex accommodation and had made separate sleeping areas and bathrooms for males and females. The provider now had vision and values that were shared with their staff. Staff felt respected, supported and valued. They could raise concerns without fear.

Management of risk, issues and performance

The service did not have access to information they needed to provide safe and effective care and were therefore unable to use information to good effect.

At the previous inspections we were concerned that managers had not sought appropriate employment checks, including disclosure and baring service (DBS) checks. We were also concerned that policies and procedures were weak that that these were not being followed by staff. Compliance with Covid 19 measures and infection prevention control were not understood by staff and therefore also not being followed. There was no risk register in place, no ligature risk assessment and client and staff information was not stored within general data protection regulation guidelines.

At this inspection these concerns remained. Employment checks still contained significant gaps in information. Employment records were in both paper files and also on an electronic record called Atlas.

We reviewed nine personnel files and found the following concerns:

One staff member had no DBS check or ID check recorded anywhere in the personnel files. The registered manager checked the online DBS update system during the inspection visit and the DBS was in place. The registered manager also telephoned the staff member who confirmed they had sent copies of their ID via email and this was present and confirmed at that time. However, this was missing from the system. This staff member had been employed since 1 April 2023.

One staff member had no evidence of any employment references. The registered manager confirmed these still needed chasing up. This employee had been employed since 12 April 2023.

One of the registered nurses had no evidence of their professional registration check being completed. The registered manager checked this during the inspection visit and this was in order. However, their professional registration was not recorded anywhere prior to employment.

The therapist had no references on file or on the Atlas electronic system. There was also no evidence of DBS certificate being received. The registered manager confirmed these documents were missing and required following up.

The registered manager had not heard of the working time directive and did not understand the rules regarding staff working excessive hours without sufficient gaps and breaks. We reviewed the staffing rota and noted staff working excessive hours and back-to- back shifts.

There was no plan in place of how to monitor professional registration checks or DBS checks each year.

There was also evidence of personal information not being stored in line with the principles of GDPR. For example, there were paper copies of DBS checks.

The registered manager said for those staff without DBS there was no lone working permitted to mitigate some risks.

We reviewed 16 of the policies the service was using. Eight policies were not dated and did not have a review date. All policies were poor and contained information that was not relevant to the service. For example, the restraint policy dated May 2023 only contained a list of definitions and statements about the use of restraint. Managers and staff told us they would never use restraint and if required they would call for police attendance. This document did not outline this. Also, the infection control policy dated and reviewed in April 2023 included a stool and vomit chart that was not relevant with this type of service.

Staff did not make sure cleaning records were up-to-date and it was unclear if the premises were clean. There were no cleaning records available to demonstrate that the building had been cleaned thoroughly. There was no longer a cleaner in place. Staff stated that cleaning tasks were completed by other staff members. However, this was not documented.

It was not clear if staff were following the infection control policy. There were no cleaning records for us to examine. There was a cleaning schedule in place but there were no cleaning rotas or audits to demonstrate infection controls were being followed. Staff had been trained in the Control of Substances Hazardous to Health Regulations 2002 which was 83% compliant. Most staff had also been trained in how to manage Covid 19 outbreaks which was 79% compliant.

There was an infection control policy in place dated April 2023. Staff were unable to locate this document during our onsite inspection visit. The policy was a generic document and contained references to PEG feeding and tracheostomies which were irrelevant to this service.

During the onsite inspection, staff were unable to demonstrate that there was a ligature risk assessment in place and available to staff to refer to.

A ligature risk assessment was provided following the inspection which was incomplete and inaccurate. For example, the ligature risk assessment did not identify ligatures we noted in the basement laundry room, boiler room and bedroom six. There was also no actions to minimise risk within the ligature risk assessment document.

The service was asked to provide a copy of their most up to date risk register. This was not provided during the inspection period.

Information management

Staff did not collect or analyse data about outcomes and performance or engage actively in local and national quality improvement activities.

Inadequate

Residential substance misuse services

At the previous inspection we were concerned about the lack of oversight to assess and manage data, the storage of client information and staffs' ability to access pertinent information regarding the running of the service in a timely way.

At this inspection we found that these concerns remained. The service did not collect data to ensure the service was well run. An outcome measure had been introduced in relation to client individual progress, but this information was got gathered and analysed to support service improvement.

Staff still had individual roles and duties that meant the service did not run smoothly. For example, the nurse confirmed they were only involved in medicines, they did not partake in any care planning or risk assessments. These documents were only completed by the support workers. This meant the service was not implementing a multidisciplinary approach and that information and decisions were not always shared with the team.

Managers still did not have access to information to support them with their management role. During the inspection, managers struggled to locate basic information that was associated with the day to day running of the service. Information was not timely or accurate; it did not identify areas for improvement. We reviewed training and recruitment systems and processes, policies that were not accurate, complete, or updated. Staff did not raise internal safeguarding with the local authority.

Engagement

The provider did not actively engage with other local health and social care providers to ensure client were fully supported whilst admitted to the service.

The service had not developed any links with health or social care providers locally or near to client homes.

Learning, continuous improvement and innovation

The service was unable to demonstrate any learning from practice or any shared learning from other providers. The service had not engaged in any quality improvement initiatives. The registered manager felt the focus of the service was around meeting the requirements of action plans developed from previous inspections.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care • The service did not ensure that client assessments and recovery plans were detailed and comprehensive. The service had not developed discharge plans and unexpected exit from treatment plans. (Reg 9 (3) (a) (b))

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The service did not ensure that there were effective systems in place to monitor the cleanliness of the service. (Reg 17 (2) (a)) • The service did not ensure that staff have access to a ligature risk assessment and that the ligature risk assessment clearly identified ligature risks and mitigation. • The service did not ensure that fire safety procedures were carried out in line with the provider's policy and fire risk assessment documents. • The service did not have an observation policy that ensured clients and areas of the environment were observed to mitigate any risks to clients. • The service did not ensure that there was suitable medical input to ensure clients were appropriately prescribed medicines in a timely and safe way. • The service did not ensure that pre-employment checks were carried out prior to staff starting work. Staff did not have disclosure and barring service checks completed. • The service did not ensure that all incidents were reported. (Reg 17 (2) (b))

This section is primarily information for the provider

Requirement notices

- The service did not ensure that there were effective systems and processes in place to identify any shortfalls in the quality of the service. Governance structures were not able to promptly highlight any failings within the service. Managers were unable to rectify any issues in a timely way. (Reg 17 (1) (2) (a) (b))
- The service did not ensure that client care records were stored in line with policy and General Data Protection Regulations. Personnel records were also not stored in line with GDPR. (Reg 17 (2) (c)

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The service did not ensure that the safeguarding policies were robust and up to date. Staff did not understand safeguarding incidents and know how to report safeguarding concerns.

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The service did not ensure that there was appropriate clinical equipment and emergency medicines available to meet the needs of clients. Medicines were not managed safely. (Reg 12 (2) (d)) • The service did not ensure that staff were suitably trained, experienced and qualified to meet the needs of the service. The staff induction did not cover all necessary modules staff required prior to starting direct work with clients. Staff were not compliant with mandatory training modules and did not receive regular supervision. Staff did not understand the needs of the clients and any associated risk. (Reg 12 (2) (c))

This section is primarily information for the provider

Requirement notices

- The service did not ensure that risk assessments contained detailed information about client risk and included concise information about how risk would be managed. (Reg 12 (2) (a))
- The service did not ensure that there was a clear admission process and criteria. Staff did not understand the admission process and criteria and were unable to follow it. The admission criteria did not correspond to the level of risk the service was able to manage. (Reg 12 (2) (a))