Turning Point - Smithfield Detoxification Unit

Quality Report

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

Ratings

Overall rating for this location

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

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

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

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

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

Summary of findings

Overall summary

We do not currently rate independent standalone substance misuse services.

We found the following areas of good practice:

- The environment at Smithfield was safe and comfortable. There were regular health and safety audits carried out that included fire safety. There were safe levels of staff on duty to ensure clients were supported 24 hours a day.
- Ligature points (a place where someone could tie something round to harm themselves) were mitigated by the use of risk assessments and observation.
- Medicines management practices were thorough and effective.
- There was a clear process around reporting incidents, staff understood what they should report and how to do this.
- The medications and detoxification plans used at Smithfield were based on the National Institute for Health and Care Excellence guidelines. These were also tailored to suit individual needs.
- There were good links with the local general hospital and GP surgeries for ongoing assessment of physical health.
- All interactions we observed between staff and clients were caring, kind and compassionate. Clients all described the staff as approachable and that they were genuinely interested in them.
- Pre-admission work including a five week pre-detox course ensured appropriate admissions to the service. There was a robust admission process and discharge plans were required to be in place before the client commenced detox.
- The hospital had information leaflets for a wide range of treatments, medications and conditions. The hospital was able to get these in other formats easily from the intranet such as easy read and different languages. The electronic notes system had a function where staff only had to click a button to change care plans into another language
- The food was described by all clients as excellent and there was a wide range of choice.
- There was a lift for disabled people to access the first floor.
- The organisation has a clear vision and a set of values, the hospital used these in their everyday practice and put them at the heart of all the work they did. Staff we spoke to described the managers as caring and supportive.
- The provider used key performance indicators to monitor how well the service was performing.
- The service had a very low level of sickness so this meant that clients received care from a stable team of staff who knew them well.
- The hospital had regular audits that assessed the quality of the work. These were reviewed in governance meetings and outcomes from this were fed back to staff at local level to action.
- All staff received six weekly supervision which followed the hospital's supervision policy. The staff training and appraisals were also up to date.
- The service had introduced naloxone training for all service users with a history of opiate misuse with the aim of improving the safety of all service users discharged from the service.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Substance misuse/ detoxification		Inspected but not rated

Summary of findings

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Summary of this inspection

Background to Turning Point - Smithfield Detoxification Unit

Turning Point is a national health and social care provider with over 250 specialist and integrated services across England and Wales, focusing on improving lives and communities across substance misuse, learning disability, mental health and employment.

Turning Point Smithfield is a 22-bed inpatient unit that provides treatment to men and women over 18 years of age who have a drug or alcohol dependency. The service provides a detoxification service. The majority of clients are referred to Smithfield by the community drug and alcohol teams, with their places being funded through their Local Authority. However, clients can also refer themselves to the service and self-fund. The service takes referrals from all over the country; however, the majority of clients on the day of our inspection were from the local area. The service is situated close to the city centre of Manchester and it is easily reached on foot, by car and public transport. There was a registered manager at the time of our inspection.

The service is registered to provide the following regulated activities:

- Accommodation for persons who require treatment for substance misuse
- Substance misuse problems
- Treatment of disease, disorder or injury
- Caring for adults under 65 years
- Caring for adults over 65 years.

Turning Point Smithfield has been registered with CQC since 08 February 2011. There have been two previous inspections carried out at Smithfield; the most recent was conducted on 09 September 2013. Smithfield was deemed to be compliant in all areas at the time of this last inspection.

Our inspection team

The team that inspected the service comprised CQC inspector Kirsty McKennell (inspection lead), two other CQC inspectors, two CQC pharmacy inspectors and one specialist advisor who was a registered mental health nurse specialising in substance misuse.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme to make sure health and care services in England meet the Health and Social Care Act 2008 (regulated activities) regulations 2014.

How we carried out this inspection

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

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

Summary of this inspection

- Is it well led?

Before the inspection visit, we reviewed information that we held about the location, asked other organisations for information.

During the inspection visit, the inspection team:

- Visited the hospital, looked at the quality of the physical environment, and observed how staff were caring for clients.
- Spoke with five clients.
- Spoke with the registered manager and the operations manager.
- Spoke with five other staff members employed by the service provider, including nurses and support workers.
- Spoke with two peer mentor volunteers.
- Attended and observed one hand-over meetings, an admission assessment, and two groups that were running on the day.
- Collected feedback using comment cards from two clients .
- Looked at five care and treatment records and all medicines records for clients.
- Observed medicines administration at lunchtime.
- Looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

All of the clients we spoke with during our inspection said the staff at Smithfield were approachable, friendly and caring. Clients felt that they did not judge them and that they could talk to them when they needed.

The clients felt that Smithfield gave them a relaxed environment which was friendly and supportive.

We also received positive feedback about the food at Smithfield and the range of choices available.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- The environment was clean tidy and well maintained.
- There was a well equipped clinic room with emergency and controlled drugs that were regularly checked.
- There was enough staff to safely care for clients and all staff were up to date with their mandatory training. There was low levels of vacancies and low sickness and turnover of staff.
- All records we reviewed contained an up to date risk assessment and risk management plan that was reviewed on a regular basis.
- Ligature points (a place where someone could tie something round to harm themselves) were mitigated by the use of risk assessments and observation.
- Medicines management practices were thorough and effective.
- There was a clear process around reporting incidents, staff understood what they should report and how to do this.
- The service had introduced naloxone training for all service users with a history of opiate misuse with the aim of improving the safety of all service users discharged from the service.

Are services effective?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- All client records we reviewed contained a comprehensive and holistic assessment of the client.
- There was a five week pre detox programme in order for potential clients to ensure that detox is right for them prior to admission.
- Clients were given information about the hospital and the programme prior to them agreeing to admission. This included a clear list of behaviours that would result in immediate discharge.
- The medications and detoxification plans used at Smithfield were based on the National Institute for Health and Care Excellence guidelines. These were also tailored to suit individual needs.
- There were good links with the local medical hospital and GP surgeries for ongoing assessment of physical health.

Summary of this inspection

- There were systems to ensure good practice around confidentiality and sharing of information and all clients were aware of this.
- Handovers were completed in a respectful manner and all important information passed on to the next shift.
- There was effective user involvement within the programme. Clients who had successfully progressed through the detox and completed a sustained period of abstinence became peer mentors to new clients. These established relationships often continued post discharge.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- We observed interactions between staff and clients and found them to be kind, caring and respectful. Clients we spoke to told us staff were always there to listen and were interested in what they had to say.
- Clients received a welcome pack when they were first admitted which gave them all the information they needed about the hospital so they could read it in their own time.
- Clients were involved in planning their own care. During one to one sessions, staff and clients would look over the care plans and make any updates or changes together.
- Clients were encouraged to give feedback on the service in various ways. This included exit surveys, community meetings and comment card boxes.

Are services responsive?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- An admissions pathway coordinator dealt with all referrals ensuring a well managed process from referral to admission. Therefore, a bed was always available for a client when they needed it. This included reserving a bed if someone was due for release from prison. This meant those ready to engage with the programme did not experience any delays in accessing the treatment they required.
- Similarly, discharges were planned so clients had a robust discharge plan and were always discharged at a suitable time of day.
- The hospital had information leaflets for a wide range of treatments, medications and conditions. The hospital was able to get these in other formats easily from the intranet such as

easy read and different languages. The electronic notes system had a function where staff only had to click a button to change care plans into another language if someone's first language was not English. They also had access to a phone line for interpreters for use during assessments and one to one sessions.

- There was a good choice of foods on the menu for clients to choose from. The chef was able to cater for any particular dietary needs whether that was for medical or cultural reasons.
- There was a lift for anyone with mobility issues to reach the first floor.
- There was a robust complaints procedure and clients we spoke to all knew how to complain.
- There were structured and meaningful daily groups which included evenings and weekends.

Are services well-led?

We found the following areas of good practice:

- The organisation had a clear vision and a set of values, the hospital used these in their everyday practice and put them at the heart of all the work they did.
- Staff we spoke to described the managers as caring and supportive.
- The provider used key performance indicators to monitor how well the service was performing.
- Staff we spoke with told us they had a passion for the work they did. The service had a very low level of sickness so this meant that clients received care from a stable team of staff who knew them well.
- The hospital had regular audits that assessed the quality of the work. These were reviewed in governance meetings and outcomes from this were fed back to staff at local level to action.
- All staff received regularly supervision as described in the policy. The staff training and appraisals were also up to date

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

- At the time of our inspection all the clients using the service were able to make decisions for themselves. There was nobody subject to deprivation of liberty safeguards.
- Mental Capacity Act training was mandatory and all staff had received this training.
- On admission, clients were talked through and given the rules they would be expected to abide by during admission. They were also asked to sign to say who information about them could be shared with and who to contact in an emergency. They also signed care plans and risk assessments to evidence agreement and consent to the detail.
- There was a clear protocol in place for if someone appeared to lack capacity due to intoxication or deterioration of physical health and staff were all aware of this.

Substance misuse/detoxification

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse/detoxification services safe?

Safe and clean environment

The environment at Smithfield was clean, safe and well maintained. Although the layout of the building did not allow staff to observe all parts this was mitigated by observations of clients and thorough risk assessments. There was a designated female lounge and female bathrooms. The bedrooms were kept as female and male areas as much as possible unless a client was having particular physical health issues during the early stages of a detox and they may then be moved nearer to the nurses station. During this time staff would be with the client at all times. All rooms including the lounge, dining room and bedrooms were accessible to clients throughout the day. The furniture, fixtures and fittings were in good condition. There was 24-hour access to an outside area which was well maintained. There were examples of artwork completed during group work by the clients displayed in the rooms where groups took place.

Where there were ligature points (a place where someone intent on harming themselves could tie something around to strangle themselves), these were mitigated through the use of thorough risk assessments of the clients and regular observations of the client area by staff. Clients at Smithfield were deemed to be mentally well enough to be able to commit to a period of detoxification. If the staff at assessment stage felt that there were underlying untreated mental health problems or a risk of suicidal ideas then the clients would be placed in a more suitable hospital nearby where the environment was more suitable for clients who had a history of self harming behaviours. Most clients previously lived in the community and were agreeable to coming into Smithfield which meant the idea of a completely ligature free environment was unrealistic.

The hospital had a fully equipped clinic room that was clean and tidy on the day of our inspection. There was equipment to take physical observations including weighing scales, blood pressure machine and temperature recording device. Medicines were stored securely with access restricted to authorised staff. A controlled drug is a medicine that is controlled under the Misuse of Drugs regulations (and subsequent amendments) and these were managed appropriately. We checked medicines requiring cold storage and found fridge temperatures had been recorded in accordance with national guidance. On two days, the temperature had been recorded as being above eight degrees Celsius and the service had acted accordingly by transferring the medicines into another fridge. We noted on the day of our inspection that the room temperatures in August had been above the recommended temperature of 25 degrees Celsius. The medicines room was not air conditioned, but the service had tried to reduce the temperature with the use of fans. There were no medication that was adversely affected by high temperature.

During our inspection, we found a good level of compliance with infection control policies this included handwashing, disposal of sharps and the use of personal protective equipment. We saw evidence of infection control audits and cleaning schedules which were completed and signed for. These also had comprehensive actions with dates for completion where necessary.

Health and safety and fire safety were well managed. There was a company-wide building and property management policy and procedure in place and Smithfield followed this. There was an annual health and safety audit dated October 2015.

There was a housekeeping checklist that was completed monthly. This covered a range of questions under the following headings; access, security and external areas, walkways, fire, utilities, equipment, contractors and

visitors, control of substances hazardous to health, welfare, cleaning rubbish and infection control, safe working practices, vehicle risk, food and drink preparation, bathrooms, bedrooms, communal areas. The most recent checklists had not identified any issues.

First aid kits were available in the administrator's office, clinic room, reception, nurse manager's office and in the emergency grab bag. During our inspection we checked the kits and found all contents to be present and in date. First aiders were identified. There were 11 appointed first aiders on the staffing establishment.

There was a legionella risk assessment. This was carried out in September 2015 with a review date of September 2017. Actions had been identified including; implementing a flushing schedule, labelling taps as drinking water or not, clean and replace filters and insulating the storage cistern. All actions had been completed. There was a record of annual water sample testing from 2014. The most recent was June 2016. We spoke to staff who showed us the schedule for flushing in the areas they were responsible for. The schedule had been completed.

Cleaning records were in place and evidenced that the building was cleaned on a daily basis. We spoke to the domestic staff who told us they felt supported in their role and could request new equipment or resources.

Control of substances hazardous to health assessments were in place for relevant cleaning products. They were in date and due for review August 2017. Product safety information sheets were also in place.

There was a record of portable appliance testing from July 2015 and valid electrical installation and gas safety certificates. There was also an asbestos survey that had been carried out in 2007 with no issues found.

Fire safety management was performed well. There was an in date fire risk assessment that did not identify any required actions. There was a fire safety folder that included a copy of the evacuation plan and a record of testing. There were quarterly checks of the fire alarm system by an external contractor and annual checks of the nurse call system. There were regular tests of the means of escape and fire doors. The policy stated that these should be done monthly but testing records showed they were being completed between weekly and fortnightly. The building had fire evacuation aids in place to help evacuate individuals with mobility issues. Evac chairs were provided on staircases and there was a diagram illustrating how to use them on the wall. There were nurse call buttons in all the bedrooms for clients to alert staff if they needed them. The box to tell staff where the alarm was activated was at the nurses' station, which was always manned by staff.

The hospital could accommodate 22 clients at any one time. Bedrooms were single occupancy and clients had a key to their room and used this to gain access at any time. All the bedrooms were situated on the first floor which was also where the nurses' station was situated

Safe staffing

At the time of our inspection, the hospital employed nine qualified nurses who were all mental health nurses and 13 nursing assistants. There was one vacancy for a qualified nurse and no vacancies for nursing assistants. In the three months leading up to our inspection there had been three shifts covered by agency staff. Agency staff were very rarely used and would only be used if someone rang in sick at the last minute and permanent staff could not cover. Sickness rate was 0.6% in the 12 months leading up to our inspection. We saw evidence in staff files of staff being supported to return to work when they had been off on long term sick. The staff turnover rate in the twelve months leading up to our inspection was 22%.

The provider had a recognised tool to estimate the minimum staffing levels on each shift. During our inspection, we reviewed the staff rotas to ensure that the numbers of staff on duty matched this and we found that it did. The registered manager was able to increase staffing levels if there was a clinical need. Examples of this included someone who may become physically unwell during their detox or if someone became aggressive or violent. There was a three shift system at the hospital this was early, late and night shifts. The staffing establishment for the hospital was a minimum of three staff on each shift, this was broken down into one qualified staff nurse and two nursing assistants. There would also be a second qualified nurse on a 10am until 6pm shift to assist with admissions which happened during the day. This was supplemented by the registered manager or the clinical team leader during core hours of 9am until 5pm.

There was always sufficient staff on duty to spend one to one time with the clients. As well as qualified nurses and nursing assistant the hospital also had peer mentors who were people who have experience of using the service. This

meant that the clients could choose the person they preferred to speak to whilst also having regular one to one time planned in with their key worker. Peer mentors also supported the substantive staff in running groups. Activities and groups were never cancelled, staff described the client care as their priority so they would always ensure groups ran as planned.

Medical cover for the hospital was provided by a consultant with a specialism in substance misuse. The doctor was present on the unit Monday to Friday and was available on call outside of these times.

The mandatory training rate for staff was 83%.

Assessing and managing risk to clients and staff

There was a clear admissions policy in place at Smithfield. This included risk issues that could not be managed at Smithfield for example untreated mental health issues. There was a face to face assessment carried out on admission and the staff also reviewed information from other agencies such as social care and GPs to get a full picture of the clients risk history. Prior to admission, the clients would agree to the terms of the hospital and any banned items and behaviour that would result in discharge with immediate effect. Each client had a comprehensive risk assessment that was reviewed at each key working session. However, if there was an incident or if there were significant changes in the presentation of the client then this would be updated accordingly. This highlighted any known risks that the client had and any risks that may develop if the client was to relapse and use drugs or alcohol. This was then incorporated into a risk management plan and into care plans so that all staff and the client were aware of the issues raised. During our inspection, we observed a handover where we saw that risk issues were discussed. This was an opportunity for staff coming on shift to be informed of any new risks that had been identified for that particular client and for staff to review these together with a multidisciplinary approach. Peer mentors had a separate handover from staff so that information that they needed to know was passed on including any risk issues, but leaving out information that was deemed out of the scope of their role.

The service was aware of the possibility of unexpected exit from treatment and had a procedure in place for when this occurred. This also included the use of immediate discharge or warning should the client break any of the conditions in the admission agreement. Clients signed the agreement on admission, which was to show their understanding of types of incidents or behaviours that would mean immediate discharge from the hospital. The procedure was able to direct staff on who would need to be informed if a client was unexpectedly discharged from the hospital, this may have included family and would always include the referrer to the hospital. Staff told us they would always discourage clients leaving during the night or without being seen by the doctor. However, there were plans in place if the client would not wait and staff had a good understanding of the process.

Prescription charts were being used in accordance with legislation. The doctor prescribed the clients regular medicine, detox medicines and when required medicines for detox symptoms before the client was admitted. The registered nurse would check the medicines brought into the service by the client against the prescription chart to reconcile them and any discrepancies would be discussed with the doctor.

We observed a medicines round and found it to be organised, thorough and caring. Information on detox medicines were provided to clients in an appropriate way and explained the reasons for being on the medicine and side effects that may occur. We found medicine incidents were discussed and shared appropriately.

Nurses carried out observations at a minimum of hourly. This was in line with the organisation's observations policy. The use of observations could be increased in line with this if staff felt clients needed more frequent observations. This included 15 minute observations and if required one to one observations. Patient records demonstrated that observations were taking place and could be increased and decreased in line with the patient risk assessment and management plan.

All staff attended local authority Safeguarding workshops as well as Turning Point's mandatory safeguarding training. This was in order for staff to be kept up to date with any changes in the way the local authority dealt with safeguarding referrals or any changes in the way the staff needed to complete safeguarding referrals. Safeguarding was discussed in team meetings and was a standard item on the agenda. There was up to date information on child and adult safeguarding within policies and there was information for clients in their welcome pack. Staff described positive relationships with their local

safeguarding team and a quick response when they made referrals. Staff had a good understanding of what constituted a safeguarding concern and how to report these to the team.

Track record on safety

There had not been any serious incidents in the 12 months leading up to our inspection. However, staff were able to talk us through the procedures to follow if a serious incident occurred and how learning from this would be fed back via team meetings and supervision.

Reporting incidents and learning from when things go wrong

All incidents at Smithfield were reported via an electronic incident reporting system. These automatically went to the risk and assurance department at Turning Point head office to be reviewed. They would in turn review the incidents and if they were above a certain level would then pass them on to the managing director. All staff had access to the reporting system and were able to complete incidents forms. Learning from incidents was fed back via staff meetings and through individual supervision if required.

Staff and clients told us that debriefs took place following incidents and that these were usually facilitated by the nurse in charge or the registered manager. The operations manager and the registered manager attended national management meetings where learning from incidents in other Turning Point locations was fed back. This was in turn fed back to staff at Smithfield if it was relevant, via staff meetings.

Duty of candour

Turning Point had a duty of candour policy which was in date. It indicated a need for openness and transparency within the organisation. This included the need for a written apology when things go wrong and explaining this to clients. Staff were aware of this and were able to give us examples of incidents when duty of candour responsibilities would be triggered.

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

Assessment of needs and planning of care

Each client had a comprehensive assessment completed prior to and on admission. This included the allocation of a key worker. They were responsible for ensuring care plans and risk assessments were up to date and that one to one sessions were planned and completed. We reviewed five care records during our inspection and found that all clients had a comprehensive plan of care that took into account their own individual needs which were identified prior to admission and added to during admission. We found that the pre admission assessments complete by staff were of a high standard and identified potential risks and triggers. In this assessment, there was information from a range of professionals involved in the client's care and these were all used to work with the client to plan their care. Whilst reviewing care records we found that issues identified in the assessment translated through into care plans and discussed in one to one sessions with clients. Clients had an active role in their care and all clients used a diary to write down anything they felt they wanted to discus with their key worker. We found that care plans were written in a positive way focusing on the strengths of the clients whilst also dealing with any areas the client wished to work on.

Clients were often referred by an external agency and were assessed by the doctor before they arrived. To determine whether a client on an alcohol detox programme was suitable for admission a blood test was taken by the clients own GP to assess their liver function prior to admission, and results were reviewed before the client was accepted into the service. All clients admitted into the service had a physical examination by the doctor and observations during detox were taken and recorded in accordance with local guidance.

Records were kept in paper format but this was also uploaded on a regular basis to an electronic records system. The records were kept in a locked office in a part of the building that clients did not access. Prior to admission clients were given copies of confidentiality and information sharing agreements and these were signed by the clients and kept in the records.

Best practice in treatment and care

The medications and detoxification plans that were used at Smithfield were based on the National Institute for Health and Care Excellence guidelines. They would also make these plans individualised by looking at the client and seeing if they needed supplementary medications for

symptoms of a client's withdrawal or detoxing at different speeds for example a three day detox or a seven day detox. The service was also able to accommodate clients for various types of detox including, heroin detox, methadone and buprenorphine detox.

The service used the severity of alcohol dependence questionnaire to establish levels of alcohol use with clients. The clinical institute withdrawal assessment for alcohol and the clinical opiate withdrawal scale were used as appropriate at regular intervals over the course of the withdrawal to establish whether as required medication would be needed to assist clients.

There were structured group sessions each day, one in the morning and one in the afternoon. The groups and one to one sessions were based on psychosocial interventions and were evidence based and recommended by the National Institute for Health and Care Excellence [CG51].Examples of these sessions were family recovery and maintaining recovery.

The clients were given a diary on admission which they were expected to complete on a daily basis. These were important so staff were aware of how the client was feeling both physically and mentally during their detox. These were also used to lead the one to one sessions that key workers provided but also for staff to see when clients may need extra support including more medication or increased observations.

There were weekly audits of the client's records which included different members of staff completing these in order to ensure all staff were aware of the audit tool and any actions. Ten files were audited each week and then the remaining files audited by the registered manager or clinical team leader. This was then monitored by senior managers through the quality improvement programme and through regular reviews and audits by the risk and assurance team.

Skilled staff to deliver care

The staff at Smithfield were experienced in substance misuse and appropriately qualified. There was 24/7 access to medical and nursing care. The team consisted of a registered manager who was a qualified mental health nurse and a team of nine qualified mental health nurses. There were 13 support staff and these were supplemented by a team of peer mentors. The peer mentoring programme offered an eight week course for clients who have maintained three months abstinence following a detox. Once clients graduated from this course, they were able to work voluntarily at Smithfield and provide ongoing support and visible recovery to the current clients. The peer mentors were led by a senior peer mentor who provided supervision and support for the peer mentors. The service had a dedicated psychiatrist with a specialism in substance misuse. He was present at the hospital each day and on call out of hours for support if needed.

All staff received a full induction at the start of their employment with Turning Point. We saw evidence in staff files that these were attended by all new starters. There was a policy for supervision and appraisals and this stated that all staff should be supervised every four to eight weeks. We saw evidence that this was happening. All staff completed an annual appraisal using the template supplied by the provider. We found at the time of our inspection that all staff were up to date with their annual appraisals.

Poor staff performance was addressed promptly and effectively. There were no staff being performance managed at the time of our inspection. However, we could see evidence of this happening effectively in the past when we reviewed staff files. There was an up to date policy for performance management which detailed the support staff would be offered and HR support for the manager.

Aside from mandatory training staff also had access to a range of specialist training relevant to their role. For the senior staff for example the registered manager and team leader this included Institute of Leadership and Management Level 5. For support workers there was NVQ Level three which all support staff were expected to complete. All qualified staff had completed the mentorship course at a local university and newly qualified staff undertook a full six month preceptorship programme prior to completing mentorship. Staff were able to undertake training in physical health monitoring this included courses to take blood samples, management of seizures and emergency medications.

Multidisciplinary and inter-agency team work

Smithfields pre admission assessment included input from the full multidisciplinary team. This included input from community drug and alcohol teams, the client's GP and criminal justice services if required. This was in order to get a full picture of the client so that the most suitable form of

detox could be offered to suit the individual needs of that client. This was also included in the discharge planning which took place prior to admission so there was a robust plan in place which again included the full multidisciplinary team. Smithfield also worked with a number of outside agencies to support the needs of their clients. This included links with narcotics and alcoholics anonymous, housing, residential rehab and local mental health trusts.

There were three handovers per day at the hospital at the beginning of each shift. This also consisted of a separate handover for the peer mentors which included only the information appropriate to their role. The handover for staff was attended by everyone on duty. Each client was discussed in turn using the handover sheet. The qualified nurse delivered the handover and covered all aspects of the client's care including withdrawal symptoms, stage of the regime, physical health, medication changes, risks and side effects. They also discussed liaison with outside agencies regarding discharging clients. For patients with physical health concerns observations were handed over and for diabetic patients blood glucose levels were passed on to the team.

Adherence to the MHA

Smithfield did not admit patients detained under the Mental Health Act.

Good practice in applying the MCA

All staff had received training in the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. At the time of our inspection there were no clients subject to Deprivation of Liberty Safeguards. All staff that we interviewed as part of the inspection had a good understanding of the Mental Capacity Act (2005) and its principles.

The care records we reviewed showed that clients had been asked to sign sharing of information and confidentiality agreements and had consented to their admission. Clients were asked on admission and during their detox about their understanding of the regime and their ability to consent.

Staff were able to tell give us examples of times when clients may lose capacity and what plans were in place to deal with this. One example given was that clients are advised to carry on drinking alcohol prior to admission so as not to endanger themselves by beginning to withdraw on the journey to the hospital. Staff explained that if the patient was too intoxicated on arrival to understand and repeat information back to them then this assessment would be redone the next day when the client was able to consent.

Equality and human rights

All staff complete mandatory equality and diversity awareness e-learning training. The provider has an up to date national core policy for equality and human rights. The equality policy included the protected characteristics set out in the Equality Act 2010. As part of the internal quality assessment tool, all staff were required to sign to say they have read and understand this policy. The service embedded a working environment that promoted equality. It was expected that everyone was treated with equality, respect, fairness and dignity. All clients were required to sign a behaviour contract on admission which highlighted zero tolerance for any negative comments around diversity.

The hospital had good links with the local religious communities facilitating clients maintaining their faith during admission. This included links with churches, mosques and temples in the local area.

There were no blanket restrictions in place at Smithfield. Clients were allowed the use of their mobile phones and visiting from family and friends was encouraged.

Management of transition arrangements, referral and discharge

All referrals to the service would go to via the care pathway coordinator. They would then go out to do a pre admission assessment alongside a member of the clinical team. Following this assessment if it was felt by the team and the client that Smithfield was the best place for them to complete their detox then a pre admission referral would be made and then a bed would be reserved and an admission facilitated as soon as possible. Smithfield also worked closely with the prison service and was able to facilitate admission from prison if required.

There was a process in place for smooth transition in the community in order to support clients to remain abstinent. One of the exclusion criteria for Smithfield was someone who did not have a robust discharge plan in place for support back in the community once they had completed their detox. The referrer usually coordinated this, in order to ensure clients were given the best chance of recovery.

Substance misuse/detoxification

On discharge each client left the service with an aftercare plan, which was tailored to the client's individual needs and developed jointly with the hospital. The referring services received a medical and nursing discharge summary within 24 hours.

There were a total of 554 substance misuse clients discharged from the service in the last 12 months, as at 9 June 2016.

The hospital had a robust pre-detox programme that was designed following a peak in clients not completing detox. The staff team looked at why this may be and felt that lack of knowledge around what detox consisted of may have been an issue. The pre-detox programme was designed to answer any questions or fears that clients may have about going into detox and lessen any worries. During the pre-detox work a number of issues were discussed including what happened in groups, how the client would have access to support form people who had previously used services, dealing with emotions and information around the 12 step model. This was facilitated with staff and peer mentors so people who had lived experience of using substance misuse services could give advice and support to potential new admissions.

Are substance misuse/detoxification services caring?

Kindness, dignity, respect and support

We spoke to five clients at Smithfield who were all currently inpatients. They all gave positive feedback about the staff that they were supportive, kind and caring. They stressed the importance of the peer mentors as they had user experience of a detox service and therefore they felt they were an inspiration and gave them something to focus on that they could realistically achieve.

On the day of our inspection we observed an art group in the morning and recovery group in the afternoon. We observed how staff explained about what would happen during the groups at the beginning and ensure that all clients understood before continuing. We observed staff to be polite and courteous when addressing clients and to show a genuine interest in what the clients had to say. During the art group we saw staff talking to clients about nutrition and mutual aid groups whilst engaging them in therapeutic activity. We saw the staff notice clients that were not engaging as much as others and take time to go and sit with them to talk on a one to one basis.

The involvement of clients in the care they receive

We observed an admission during our inspection. We found this to be sensitively managed whilst ensuring all the appropriate information was conveyed. There was a nurse and a doctor present during the admission assessment. During the admission all aspects of care were discussed with the client including medication regime, client choice, side effects, withdrawal symptoms and treatment plan. We were told by other clients using the service that on admission they were shown around by the staff and introduced to the staff and other clients. They were shown their bedrooms and given a general orientation to the hospital.

Clients were actively involved in their care planning at the earliest opportunity in their detox. For some clients this was a few days into the detox when they were physically well enough to take part. For others this began from day one. The one to one key working sessions were a time where care plans were discussed and changes made depending on the progress of the client.

Clients were encouraged to self advocate although there were also good links with the local advocacy service. There were weekly community meetings which took the "you said, we did" structure where clients could talk to staff about any issues and staff would respond how they have tried to achieve actions in the minutes and at the next meeting. We saw evidence of these meeting minutes and actions from these meetings being followed up on. For example one client group who were in the hospital in June suggested they may want to trial prohibiting mobile phones so they could fully concentrate on their recovery. This was trialled for one month, however, clients did not want this to continue at the end of the trial.

Clients were actively encouraged to maintain links with positive influences in their lives such as friends, family and children. Clients could have visitors to the hospital and there were rooms to accommodate this. A small lounge was used for child visiting although staff insisted they were made aware of any planned visits beforehand so they could risk assess the current client group.

Substance misuse/detoxification

Peer mentors who have previously used the service were involved in all interviews for potential new staff. They also attended national peer mentor meetings in order to share learning across the service and give opinions on proposed changes in the service.

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

Access and discharge

Clients were referred by 25 organisations that commissioned the service. Out of the 25 there were 11 that actively used the hospital on a regular basis. Clients were also able to refer themselves although we were told this was quite rare. The hospital had 22 beds and at the time of our inspection there were 14 clients.

All referrals came in via the care pathway coordinator. They were then assessed by one of the clinical team and a decision made if the hospital was the appropriate place for the client to complete their detox. Clients were able to visit the hospital beforehand to have a look around.

On admission clients were admitted by the doctor and a member of the clinical team who was either a registered nurse or the registered manager. Physical health checks were undertaken on admission and drug or alcohol screening was completed to gain a baseline a few days into the detox. Physical healthcare continued to be monitored throughout the admission. Clients typically spent between three and 28 days at the hospital although this was able to be tailored to suit individual needs.

Clients were made aware on admission of any behaviours that may result in immediate discharge and they signed an agreement to clarify they understood and agreed. If a client wanted to leave early or was asked to leave then the staff were clear on the procedures they would follow. This included contacting the client's referrer, next of kin (if consent was given) and asking the doctor to review the client before they left so they could arrange some medication if required. This would all ensure a safe exit from the service.

Before clients were discharged they were encouraged to make links with mutual aid groups and other local support networks in order to continue to gain support from these when they left the hospital. On a Sunday there was a group for past clients which was run by the hospital, this was well attended.

The facilities promote recovery, comfort, dignity and confidentiality

The hospital had a full range of rooms to support treatment and care. This included a clinic room where physical examinations could take place. There was a range of other rooms such as lounges, dining room and activity rooms as well as access to an outdoor space. There were several quiet rooms for clients to be able to meet with visitors or family or use if they wanted some time alone. Clients also had access to their own bedroom at any time with their own key so they could also use this space for some privacy.

Clients could make a phone call at any time using their own mobile phones. There was also a phone at the hospital that they could use to make a phone call in private if they did not have their own phone.

All of the clients we spoke to said the food was of a high quality. We observed food being served at lunchtime that was of a good quality in terms of choice, portion size and presented well. There was access to drinks and snacks at all times and clients could help themselves.

We saw the client's bedrooms and observed that they had personalised these with photos and artwork they had completed in the groups. Clients had access to a lockable space in their room to keep personal possessions safe.

There was a wide range of activities available at the hospital each day. This included evenings and weekends. During the day the groups were a mixture of structured group work and also activities such as art and crafts. In the evenings and at weekend there were more fun activities such as cinema nights and quizzes. On a Sunday and a Wednesday there was a group for past clients who remained abstinent and this was well attended and current clients were also encouraged to attend to speak to ex clients for advice and support.

Meeting the needs of all clients

The hospital was over two floors. There was a lift to access the first floor and evacuation chairs in situ for use in the event of a fire.

Substance misuse/detoxification

Information leaflets were available in different languages and easy read if required. These were obtained via the Turning Point intranet. The hospital utilised translators for one to one sessions if the client needed some support in this area. We saw evidence of care plans being translated into another language to support clients understanding of these. This was done by simply clicking a button on the electronic system that the hospital used to change it into any language required.

The chef was able to tailor menus and order food in specially to meet special dietary requirements. This included for religious reasons and for other reasons such as coeliac disease or if someone was a vegetarian or vegan.

There was good links with local religious groups. For example the hospital had recently facilitated client visits to Church and the local Gurdwala. There were also quiet rooms in the hospital that clients could use to pray as well as their own private space in their bedroom.

Listening to and learning from concerns and complaints

There were 77 compliments received by the hospital in the last 12 months, as at the time of reporting. There were three complaints received by the hospital in the last 12 months, as at the time of reporting. None of these were upheld.

There was information given to clients in their welcome pack about how to complain. Clients that we spoke to told us they knew how to complain if they wanted to. There was a weekly community meeting were the clients were able to raise any minor concerns they had and then the registered manager would respond to these in the minutes and at the following weeks meeting. There was a suggestions box in the reception area and satisfaction surveys were given to service users at their final key working session.

The hospital had a policy and procedures for dealing with complaints, compliments and concerns which was monitored by risk and assurance and senior managers. This included a 'have your say' policy, complaints process flowcharts, recording on the Datix system and monthly feedback to service users, commissioners, partners and other local stake holders.

Are substance misuse/detoxification services well-led?

Vision and values

The vision at Smithfield was "To constantly find ways to support more people to discover new possibilities in their lives"

The values were:

- We believe that everyone has the potential to grow, learn and make choices
- We all communicate in an authentic and confident way that blends support and challenge
- We are here to embrace change even when it is complex and uncomfortable
- We treat each other and those we support as individuals however difficult and challenging
- We deliver better outcomes by encouraging ideas and new thinking
- We commit to building a strong and financially viable Turning Point together

Staff were aware of these values and their practice throughout the organisation kept these values central to everything they did. We saw that the staff appraisals and interview process incorporated the values that were expected from staff at all levels.

Staff were aware of who the more senior managers were at the organisation and told us that they visited regularly and felt that they were friendly and approachable.

Good governance

The provider has a clear governance structure. This included good systems for monitoring all aspects of care and from this being able to see areas for improvement.

The hospital staff completed a range of audits that gave them the opportunity to analyse the safety and effectiveness of the hospital. There were audits such as cleaning audits, fire audits, environmental audits and records audits. There were examples of action plans addressing any issues found in these audits and examples of changes being made.

Substance misuse/detoxification

There was an electronic system which allowed staff to see their compliance with mandatory training. Supervision was required to be monthly to six weekly in the policy and we found that this was being adhered to. Appraisals were annual and again these were up to date and complete. All policies were available in their most up to date form on the provider intranet system and this was where staff accessed them from to ensure they were using the most up to date version.

We reviewed staff files as part of our inspection and found that all staff had completed disclosure and barring service checks undertaken before they were able to work within the service. We saw evidence of appropriate references being sought prior to employment and any gaps in employment were explained.

Turning Point used key performance indicators to monitor the performance of Smithfield. Any issues identified were discussed at monthly manager's meeting and with more senior managers within the organisation at regional meetings. We saw from reviewing these minutes that actions were identified where necessary and acted upon accordingly.

Leadership, morale and staff engagement

The hospital had an effective leadership team, the registered manager was highly motivated and was enthusiastic to make sure that the clients received a high quality service. More senior managers had clearly defined roles and expectations of service delivery.

The sickness and absence rate as of 9 June 2016 was 0.6%.

There were no grievances at the time of our inspection, and there were no recorded allegations of bullying or harassment.

The organisation had a whistleblowing policy and a telephone number that the staff could use to report any concerns confidentially.

During our inspection we observed the staff team and found them to have good morale and work well together. Staff we interviewed told us that the team were supportive and worked well together in a supportive way. All staff were passionate about their roles and the client group.

Staff we spoke to told us that they were well supported by the managers and that they felt supported to progress within their role. For example, staff going on specialised training courses for taking blood samples. They told us that the manager was always available to talk to if they needed them and that they had an open door policy.

There was a culture of openness and transparency in the organisation, staff explained to clients if something went wrong. The manager discussed incidents with staff and clients.

Staff were able to give feedback on the service and had input into service development through their staff meetings.

Commitment to quality improvement and innovation

The service has introduced naloxone training for all service users with a history of opiate misuse with the aim of improving the safety of all service users once discharged from the service. Nalaxone is a medication used to block the effects of opioids in overdose.

The service had introduced a pre-detox programme. This was for clients who may be interested in detox to attend in order to find out more about what happens at detox, the level of commitment needed and to discuss any worries or fears they may have as well as discussing the effects of substance misuse on the body and mind. This is a five week course and ends with a virtual tour of Smithfield so clients can see the service if they wish to. This was introduced in order to try and reduce numbers of clients dropping out of the detox before it ended.

The hospital accepted student nurses from the local universities and feedback from students was consistently positive. We looked at the last ten student feedback forms during our inspection and found scores for all areas to be above 80%.

Outstanding practice and areas for improvement

Outstanding practice

- The hospital was able to change care plans into another language by using a function built into the electronic notes section. This enabled clients whose first language was not English to have more complex information in a language they would understand.
- The service had introduced a pre-detox programme. This was for clients who may be interested in detox to attend in order to find out more about what happens at detox, the level of commitment needed and to discuss any worries or fears they may have as well as discussing the effects of substance misuse on the body and mind. This was a five week course which ended with a virtual tour of Smithfield so clients could see the service if they wish to. This was introduced in order to try and reduce numbers of clients dropping out of the detox programme before it ended.
- The service has introduced naloxone training for all service users with a history of opiate misuse with the aim of improving the safety of all service users once discharged from the service.