Phoenix Futures Sheffield Residential Service

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

Overall summary

We do not currently rate independent standalone substance misuse services.

We found the following issues that the service provider needs to improve:

- The provider had failed to make sufficient improvements to fully address the governance issues identified as requiring improvement at our last inspection of May 2016. The provider's audits did not highlight issues we identified with medication storage such as missing temperatures. Storage of medicine was not in accordance with the provider's policy.
- The system in place for clients who self administered medication was not robust and consistent as there was a lack of clear guidance for staff to follow.
- There was contradicting information at provider and service level about what training was mandatory and which staff groups were required to complete which training. Training figures had improved since our previous inspection however, there were still gaps and low compliance in some subjects.
- The quality of care plans and their content was inconsistent. Some care plans were not clear about what objectives clients were working towards and when these were to be achieved. There were omissions in records such as names, dates and signatures. The provider's audits had not always identified all of these issues.
- The service improvement plan did not contain specific actions about how improvements would be made. Internal audits and service reviews did not clearly link to the improvement plan. Actions included did not always portray an accurate reflection of actual practice and there were no mechanisms for ensuring actions were followed up. A number of actions were not met.

However, we also found the following areas of good practice:

- Staff regularly reviewed and updated clients' risk assessments following incidents. Clients had safety plans in place, which provided guidance for staff about support they needed in a crisis. Risk was discussed on an ongoing basis in handovers and team meetings.
- The service provided separate male and female accommodation and risk assessed any situation where they could not facilitate this.
- The service had a designated medication administration room and had started to use a new

medication system, which received positive feedback from staff. Infection control practices for testing clients had also improved, as there was a dedicated area for staff to undertake urine testing with appropriate equipment in place.

- The prescribing doctor's assessments were kept jointly within clients' detoxification records so staff had access to necessary information. Staff had been trained in, and used, recognised good practice withdrawal tools in order to monitor withdrawal from opiates and alcohol.
- Sessional staff and volunteers received regular supervision and support.
- The service had identified a need for, and recently employed, a clinical quality manager. Their role was designed to provide clinical input into the service and assist with clinical governance.

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Summary of this inspection

Background to Phoenix Futures Sheffield Residential Service

Phoenix Futures Sheffield residential service provides a rehabilitation service for people who are recovering from drug or alcohol misuse. The service accepts national referrals and privately funded clients. It was registered with the Care Quality Commission on 20 January 2011. It is registered for the regulated activity 'accommodation for persons who require treatment for substance misuse'.

The service had a registered manager in place at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service could accommodate a maximum of 36 people. At the time of our inspection there were 15 people using the service. The premises consisted of one main house and a smaller separate annexe building on the same site.

The provision of support was based on a therapeutic community model. A therapeutic community is a participative, group-based approach to addiction. External counselling services attended on a regular basis.

The service has been inspected four times since registration. At our most recent inspection of May 2016, we identified three breaches of regulation under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued three requirement notices relating to the following regulations:

Regulation 12: Safe care and treatment

Regulation 17: Good governance

Regulation 18: Staffing

Following that inspection, the provider submitted an action plan setting out the steps they would take to address these breaches. At this inspection, we found the provider had met the legal requirements of regulations 12 and 18. We found a continued breach of regulation 17.

Our inspection team

The team that inspected the service consisted of three Care Quality Commission inspectors including the team leader.

Why we carried out this inspection

We undertook this inspection to find out whether Phoenix Futures Residential Service had made improvements following our last comprehensive inspection. At that inspection in May 2016, we told the provider it must take the following actions:

- The provider must ensure that staff assess all risks to the health and safety of people using the service. There must be plans in place for how these are to be managed, which must be reviewed and updated as necessary.
- The provider must ensure environmental risks are assessed to establish what support people may require to keep them safe in relation to these. Particularly where people have a history of self harm and/or suicidal ideation.
- The provider must ensure and demonstrate that staffing levels are appropriate to meet people's needs at all times, including at nights. Safe staffing should not be reliant on support from people using the service to the extent it has a detrimental impact on people's recovery.

Summary of this inspection

- The provider must ensure that care records accurately reflect people's needs, are personalised and have clear objectives. These should include how people are to be supported in the event of unplanned exits. Records of care and treatment should be complete, contemporaneous and include details of any decisions made in relation to people's care and treatment.
- The provider must ensure all incidents are reported where these meet the criteria. These should be investigated as proportionate to identify area for learning and improvements. Findings and learning opportunities should be shared with staff as necessary.
- The provider must ensure medicines are managed safely. People must receive medicines as required, in a timely manner, and in accordance with how they are prescribed.
- The provider must ensure infection control procedures and practices, especially in relation to drug and alcohol screening, are undertaken in a way to minimise the risk of the spread of infection.
- The provider must ensure that staff have completed necessary mandatory training to carry out their roles safely and effectively, especially when working alone. Staff must have the necessary skills and training to support people using the service. Staff must be competent to identify and monitor symptoms of withdrawal.
- The provider must ensure all staff employed by, and working within, the service have regular supervision and appraisal as necessary. These should be used to identify any training needs and areas for further development. Volunteers should receive necessary support as required.
- The provider must ensure that doctors they source to deliver treatment at the service have necessary revalidation as required by the General Medical Council.
- The provider must ensure that there are policies and procedures in place for staff to follow which are based on recognised good practice and national guidelines where applicable. Systems and processes in operation to improve the service, such as audits and quality monitoring, must be robust and effective to identify risks and make improvements

We also highlighted areas where the provider should consider taking further actions to improve. These did not constitute breaches of regulation and we did not review all of them at this inspection. These were as follows:

- The provider should continue to embed and enhance staff understanding and responsibilities in relation to the Mental Capacity Act 2005 and how this applies in practice.
- The provider should review the risk register to ensure it appropriately captures all current risks applicable to the service.
- The provider should review the need and implementation of separate male and female accommodation. Risks around shared accommodation should be considered as part of this.
- The provider should review their complaints process to consider including information about how complaints can be escalated to the applicable ombudsman service and details of how to do this.

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?
- Is it well led?

Before the inspection, we reviewed information that we held about the location. At the inspection, we assessed whether the service had made improvements to the specific concerns we identified during our last inspection, These related to the key questions of is the service safe, effective and well-led. We did not receive any information

Summary of this inspection

which caused us to re-inspect the caring and responsive domains. This was a short notice announced inspection. We announced the inspection so that the provider could ensure there would be clients and staff available at the service to speak with us.

During the inspection visit, the inspection team:

- visited the location, looked at the quality of the physical environment and observed how staff cared for people who used the service
- spoke with five clients
- spoke with the registered manager, the programme manager, the head of quality and performance and the head of operations
- spoke with eight other staff members employed by the service provider, including administration staff , therapeutic workers and members of the care team
- spoke with one volunteer
- attended and observed a staff meeting
- looked at four staff personnel records
- looked at seven care and treatment records, including medicines records, for clients
- observed medicines administration at lunchtime
- looked at policies, procedures and other documents related to the running of the service

What people who use the service say

We spoke with five clients using the service at the time of our inspection. All told us they felt safe at the service and within the environment. They said staff provided information about the service in the admission process and this enabled them to know what to expect.

Each client was involved in their care plan and said that staff discussed information in relation to their treatment and what support they required. All said discussions about risks and how best to manage these took place. Two clients told us they had specific relapse prevention plans in place. All said they were aware, to varying degrees dependent on length of treatment, of their objectives for their future and discharge.

Most clients felt there was a suitable amount of staff working at the service. One felt there was not enough staff at night but had not experienced any detriment due to this. Clients said staff were supportive, caring and respectful. Clients knew how to make complaints and were comfortable in speaking to staff about any concerns they had.

There were various groups available that clients were encouraged to attend to aid their treatment. Clients spoke about activities on offer. One said they would like to get out more as felt there were not enough opportunities for activities outside of the service.

Clients reported no concerns with management of their medicines and one commented about improvements in timeliness of administration following a new medication system. All said that the service was clean.

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:

- Staff regularly reviewed and updated clients' risk assessments following incidents. Clients had safety plans in place, which provided guidance for staff about support they needed in a crisis. Risk was discussed on an ongoing basis in handovers and team meetings.
- An environmental ligature risk assessment had been completed in accordance with the provider's own policy to help staff identify and mitigate risks to clients.
- The service provided separate male and female accommodation in line with information advertised on their website. Where there was any contravention of this arrangement, such as to meet a client's mobility needs, staff risk assessed the situation.
- The service had a designated medication administration room and had started to use a new medication system. Medication administration was calm and not disruptive. Feedback from staff and clients was positive.
- The service had improved infection control practices for testing of clients. There was a designated room for staff to undertake urine testing with appropriate equipment in place. Breathalyser tubes were single use and used in accordance with the manufacturer's instructions.

However, we also found the following issues that the service provider needs to improve:

- Staff did not always record daily fridge and room temperatures to help ensure safe storage of medicines.
- Where people self-administered medication, the process for staff to risk assess and monitor this was not robust and consistent.
- Mandatory training figures had improved since our previous inspection of May 2016 however there were still gaps and low compliance in some subjects.
- We saw examples where staff did not always adhere to infection control practices during medication administration.

Summary of this inspection

Are services effective?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- The prescribing doctor's assessments were now kept jointly within clients' detoxification records. This allowed staff better access to the required information to help support clients with their detoxification.
- Sessional staff and volunteers received regular supervisions and support.
- Staff had been trained in, and used where required, recognised good practice withdrawal tools in order to monitor withdrawal from opiates and alcohol.

However, we also found the following issues that the service provider needs to improve:

- Clients' care plans were not clear about what objectives the client was working towards and in what timescales. There were some omissions in records such as names, dates and signatures. Audits had not always identified all of these issues.

Are services caring?

Since our last inspection in May 2016 we have received no information that would cause us to re-inspect this key question.

Are services responsive?

Since our last inspection in May 2016 we have received no information that would cause us to re-inspect this key question.

Are services well-led?

We do not currently rate standalone substance misuse services.

We found the following issues that the service provider needs to improve:

- The provider had failed to make sufficient improvements to fully address the issues identified as requiring improvement at our last inspection.
- Managers completed medication audits but these had not identified gaps in the recording of fridge and room temperatures. Naloxone was not stored in accordance with the provider's policy and was not subject to any audit.
- Detoxification protocols were accessible to staff but there was no evidence of any input or oversight of these by the provider's board or clinical governance group.

Summary of this inspection

- There was contradicting information at provider and service level about what training was mandatory and which staff groups were required to complete which training.
- The quality and performance team had implemented a service improvement plan but it was not evident how this was used to follow up and monitor actions from internal audits and service reviews. The actions did not always portray an accurate reflection of actual practice and there was limited detail about how actions were to be achieved and in what timescales.
- These findings constituted a continued breach of regulation. You can read more about it at the end of this report.

However, we also found areas of good practice, including :

- The service had identified a need for, and recently employed, a clinical quality manager. Their role was designed to provide clinical input into the service and assist with clinical governance.
- Staff were positive about the leadership of managers at service level.

Detailed findings from this inspection

Mental Health Act responsibilities

We include our assessment of the service provider's compliance with the Mental Capacity Act 2005 and, where relevant, the Mental Health Act 1983 in our overall inspection of the service.

Phoenix Futures Residential Service does not admit people who are detained under the provisions of the Mental Health Act.

Mental Capacity Act and Deprivation of Liberty Safeguards

We did not review the service's compliance with the Mental Capacity Act and Deprivation of Liberty Safeguards at this inspection as this was reviewed within our comprehensive inspection of May 2016. We received no information to cause us to re-inspect this area.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

At our inspection in May 2016 we found that although the service advertised separate male and female accommodation, there was no separation in place. We did not identify this as a breach of regulation but told the provider they should consider this arrangement. At this inspection we saw the service now operated with separate male and female sleeping areas. The provider had implemented a same sex accommodation briefing which gave guidance for staff about maintaining this arrangement. The annexe was designated as female only accommodation. The manager told us there were plans to allocate one floor of the main house as female only with access via a key fob. The intention was to use this in situations where there were more females using the service than could be accommodated in the annexe. There were no definite timescales for these plans at the time of our inspection.

The annexe was accessible via ground level for people with limited mobility. We saw occasions where male clients had been housed in the annexe due to such needs. Staff told us they would only do this following discussion with the female clients and if they agreed. We saw completed risk assessments in each of the three instances this had occurred. Staff said they kept the situation under regular review in daily discussions with both staff and clients. Both clients and staff told us the separate accommodation arrangements worked well and meant more privacy for individuals.

Our previous inspection highlighted some concerns around safety and security as clients were not able to lock their own bedroom doors. Since then, the manager had completed a risk assessment stating the rationale for clients not being able to lock their doors. The primary reason being that the therapeutic community benefits were deemed to outweigh the risks. A therapeutic community is a participative, group based approach used to support people recover from substance misuse that usually involves individuals residing together. The risk assessment was to be reviewed and re-assessed by the registered manager in response to any incidents. There had been no incidents where this was shown to be a contributing factor at the time of our inspection and all clients we spoke with told us they felt safe. Clients had access to lockable storage in their rooms they could use for any personal possessions.

At the time of our last inspection the service did not have a ligature point risk assessment in accordance with their own policy for assessing and managing suicide risk. At this inspection we saw a completed audit that had been undertaken on 3 April 2017 by the department co-ordinator and a representative from the organisation who owned the building. This was subject to quarterly review as per the policy. The registered manager and programme manager told us, and minutes showed, staff discussed environmental risks in team meetings, supervisions and as part of recent suicide workshop training staff had undertaken.

Since our last inspection, the provider had taken action to improve infection control processes. Breathalyser tubes were all single use and there was a dedicated room where staff undertook drug testing of clients. There was appropriate personal protective equipment available for staff and suitable facilities to dispose of clinical waste. A staff member talked us through the process for urine testing which matched the procedure set out in the policy. However, we observed two occasions where staff did not adhere to the infection control protocol when administering medication. The medicines management policy said staff should wash their hands prior to administering medication and wear gloves but one staff

member did not do this on two separate occasions. They did not touch the medicines directly but not following these procedures could increase the risk of the spread of infection. We raised this with the registered manager so they could address it with the staff member.

Safe staffing

At our previous inspection of May 2016 several clients commented adversely about staffing levels and occasionally missing key work sessions or activities. The provider had not changed their core staffing levels since our last inspection. At the time of this inspection there were vacancies for a therapeutic worker and two administration staff. The service was recruiting into the administration roles and managing the therapeutic worker vacancy by the use of sessional staff. The quality and performance team's service improvement plan included an action to reduce cancellation of groups and one to one sessions. A comment against the action said this had improved. This was monitored by way of internal audits, service user feedback and the service user council and it was identified no groups had been cancelled. However, clients we spoke with told us there were enough staff about and they could also get support from volunteers and senior peers. No clients reported any cancelled activities. One client felt there were not enough staff at night but said they had not experienced a lack of support, or any impact, from this.

All the staff we spoke with felt safe and said staffing levels were suitable. One commented that having one staff member at night when the service was full could cause issues and a reliance on senior clients helping out. As 15 people were using the service at the time of our inspection, which meant less than half of the service's beds were occupied, they felt this was manageable.

The provider had commissioned an external consultant to undertake a review of the staffing model across all services due for completion at the end of May 2017. This piece of work had not been completed and reviewed by the board for a final decision at the time of our inspection so we were not aware of what, if any, changes were to be implemented in relation to staffing.

We identified shortfalls in mandatory training at our last inspection in May 2016. At this inspection we found training had improved. The registered manager kept a matrix of which staff were outstanding for what subjects. One of our concerns in May 2016 was low compliance with first aid training, particularly where staff worked alone, but all except one member of staff had now completed this. All staff were up to date with medication administration training and safeguarding adults training which had improved from the previous inspection. However, there were still some gaps where staff had not completed necessary training. For example, less than half of the staff had completed infection control training and 12 out of 20 eligible staff were not up to date with their annual refresher for safeguarding children training.

Assessing and managing risk to clients and staff

At our May 2016 inspection we identified that staff did not always update and review clients' risk assessments in response to incidents and in accordance with policy. At this inspection we saw evidence in client records that staff now regularly reviewed and updated risk assessments in response to incidents. Staff discussed client risks, incidents and significant events in team meetings and daily handovers. Team meeting minutes confirmed that discussion of risks was a standing agenda item. We observed a staff team meeting and heard staff discussing changes to individual clients' risk levels and how risks were to be safely managed. Clients told us they had regular discussions with staff about their risks and triggers and felt staff managed these effectively.

We reviewed seven care records of clients currently using the service. All of the care records showed that staff had used risk information obtained at referral and assessment stage and incorporated this into the management plans. However, we found two instances where referral information included detail about a risk which staff had not fully incorporated into the risk management plan. This meant staff might not have been aware of the full extent of the risks. These issues had not been identified within the corresponding care file audits

Some clients had 'safety plans' in place which had been completed by them to inform staff what support they may need in times of a crisis. The registered manager told us these would be completed at initial assessment or any time when an issue arose. We saw these in client records and the information reflected the content of the risk management plans. There was information about support clients required for unplanned discharges.

At our previous inspection, we identified concerns with medicines management. Two of these were staff not

recording fridge temperatures correctly and incorrect temperatures cited in the medicines management policy. Since then, the provider had acquired a new medication fridge which allowed staff to record daily maximum and minimum temperatures. However, we found gaps in the recording of temperatures. Between 1 February and 2 May 2017, there were 20 occasions where staff had not recorded fridge temperatures and 19 occasions where staff had not recorded the room temperature. Although the medicines management policy had been updated to include the correct ranges for storage, there was no guidance for staff about action to take if temperatures were outside of these ranges. If medicines are not kept within recommended temperatures for safe storage this can affect their efficacy.

The medicines management policy stated where people wished to self-administer medication, staff should risk assess this for the client and follow up to ensure self-administration was still appropriate. However, there was no guidance included for staff about what to include in the risk assessment to ensure this was a consistent process. Staff told us they discussed risks of self-administration medication with clients but did not document this. Therefore we could not be assured that the service had an effective system to assess and mitigate any associated risks where clients self-administered their own medicines.

At our last inspection, we witnessed that medication administration was disruptive for both clients and staff due to it taking place in an office environment also used for other purposes. At this inspection we saw one designated room was used solely for medication administration. Staff feedback about this was very positive as the new arrangement helped eliminate disruptions. With the clients' consent we observed staff administering medication to three people. The process was calm, unrushed and there were no interruptions. The staff member was able to talk privately with the client about how they were feeling and any health concerns they had. Staff were able to accommodate clients who needed medicines at times outside of set administration times. One client requested some pain relief medication in the afternoon and we saw the staff member promptly facilitated their request. Feedback from one client was that the new process was much quicker and safer. No one we spoke with expressed any concerns with their medication.

The service had recently implemented a new medication system which was a monitored dosage system with pre-printed medication administration records. All staff had been trained in use of the new system. Staff felt it was a much safer system and posed less risk of errors as they were not writing out all medication records themselves. Where people used 'as required' medicines, staff still recorded this on a handwritten administration record. However, we saw on two of these that staff had incorrectly recorded two clients of having 'no allergies' when the pre-printed administration records and medical information showed they did each have an allergy. We raised this with the programme manager and saw that these were amended immediately.

Reporting incidents and learning from when things go wrong

At our inspection of May 2016 we discovered that some incidents were documented in the duty book but had not been reported by staff. We also saw limited evidence of investigation of incidents. At this inspection we did not find any reportable incidents documented that had not been reported in accordance with policy. Incident forms showed that managers had investigated incidents and outcomes and documented learning from them. Discussion about incidents was a standard item agenda in team meetings and we observed a team meeting where staff discussed a recent incident. The registered manager kept a monthly log of incidents which allowed oversight of any recurring themes and trends. Incidents were fed into the quality and performance team who took responsibility for investigation of any serious incidents. There was evidence of discussions in staff supervisions and staff records to show managers discussed incidents and followed up with individual staff where necessary.

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

Assessment of needs and planning of care

At our previous inspection of May 2016 the prescribing doctor's medical assessments were not kept with clients' care records at the service. This meant that staff did not have access to a complete record of information about the client's needs for their detoxification. Since then, this practice had changed and we saw the doctor's assessments were now kept on site in clients' individual detoxification files. The doctor also took a copy for their

own records. We saw the doctor's assessments and consultation notes were present and accessible to staff in the two detoxification files we looked at. The manager and staff told us this was an improvement as it helped to reduce extra queries with the doctor and gave them access to necessary information to help enable them to support people appropriately.

At our last inspection, we identified shortfalls in the quality of the information contained within care records. These referred to omissions in records, such as names and dates, and care plans which contained generic information which was not always person centred. At this inspection, while there were improvements, these were variable. For example, we saw some documents such as key worker records which were unsigned in client records. We saw two care plans which had minimal information about the client's objectives and no information about when and how these would be completed and by whom. However, we also saw evidence where staff had documented clear, detailed objectives in client care plans.

We also identified in May 2016 that discharge information was not always apparent in clients' care records. The service and programme manager explained that specific discharge plans were completed at a certain stage within a person's treatment at a set number of weeks into the program. Managers told us that staff incorporated clients' goals post discharge into the care plans. We saw evidence of this in the records we reviewed. Clients we spoke with told us staff involved them in planning future goals regarding their move on from the service.

The residential and program managers completed regular care plan audits, some of which had not identified all of the issues we found in the records. Where managers identified issues, , they followed these up with individual staff members to improve practice. They told us they had seen notable improvements in the quality of documentation but recognised there was still some further work to be done.

Best practice in treatment and care

At our inspection of May 2016 we found staff did not monitor alcohol withdrawal in line with the service's medication and detoxification policy in place at the time. The policy said staff should use the clinical institute withdrawal assessment scale but there was no evidence this took place. No withdrawal scale was in use to monitor opiate detoxification. At this inspection, we saw staff used the Clinical Institute Withdrawal Assessment and the Clinical Opiate Withdrawal scales to monitor clients' detoxification and had been trained in the use of these. They had necessary equipment, such as a blood pressure monitor, required to complete the checks. The provider included guidance in the medicines management policy about the use of these tools. Staff had access to protocols for detoxification which had been written by the prescribing doctor.

Skilled staff to deliver care

In May 2016, we saw no evidence that the service's prescribing doctor had been revalidated. Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice. At this inspection we saw evidence that the doctor had been revalidated.

In May 2016 we identified that sessional workers employed at the service did not have regular supervisions and appraisals. At this inspection, the registered manager told us that all sessional workers and volunteers now had regular supervisions the same as the substantive staff. All staff we spoke with, including one volunteer, confirmed they had regular supervisions. We looked at four staff files including two sessional workers and a volunteer. These showed that each member had regular supervisions. These covered a number of areas including general progress and wellbeing, what support the staff member required, praise and success, training, safeguarding, incidents and service objectives amongst other areas. Staff told us they could access support from both the registered manager and programme manager at any time should they require this.

Are substance misuse services caring?

Since our last inspection in May 2016 we have received no information that would cause us to re-inspect this key question.

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

Since our last inspection in May 2016 we have received no information that would cause us to re-inspect this key question.

Substance misuse services

Are substance misuse services well-led?

At our inspection of May 2016, we identified that governance systems in operation were not suitably robust and effective and did not allow for sufficient oversight of the service. At this inspection we found continued deficiencies in governance systems.

We identified issues in relation to medication storage at our inspection in May 2016, primarily in relation to storage temperatures. At this inspection, although some action had been taken to address this issue, we found further similar shortfalls with temperatures which demonstrated that the systems had failed to identify ongoing risks and to make sufficient improvements in relation to this issue.

Since our last inspection, the provider had acquired the emergency drug naloxone. This is used to reverse the effects of an opiate overdose. The service's policy for the storage of the drug said it should be stored between 15 and 20 degrees celsius in a locked cupboard. However, guidance by the resuscitation council on the use of emergency drugs states they should not be locked away which meant the policy was not in line with best practice. Staff practice was to carry the naloxone around in a bag they wore to be used in an emergency so we did not identify that clients were at risk due to this. However, staff did not check the naloxone when they conducted medication audits, whereas the policy stated that this should be included within the audits.

Minutes of a clinical governance meeting in September 2016 stated there was a need for the development of detoxification protocols within the organisation. There were various protocols for detoxification available in the residential service dated June 2016 written by the prescribing doctor. It was not apparent whether input from the clinical governance board about these protocols had been required, and sought, as no such information was included within them to evidence this.

The head of operations told us there was no definitive list of mandatory training for each role. They said the Human Resource department were in the process of reviewing training requirements for staff across the organisation but this was not complete at the time of our inspection. The service kept records of staff training described as mandatory and additional training. Subsequent to our inspection, the quality manager provided us with a list of mandatory training for each job role they said was in place during the inspection. However, there was conflicting information as to what constituted mandatory training. For example, training in the use of the recognised withdrawal scales was stated as required training on this document but included as 'additional training 'on the service's training matrix. An induction program that was in place for new staff included a list of required mandatory training but this did not correspond with the list of mandatory training information that was provided to us. As such, it was unclear how the service could be assured staff were appropriately trained to the required skill set for their role.

Since our last inspection, the quality and performance team had implemented a service improvement plan, which they used to monitor the service. We requested the current improvement plan and reviewed the document that was provided in response to our request. An unannounced internal inspection of the service took place between 24 and 31 October 2016 by a team of staff employed by the provider but not who did not work at the service. They identified a number of areas for improvement across the whole service. The recommendations from that visit were not included in the plan and we could not establish whether, and how, the findings had been used to make improvements to the service.

Actions shown in the improvement plan as completed were not always reflective of practice. For example, one action stated that a ligature risk assessment had been completed in October 2016 and that this was subject to annual review. However, the ligature risk assessment we saw on site was completed March 2017. The associated policy stipulated this was to be reviewed quarterly, not annually. The plan contained a number of actions where it was not clear how progress would be measured or reviewed. For example, implementation of a new handover process, an action to ensure that incidents and accidents were reported and actions to ensure client's had safety plans in place. We could not establish from the plan whether these actions were reviewed to establish if any improvements had been sustained. Some actions relating to ongoing areas, such as the monitoring of complaints, were still attributed to the previous registered manager as having ownership of these. This meant the plan did not provide an effective representation of who had oversight of all areas of the service.

Substance misuse services

We did also recognise that improvements within the service had been made. Since our last inspection, the provider had identified a need for more clinical input into the service in order to provide guidance and oversight. As a result the provider had employed someone into a new role of a clinical quality manager. We were told that this new staff member's role included supporting the service in clinical areas such as training and policies.

The service had also acted upon our findings at the previous inspection in relation to the environment and had improved the procedure for medication administration. Managers now provided sessional staff with regular supervision. Staff we spoke with told us they recognised improvements at the service and spoke positively about the service managers.

We also found that reviews of incidents and individual risks to clients using the service were better embedded than at our previous inspection of May 2016.

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 17 HSCA (RA) Regulations 2014 Good governance Systems did not operate effectively to monitor risks to people using the service and to improve the quality and safety of the service provided. The provider did not ensure appropriate systems were in place to identity, and act upon, risks relating to the safe storage of medicines and the self administration of medicines. There was no evidence detoxification protocols had been agreed between all relevant parties, including the provider's clinical governance framework if necessary. The provider did not have suitable systems in place to identify, and provide oversight of, mandatory training requirements for staff. Service improvement plans were not subject to regular review, did not link to audits and internal reviews carried out in the service and were not reflective of practice. Regulation 17 (1) (2) (a) (b)