# St Clements Court

## Quality Report

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Oldham,
OL81NG
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Website:

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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

### 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.

## Overall summary

We do not currently rate independent standalone substance misuse services.

**We found multiple breaches of regulations. We used our enforcement powers to take urgent action and prevent the provider from admitting any more people to the service. We did this to ensure that people received safe care and treatment. We also required the provider to send us a weekly summary of the care and treatment provided to people using the services.**

**Full information about our regulatory response to the concerns we have described in this report will be added to a final version of this report we will publish in due course.**

We found the following areas of concern:

- Risks were not managed safely. There were no fire safety risk assessments and personal emergency evacuation plans, despite several clients having mobility difficulties and two wheelchair users. There was no assessment of ligature points, despite the service admitting clients who were intoxicated and with little risk history available. Staff were not following the infection control policy. Medicines management was unsafe. Staff did not report incidents and there was no policy or procedure for incidents to guide them.
- Staffing levels were unsafe and not sufficient for the service. The provider did not follow recruitment

# Summary of findings

procedures in terms of disclosure and barring checks and obtaining references prior to employing staff. Staff had not received mandatory training. Staff and managers had no awareness of safeguarding and policies were poor. Staff did not receive supervision or appraisals. There were no male support staff employed despite the service being for male clients.

- Record keeping was poor. The service did not maintain individual contemporaneous records. We found no care plans in the records we reviewed. There was little information about the reason why clients were admitted. There were no physical health plans or information for staff, despite several clients having physical health conditions which required monitoring.
- There was no structured alcohol treatment programme and no policies, procedures or guidance relating to alcohol treatment. Staff were not correctly totalling alcohol or reviewing the total daily quantities being received for the client undergoing a reduction. There was no use of recognised assessment tools or withdrawal scales. Staff had not received training in alcohol misuse or treatment.
- Staff had no awareness of the Mental Capacity Act. There was no Mental Capacity Act training available to staff. The Mental Capacity Act policy was undated and did not contain practical guidance for staff. There were no assessments of client's capacity undertaken, for example, in relation to medication.
- One client reported that a previous member of staff had shouted at him, the provider had not investigated this or referred it to safeguarding. Two clients expressed concerns about financial arrangements. The registered manager had written a derogatory comment in the day book and spoke in a derogatory manner about clients at interview.
- There was no structured activity programme. There was no information displayed about local services, client's rights, how to complain, CQC registration or information about the service. The complaints policy was not followed. There was no interpreter provision for one client who did not speak English.
- The overall governance and management of this service was poor. The provider failed to provide information we requested before the inspection. Managers had not registered the service with organisations such as the environmental health department and the information commissioner's office. Managers did not display knowledge of relevant legislation, for example the Mental Capacity Act. Safeguarding procedures were not in place and staff and managers did not understand safeguarding. All policies and procedures had been written in 2013/14 and had not been reviewed. They provided no guidance to staff. Overall, the service had a task based approach to care, with several recording books serving as the only continuous records of the day to day life of clients residing there.

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

- The overall building was clean and tidy and the kitchen where the chef prepared food for clients was well maintained.
- Clients described staff as positive, helpful and supportive and a carer was positive about the care their relative was receiving.
- The provider offered support to clients with housing applications and resettlement plans.
- There was a small gym available for clients and two computers were available so clients could access the internet.

# Summary of findings

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**Services we looked at**
Substance misuse services

# Summary of this inspection

## Background to St Clements Court

St Clements Court is based in Oldham. It offered an alcohol reduction programme for men with alcohol dependency, using reducing regimes of alcohol rather than a chemical detoxification.

The service was on three floors and accommodation was in the form of 29 self-contained flats. At the time of the inspection, there were 23 clients residing there.

Most clients were funded by local commissioners but several were self-funding via housing benefit.

The service was registered for the regulated activity of accommodation for persons who require treatment for substance use. This regulated activity requires that clients are receiving active treatment for substance misuse. At the time of the inspection one client was on an alcohol reduction programme. We have concerns that the service was providing a regulated activity which they were not registered for and are looking into this.

There was a registered manager at the time of this inspection. The registered manager was not available at the time of the planned inspection due to sickness. An unannounced visit took place the following week when we interviewed the manager and looked at records.

This service was previously inspected by CQC in 2014 and was found to be meeting the standards that were in place at that time.

## Our inspection team

The team that inspected the service on 5 and 6 December 2016 comprised CQC inspector Andrea Tipping (inspection lead), one other CQC inspector, and an expert by experience. An expert by experience is a person who has personal experience of using, or supporting someone using, substance misuse services.

The team that visited the service on 12 December 2016 comprised CQC inspector Andrea Tipping (inspection lead), an inspection manager and one other CQC inspector.

## 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?
- Is it well led?

Before the inspection visit, we were unable to review specific pre inspection information that CQC requests of all providers as the provider did not respond to this request.

During the inspection visit, the inspection team:

# Summary of this inspection

- visited the service, looked at the quality of the physical environment, and observed how staff were caring for clients
- spoke with four clients and one carer
- spoke with the registered manager and the general manager
- spoke with two other staff members employed by the service provider
- received feedback about the service from four care managers
- attended and observed two group sessions
- looked at 15 care and treatment records
- reviewed medicines management arrangements
- reviewed policies and procedures relating to the service.

Following the inspection, we sought feedback and liaised with commissioners for the service and the local statutory services.

## What people who use the service say

Clients all described staff as positive, helpful and supportive although two felt they were not always a visible presence. We spoke with one carer who was positive about the support their relative was receiving. Two clients expressed concerns about financial arrangements.

None of the clients we spoke to had been involved in planning their care. One client also reported he was not aware of what plans there were for his discharge from the service.

There has been no client survey undertaken at this service and no regular client community meetings. Three clients said they did not know how to feedback about the service. Two clients did not know how they would complain about the service.

# 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 multiple breaches of regulations. You can read more about these at the end of this report.

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

- There was no fire safety risk assessment and no personal emergency evacuation plans in place.
- The service did not have a ligature point assessment in place, there was no guidance for staff regarding the potential risks in the environment and how to mitigate these.
- Staff were not following the infection control policy in terms of body fluid spills and the disposal of sharps.
- Staffing levels were not adequate for the size of the service.
- Staff had not received mandatory training.
- The provider was not following recruitment procedures in terms of disclosure and barring checks and obtaining references prior to employing staff.
- Risk assessments were not completed in the majority of records we reviewed and completed assessments lacked content and were not up to date.
- Staff did not complete accident forms for all accidents.
- Staff were not aware of safeguarding, what to report and to who and staff had no safeguarding training.
- There were restrictive practices in terms of finances, medication and freedom of movement.
- Medicines management was poor, including record keeping, medication errors and storage.
- There was no incident reporting policy or system to record incidents.
- Staff were not aware of the duty of candour and there was no policy for guidance.

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

- Communal areas were clean and tidy.
- The main kitchen was clean, with appropriate food storage and equipment which was well maintained.

### Are services effective?

We do not currently rate standalone substance misuse services.

# Summary of this inspection

We found multiple breaches of regulations. You can read more about these at the end of this report.

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

- Records were poor, with no daily records kept for individuals.
- Of 15 records reviewed, only three contained a summary of the reason for admission.
- Of 15 records reviewed, only two contained a completed arrival form with personal information recorded.
- There were no individual care plans.
- There were no physical health plans.
- There was no structured treatment programme.
- Staff were not following the alcohol reduction plan for the one client who was on a reduction plan.
- The service did not use recognised assessment tools or withdrawal scales.
- Staff had not received training in alcohol misuse or treatment.
- Staff did not receive an induction when starting work at the service.
- Staff did not receive supervision or appraisals.
- Staff at night were from a security agency with no care background.
- Staff had no awareness of the Mental Capacity Act.
- There was no Mental Capacity Act training available to staff.
- The Mental Capacity Act policy was undated and did not contain practical guidance for staff.
- There were no assessments of client's capacity undertaken, for example, in relation to medication.

## Are services caring?

We do not currently rate standalone substance misuse services.

We found multiple breaches of regulations. You can read more about these at the end of this report.

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

- One client reported that a previous member of staff had shouted at him, this had not been investigated or referred to safeguarding.
- Two clients expressed concerns about financial arrangements.
- There were no male support staff despite this being a service for men.
- Client visits took place in a room fitted with cameras and without explicit consent by clients or visitors.

# Summary of this inspection

- The registered manager had made a derogatory comment in the day book and at interview about clients.
- Clients did not receive information at admission about the service
- There was no client involvement in planning care.
- There were no client community meetings or surveys to elicit feedback about the service.
- There was no information about advocacy services or how to complain displayed.

However, we found the following areas of good practice:

- Clients described staff as positive, helpful and supportive.
- A carer was positive about the care their relative was receiving.

## Are services responsive?

We do not currently rate standalone substance misuse services.

We found multiple breaches of regulations. You can read more about these at the end of this report.

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

- The referrals policy was not followed in terms of a pre-admission assessment form and risk assessment being completed.
- There was no system to record, analyse or learn from unexpected exit from treatment.
- The lift was out of order during this inspection and there was no timescale for this to be repaired.
- There was no structured activity programme.
- There was no interpreter provision for one client who did not speak English.
- There was no information displayed about local services, client's rights, CQC registration or information about the service.
- There was no information available to clients about the complaints procedure.
- The complaints policy was not followed.

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

- Clients were offered support with housing applications and resettlement plans.
- There were several rooms available for sessions and interviews.
- Clients could make hot drinks or snacks with no restriction.
- A small gym was available for clients to use on the second floor.

Clients could make use of two computers to access the internet.

# Summary of this inspection

## Are services well-led?

We do not currently rate standalone substance misuse services.

We found multiple breaches of regulations. You can read more about these at the end of this report.

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

- Staff had been employed and were working with vulnerable adults without adequate safeguards in place.
- There were not sufficient numbers of staff with skills or training working within the service.
- Staff had not received mandatory training.
- Staff did not receive formal supervision or appraisal by managers.
- There was no knowledge of relevant legislation by staff or managers, for example, the Mental Capacity Act.
- The service was not registered with the local environmental health department despite cooking food on the premises for clients.
- There had not been an application to register with the information commissioner's office, despite the service dealing with confidential information and using an intrusive close circuit camera recording system.
- All policies and procedures had been written in 2013/14 and had not been reviewed. They provided no guidance to staff.
- Safeguarding policies and procedures were not adequate.
- We saw restrictive practices around medication, finances and use of curfew arrangements.
- There were no policies or procedures describing the alcohol reduction plans, emergency situations for example, withdrawal seizures, or any treatment programme in place for alcohol use.
- Alcohol reduction was not being managed safely for the client who was undergoing this.
- Medicines management practice was unsafe and this had not been identified or addressed.
- There was a task based approach to care, with the use of recording books noting money, medicines and clients whereabouts.
- Data protection was poor, with confidential information stored on external hard drives with no back up.
- The service had no risk register.
- There were no audits undertaken.
- Outcomes were not monitored.
- When incidents occurred, there was no investigation process or learning apparent from these.

# Summary of this inspection

- The service was unable to provide us with any sickness or absence figures for this service.
- There were no staff surveys or meetings and no way for staff to formally feedback.
- There was no monitoring of incidents or accidents.

# Detailed findings from this inspection

## Mental Capacity Act and Deprivation of Liberty Safeguards

The service had a policy detailing the Mental Capacity Act and Deprivation of Liberty Safeguards, dated December 2013. This had not been reviewed. The policy outlined the five principles of the Act but did not provide guidance to staff on the applicability of the Act to this setting or any guidance if a client was felt to lack capacity.

Staff we spoke with were not aware of the Act or it's applicability to this service. There was no training available to staff related to this.

There were no capacity assessments in use at this service, despite clients being admitted who were intoxicated. We were also concerned that several clients had conditions which may affect their capacity and ability to understand and retain information and that this had not been assessed or considered. This included clients with acquired brain injury and learning disabilities.

We saw evidence that clients were assumed to lack capacity, for example, the service administered medicines to most clients with no assessment of their ability to self- manage.

# Substance misuse services

| | |
|---|---|
| Safe | |
| Effective | |
| Caring | |
| Responsive | |
| Well-led | |

## Are substance misuse services safe?

**Safe and clean environment**

St Clements Court was a large three storey building with communal areas on the ground floor and self-contained flats which clients maintained themselves. There was extensive closed circuit camera coverage throughout the corridors, communal areas and interview rooms of the buildings. There were no signs to inform people of this, no policy covering the use of this, a privacy impact assessment had not been completed and the service had not registered with the information commissioner's office for the use of these. We were told clients were informed of the use of cameras prior to admission but did not find evidence of this.

The front door to the building was locked with an intercom access. We were told that clients sometimes used this to speak to staff in the office on the first floor as clients with mobility problems could not access the office due to the lift being broken.

Staff kept in touch by using two-way radios. Staff were aware of not using these to transmit personally identifiable information but we saw no written guidance for this.

There were seven empty flats and staff spoke of running water regularly in these, however we were not clear that this was specifically with the risk of legionella in mind or to ensure the pipes were working. There was no policy, risk assessment or other documentation relating to legionella checks. Legionella bacteria can accumulate in pipes and water systems which are not used regularly and can cause outbreaks of Legionnaires' disease.

There was no fire safety risk assessment completed. During the inspection we saw no personal emergency evacuation plans for clients, two of whom we observed were wheelchair users and other clients with mobility needs. Staff had not received mandatory fire training. We have discussed these concerns with the local fire department.

There were ligature points throughout the building and within the flats. There was no audit of ligature points or evidence that this had been assessed or guidance for staff of how to mitigate the risks. Ligature points are places to which patients intent on self-harm might tie something to strangle themselves. This was of concern given that there was no evidence that suicide risk was assessed before or after admission, because clients were admitted who were heavily dependent on alcohol which is a risk factor for suicide.

Communal areas were clean and tidy. There were no cleaning staff and clients maintained the cleanliness of communal areas and their own flats.

Most flats were clean and tidy but several clients lacked ability or motivation to maintain their flats. Three rooms were dirty and clients were not able or supported to look after the rooms themselves. In one flat, the floor was covered in cigarette ends, and there were flies in the kitchen. In a second flat, the bathroom was noted to be very dirty with the bath full of clothes. In a third flat, the bathroom had faecal matter all over the toilet and floor and the sink was full of yellowing water. There were clothes on the floor which were urine soaked. There were no plans in place to guide staff about the care of these clients.

We observed poor infection control practice. During a tour of the service a client had urinated on the floor. He was prompted to clean this by staff. The client had a mop propped up in the corner which he used to sweep the urine around the floor and then replaced the mop in the corner of the room. There was an infection control policy which detailed a procedure for managing waste spills and this was not followed.

Communal area cleaning equipment was stored appropriately, with colour coded equipment.

An evening meal was prepared by staff for all residents. The main kitchen was clean and tidy. Food was stored appropriately and dates checked. Fridge temperatures were checked and a record kept of these. The service had not been registered with the local environmental health department but they were notified by CQC and visited shortly after this inspection. They found no major concerns and will award a rating in due course.

**Safe staffing**

The overall staff team consisted of two managers, one of whom was the registered manager, the chef who also undertook care work and a support worker. We were told the staffing establishment was four support workers but that there were vacancies due to staff leaving earlier in the year. There were no plans to recruit to these vacancies. The registered manager said they were aware the staffing levels were not adequate to complete all the care and treatment needs.

The duty rota showed the chef and support worker working 12 hour shifts during the week. On some days they were both off and there were no staff on the rota. Both managers told us they were available every day and would cover support work. There were no records showing the specific hours they worked.

At nights, there was a night security officer and a manager who slept in at the service. The night security officers were employed by an external agency. We have not been shown a copy of their contract or had access to whether they have disclosure and barring service checks in place.

There was not adequate staffing to enable individual sessions to take place. There were two whiteboards in the office, one for 1:1 sessions, and one for activities. The 1:1 board was blank and the activity board listed several Kindle gym sessions. Kindle sessions involved using brain training type applications and puzzle games. A second whiteboard for 1:1 sessions was downstairs in one of the interview rooms, a client told us this did not happen.

One client told us he had missed a hospital appointment due to staffing difficulties.

We also saw records that clients accompanied other clients to appointments and on other occasions staff accompanied clients to appointments. We were concerned that clients may be accompanying due to a lack of staff. We also noted that a client was often asked to collect several other clients' supplies of medication.

Staff had not received any mandatory training in the last twelve months. There was no record of what mandatory training was needed in the service. The support worker had not received any training following commencement of employment. We were unable to access any individual training records for staff. The registered manager confirmed that there had been no mandatory training provided this year. The registered manager told us that the support worker was being provided comprehensive on the job training however there were no records to capture training needs and support given. There were no records of training for the chef who was also involved in support work with clients.

Staff prepared evening meals for clients when the chef was not on duty and had not completed food hygiene training.

The support worker had not had a disclosure and barring service check undertaken and no references had been sought from previous employers. The chef told us she was employed by the service; the manager told us she was working for an agency. We asked to see personnel records for all staff but these were not provided. The registered manager confirmed that disclosure and barring service checks were not available for either staff members. References were also not available. Where recruiting procedures are not followed, there is a risk that staff may be employed who are not suitable.

**Assessing and managing risk to clients and staff**

The service had a policy for risk assessment, which had been written in 2014 and not reviewed. This detailed that clinical risk assessments would be "working documents" and would be reviewed at least every six months. They would also be updated following incidents or significant concerns.

Of the seven files containing risk assessments, staff had completed risk assessments at admission and not updated since. For two records, this dated back to 2014. Several incidents had occurred since.

Risk assessments were completed using the provider's own format, which gave no further analysis or generation of a risk management plan.

# Substance misuse services

We were concerned about the lack of completed assessments and risk assessments for clients admitted, often who were alcohol dependent and intoxicated. This put staff and clients at risk if there was not sufficient information to assess risk to others and self.

There were no incidents recorded for the last year, despite incidents documented in the handover book, for example, a resident throwing a pool ball across the communal area in anger. Clients leaving treatment unexpectedly were not reported as incidents. We saw that incidents were not reported, reviewed and learning shared.

Accident forms were completed on occasion: there were five completed accident forms for 2016. However, on reviewing the day book, there had been other accidents which had not been reported. These included in recent months a client falling out of bed and a client who had a cut on his head and eyebrow. In this instance, the day book entry was that he was sent back to his room to clean it. There was no record that showed the service exploring how the person had suffered the injury and no accident form. There was no evidence of staff providing first aid to this client.

Staff had no training in safeguarding and did not know how or what they would report. There were several related policies but none provided guidance to staff. The abuse policy listed types of abuse, the safeguarding adults policy detailed disclosure and barring checks should be undertaken and the child protection policy had sections highlighted where the local authority details should be inserted. It outlined that children under 18 would not be allowed to visit the service but there was no acknowledgement that there may be other situations were child safeguarding concerns may arise.

The general manager described a safeguarding situation relating to a previous member of staff who a client reported had shouted at him but the service had not reported this to the safeguarding team. CQC reported this to the local authority safeguarding adults' team. We were unable to access staff records to see whether the incident had been discussed with the staff member.

We were concerned about restrictive practices in terms of managing patients' monies, bank cards, tobacco and documents.

Four client files contained benefit letters and /or bank statements and in one case a passport and birth certificate. A financial agreement was one of the core admission documents which each client was expected to sign. In 12 of the 14 paper files we examined, this was blank. This agreement authorised the paying of benefits to St Clements Court and advised clients that this was a condition of their tenancy. This was to pay a contribution toward the placement as agreed by the commissioners for the service.

The registered manager said that no benefits were paid directly to the service. However, clients did have to hand in their bank cards to the service when admitted. Every few weeks, staff would take a group of clients to the bank so that they could withdraw their contribution to pay to the service. A receipt book showed when money had been received by the service. Clients would also pay off money they had borrowed from the service in the preceding weeks. We saw clients' financial statements showing what monies the service had made available and what the balance owing was. In some cases, this was for high amounts of money and in one case was for over five thousand pounds. There were no records to show clients had agreed to these arrangements and had consented to them. There was no information provided to clients to describe these arrangements and what they were contributing for.

One client told us he had requested bank statements but not received these and one said he was unhappy with staff having his bank card. Two clients spoke of signing forms but not being sure what these were.

CQC raised a safeguarding alert following inspection due to concerns about how the service was managing clients' finances.

Medicines management arrangements were poor. At the time of inspection, 15 of 23 clients had medication stored by the service, including over the counter medicines.

Medicines were stored in baskets on shelves in a locked room. Most medicines were dispensed by the chemist as disposable individual weekly dosettes. Medicines were then dispensed from these into plastic cups with the client initials written on and given out to clients at the office door. A client's insulin was being stored in the staff kitchen fridge. This fridge was not locked, had not been temperature checked and was being used to store food.

Controlled drugs had not been stored or administered according to the legislation and there was no controlled

drugs procedure. One client had been recently prescribed methylphenidate, a controlled drug, and this was being stored in a locker with two staff signing a sheet for administration.

There was a policy which related to handling medication which had been written in 2013. This was related to safekeeping medication for clients for short term periods if needed. This offered no guidance in terms of the current practice and documentation. There was no other medicines management guidance. Staff had received no training in medicines management.

There were instances of paracetamol given at 17.30 and then again at 20.00 as these were the administration times of the service. Paracetamol should be given with doses at least four hours apart to prevent liver damage. This is of greater concern in this service where many clients may already have liver damage due to heavy alcohol use. These had not been recognised as medication errors by the service because staff had not had relevant training in medicines management. This meant that these errors had occurred repeatedly for a prolonged period of time, increasing the risk to clients of further liver damage and overdose. CQC raised this with the provider and they took action to address this immediately.

Medicines were recorded in an A4 loose leaf book with initials, room number and a one line entry, typically "all medication given". This meant that once the medication packaging had been disposed of, there was no record of what medicines had been given to clients. Some staff recorded when over the counter medication, for example paracetamol, had been given but on other days there was no recording of this.

We saw three full sharps bins on a cupboard in the manager's office. Two of these had been overfilled. None were labelled with the date of opening or the lock date on. We were told by the registered manager these were being taken to the local care centre. The previous week, we had been told there were arrangements in place with a local chemist for the disposal of sharps bins. The infection control policy stated that bins should not be overfilled and did not outline disposal arrangements.

**Track record on safety**

There was no incident reporting process or policy in place. Where incidents were identified in the day record, there was often no corresponding clinical record to cross reference. When adverse events occurred, for example, clients unexpectedly leaving treatment, this was not reported or analysed.

**Reporting incidents and learning from when things go wrong**

There was no incident reporting process or policy in place. Staff reported accidents on loose leaf forms which were stored in the office. There were five forms for 2016 completed with immediate actions taken. We saw evidence of accidents and incidents that were not reported.

**Duty of candour**

The duty of candour is a requirement for health services introduced in 2015. Providers of healthcare services must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology.

Staff were not aware of the duty of candour. There was no policy, procedure or training to guide staff.

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

**Assessment of needs and planning of care** (including assessment of physical and mental health needs and existence of referral pathways)

During the announced inspection, we reviewed 13 paper case files and eight were cross checked with electronic records. At the unannounced visit, we reviewed three electronic records and one paper file. Overall we reviewed 15 individual clients' records.

Three clients had initial plans, with details of where they were referred from and a brief plan for admission. Two initial plans were from clients admitted in September 2016 and one client admitted November 2016. One had another client's initials in one section and had the same content as that person's plan. This meant that information was not personalised.

Two paper files contained an arrival form (a summary of personal information) but only one was fully completed.

# Substance misuse services

There was no summary in 12 of the files of the assessment or reasons for admission.

There was a keyworker policy but this was not being followed. This said that keyworkers would be identified within 48 hours of admission and that regular keyworker sessions and collaborative planning would take place. We found no evidence that this was happening.

There were no individual care plans in any of the records we reviewed.

There were no daily individual client records. Individual notes regarding clients' care and treatment were recorded in an individual electronic spreadsheet on an ad-hoc basis. We reviewed one spreadsheet where there were three entries for 2016, one where there were four entries for 2016 and one spreadsheet with one entry from September 2016 which was a tenancy warning.

Daily information was recorded in the day book, where information about all clients was noted. This information included, medication times, meal times and who attended, equipment (hoovers, laptops) signed in and out to clients, cigarettes and money signed out to clients and clients leaving the building and returning. There was no information that clients were debriefed on return to assess issues of potential risk, for example the temptation to drink alcohol.

There was no individual information about physical health. Clients were assisted to register with a local GP. There were entries in the day book noting when clients had visited the GP or walk in centre but no information about what needs they may have.

There were no care plans relating to physical health care, despite two clients who were prescribed warfarin (a medication to prevent blood clots which requires close monitoring), two clients who had epilepsy and one client prescribed insulin for diabetes. Changes to warfarin doses were made by a specialist nurse who visited and recorded these on a separate dispensing sheet. There was no guidance for staff as to what changes to be alert for with clients taking warfarin. The client prescribed insulin had occasional blood sugar readings recorded in the medicine book but there was no guidance for staff as to what readings meant and what monitoring was needed.

**Best practice in treatment and care**

The service was registered to provide the regulated activity of accommodation for persons requiring treatment for substance misuse. There was no structured treatment programme other than the alcohol reduction which set out how many units of alcohol the person could have daily. We reviewed the most recent alcohol reduction programme.

We were concerned that this alcohol reduction was not planned or carried out safely and put the client at risk. We reviewed the alcohol record book and the spreadsheet containing reviews. In the alcohol record book, week two and three of the reduction showed differing alcohol units for each day. There was a marked reduction of 9 units noted on day 10 (from 31.3 units the previous day to 22.2 units) and this decrease was maintained for two days before units then increased again. This appeared to be the client missing tea and alcohol allocation but had not been noted in the reviews in the spreadsheet. On day 13, overall alcohol intake increased again by just under five units to 25.5 units and then again on day 14, to 29.3 units with smaller increases and decreases noted over the next week. The spreadsheet throughout this two week period said the client was receiving 30.4 units per day but this was not the case on any of these days with units varying between 20.6 and 29.3 units. There did not seem to be a set allocation consistently maintained until week four, when the client stabilised for the next week on 17.9 units per day.

There was no written guidance regarding the alcohol reduction programme or recognised assessment tools in use. From the alcohol log and client records, it was unclear how overall alcohol was calculated. National Institute for Health and Care Excellence guidance CG115 recommends that level of dependency be assessed using recognised assessment tools.

There was no guidance to staff regarding assessing or managing delirium tremens or withdrawal seizures. There were no withdrawal scales in use to assess clients. Staff had received no training in relation to alcohol dependence or treatment.

We were concerned that in a setting registered for treatment for substance use there were no policies and procedures relating to alcohol treatment or rehabilitation.

There were no structured group or individual programmes relating to alcohol misuse. Department of Health guidance emphasises that treatment for substance use should always involve a psychosocial component and that these

interventions are the "mainstay of treatment" (Drug misuse and dependence: UK guidelines on clinical management, 2007). We were concerned that whilst clients may be able to complete a reducing regime and become abstinent, no psychological interventions took place to maintain this, to explore triggers or to develop relapse prevention plans for the future. There was no evidence of psychosocial interventions used within this service.

We saw evidence of two group sessions in the last three months relating to alcohol use, one an entry in the day book in October 2016 and one during our inspection which was a showing of a DVD relating to alcohol's effects on the brain.

The registered manager confirmed the service did not offer a "traditional" model and described the model of treatment as "intuitive recovery based on incentive and hierarchy of need". They could provide no written guidance about this model.

**Skilled staff to deliver care**

None of the staff we interviewed had received training relating to alcohol dependency and treatment.

There was a staff induction procedure, but neither of the staff working within the service had completed an induction.

Staff did not receive supervision or appraisals and there were no regular team meetings.

No training was available to staff.

We were unable to view personnel records to see how staff performance was addressed, including how the support worker's probationary period was being monitored. We asked to see these during the planned inspection but were told only the registered manager could access these and she was absent. At the further visit the registered manager could not find the keys to access these.

**Multidisciplinary and inter-agency team work**

We saw from documentation that handovers took place between the security staff at night and the day staff arriving in the morning. This was a written handover sheet outlining if clients had been seen overnight and checks of the building.

Substance use case managers described good working relationships with the managers and attended the service to review their clients.

We became aware of clients during this inspection who had been living at the service long term once the initial funding for treatment had expired. Some clients were paying housing benefit as part of a tenancy agreement and had no involvement from health services once their funding stopped. Others were being funded for longer term care rather than for alcohol treatment with some having lived at the service for four years. Their care was funded by adult social care teams rather than substance misuse teams. There was no evidence in records of reviews of these clients.

**Adherence to the Mental Health Act** (if relevant)

This was not applicable to this service.

**Good practice in applying the Mental Capacity Act** (if people currently using the service have capacity, do staff know what to do if the situation changes?)

Staff we interviewed had no awareness of the Mental Capacity Act and it's applicability to this setting. There was no training provided to staff relating to the Act. There was a Mental Capacity Act policy which was undated. This outlined the principles of the Act and the role of the independent mental capacity advocate. It contained a description of Deprivation of Liberty Safeguards. There was no guidance to staff of the applicability of the Act or the safeguards to this setting. The read and sign sheets kept with the policy folder were all related to staff who had left the organisation and no current staff had signed that they had read the policy.

There was no evidence of assessment of capacity. The service accepted people who may be intoxicated at the time of admission but we did not find this was taken into account when considering consent issues. Two clients told us they did not know what forms they had signed at admission. Staff reported two clients as having an acquired brain injury and one was reported to have learning disabilities but their capacity to consent or understand information had not been assessed or considered.

Despite this, the service subjected clients to restrictive practices in relation to finances, medication and freedom of movement.

# Substance misuse services

We were concerned that clients were subjected to curfew arrangements with no evidence these had been discussed or agreed with clients. We saw examples were clients were told they could not leave the building for up to two weeks at a time. We saw one example of a client placed on "room curfew" which would seem to be him being restricted to stay in his flat. A newly admitted client was noted to be "brought back by staff and advised that he can go outside for a cigarette but no further than the garden". There was no signed contract or agreement from the client for this. In October 2016 a client was noted to be reminded of the house rules and told he needs to remain in communal areas all day. The house rules were not displayed in the communal areas.

We were concerned that other clients accompanied clients to appointments, which was described as client mentoring, for example, there was a description in the day book from 3 November 2016 that one client was going to the GP and another client "in support as a client mentor". There was no indication that this was an arrangement by choice or that the client with an appointment had requested this. There was nothing documented about the role or training for being a client mentor.

All clients had to hand in their bank cards to staff when admitted. We also saw that other documents were in the possession of staff, including birth certificates, bank statements, benefit letters and bus passes. Cigarettes and tobacco were also kept by staff and signed out at regular intervals.

Most clients were receiving their medication from staff. There were no assessments taking place of whether this was necessary and whether clients could manage their own medication.

**Equality and human rights**

The service had a comprehensive anti-discrimination policy, which covered the Human Rights Act, principles of equality and diversity and responsibilities of staff and managers, dated 2013. This had not been reviewed. None of the current staff had signed to say they had read this policy.

**Management of transition arrangements, referral and discharge**

Referrals to the service were generally made by telephone to the registered manager. The referrals policy outlined the forms which needed to be completed following assessment by the manager and the timescales for admission. We did not see any completed pre-admission review forms in records we reviewed. We saw brief information relating to referral and admission within the electronic care records for three clients. Clients would sometimes be assessed and immediately admitted to the service and care managers described this as necessary in some cases due to the vulnerability of individual's circumstances.

Staff assisted clients in resettlement options as they approached the end of their funding. This involved assisting with housing applications and identifying moving on options. Some clients continued to live at the service and became tenants with their rent paid by housing benefit.

## Are substance misuse services caring?

**Kindness, dignity, respect and support**

We saw positive staff interactions with clients during this inspection.

We spoke with four clients during this inspection and observed several sessions including a grocery ordering session, a kindle mind gym session and a DVD session. Clients all described staff as positive, helpful and supportive although two felt they were not always a visible presence.

One client reported that staff shouted at him, this was related to a previous member of staff and was referred to the local authority safeguarding team by CQC.

We spoke with one carer who was positive about the support their relative was receiving.

Two clients expressed concerns about financial arrangements.

One client said he was unhappy with the evening meals, describing these as mainly processed foods.

We observed that the staff team were all female. There were no male staff available apart from the night security officers, who were not employed as care workers. This meant that clients did not have the choice of being able to discuss issues with another male.

# Substance misuse services

Visits from family and friends took place in a private room on the ground floor, although this room was fitted with close circuit cameras and there was no room which could be used privately. Visitors were not allowed in clients' flats. No children were allowed to visit the service.

The registered manager did not talk about clients in a caring and respectful way. We saw an entry in the handover book made by the registered manager where they referred to a client in a derogatory manner. They stated the client was 'in sulk mode'. This person had their phone removed from them the day before. During interview, the registered manager stated "stupidness" "that's what we get from the clients here".

**The involvement of clients in the care they receive**

We asked clients about the admission process. One client described having been brought to the service by the homeless team and another via his community alcohol keyworker. Two clients told us the only information received on admission was forms to sign and they could not recall what they had signed. Two could not recall anything of admission.

None of the clients we spoke to had been involved in planning their care. One client also reported he was not aware of what plans there were for his discharge from the service.

There was no information available to clients about advocacy services.

There has been no client survey undertaken at this service and no regular client community meetings. Three clients said they did not know how to feedback about the service. Two clients did not know how they would complain about the service and two others said they would speak to a manager. There was no information displayed within the building about how to complain or give feedback about the service.

There was a resident's involvement policy dated 2013 which outlined strategies for client involvement in the service but none of these had been actioned.

## Are substance misuse services responsive to people's needs?

(for example, to feedback?)

**Access and discharge**

The service accepted referrals from three commissioning authorities. The service did not have any clients commissioned from the area the service was in.

Referrers generally made referrals by telephone to the registered manager. The referrals policy outlined the forms which needed to be completed by managers following assessment and the timescales for admission. We did not see any completed pre-admission review forms in records.

Clients would sometimes be assessed and immediately admitted to the service and care managers described this as necessary in some cases due to the vulnerability of individual's circumstances. Clients were often homeless or at risk of eviction, with high levels of dependent alcohol misuse.

The statement of purpose stated that the service would provide detailed information on the project by publishing a service user's guide and clients would be given a contract or statement of terms and conditions specifying the details and responsibilities within the relationship. They would also have their needs expertly assessed before a decision on admission was taken, the service would demonstrate to prospective residents that they were confident that they can meet clients' assessed needs and would offer introductory visits to prospective residents to reduce the potential of clients changing their minds and requesting a move to an alternative facility. We found no evidence that any of this occurred.

The service initially admitted clients to a ground floor flat and as they become abstinent, they moved to the first and second floor flats.

Staff assisted clients in resettlement options as they approached the end of their funding. This involved assisting with housing applications and identifying moving on options. Some clients continued to live at the service and became tenants with their rent paid by housing benefit.

# Substance misuse services

Records reviewed showed several clients had unexpectedly left the service in 2016. There was no system to assess or analyse these failed treatment episodes.

**The facilities promote recovery, comfort, dignity and confidentiality**

The service had a number of workshop rooms, therapy rooms and communal spaces. There were two larger rooms to enable large group work sessions. There was no specific clinic room and visiting health professionals used one of the therapy rooms.

The service had level access and ramps for wheelchair users. The lift was out of order and staff told us that there were ongoing problems with this being repaired and then failing again. This meant that facilities on the two upper floors were not accessible to wheelchair users. This included the staff office on the first floor. Satisfactory arrangements had not been made to ensure that clients who could not access the first floor could call staff. Clients had to leave the building and use the intercom at the door to communicate with staff in the office.

There was an accessible shower facility on the ground floor. All flats had en suite bathroom facilities.

There were small outside garden areas that were well used by clients.

Clients made their own meals during the day, however, an evening meal was provided by the service. Clients received a budget from the service to purchase individual provisions for the week. The service ordered provisions online and the supermarket delivered them twice per week. The service also kept a stock of essential items if needed, such as toiletries and cleaning products.

Clients could make hot drinks and snacks at all times. The service provided kettles and toasters for all flats. Furniture within the flats appeared comfortable and well maintained.

There was no structured activity programme for clients. We saw that there were film/DVD nights, kindle sessions (which involved puzzle and brain training type games) and occasional themed activities, for example, pumpkin carving. A small gym was available on the second floor for clients to use but there were no staff trained to ensure equipment was used correctly.

We were told by staff that two clients were assisting with painting and decorating empty flats as work experience. We also saw in the day book that clients were being given jobs to do around the service in exchange for money or cigarettes.

One client was attending a local support group, which he had organised himself.

Clients could make use of two laptop computers with internet access, to assist in keeping in touch with family and friends and searching for information, for example, relating to housing.

**Meeting the needs of all clients**

There was no information displayed about local services, advocacy services, clients' rights, complaints, CQC registration or information about the service.

One client did not speak English and had been assisted by staff to find a local college offering English lessons. There had not been any arrangements made for an interpreter to be booked for him. Written information was not available in his language.

Clients were assisted to find local religious services and facilities as needed.

Staff supported clients with limited literacy skills to order their food online.

**Listening to and learning from concerns and complaints**

There was a complaints policy dated 2013 but no complaints either verbal or written, had been received or documented. The registered manager told us that if a client made a complaint to them, they would try and resolve it there and then. This was not documented anywhere. This did not follow the service's own policy. Clients and staff were not aware of the complaints policy. There were no arrangements for independent scrutiny of a complaint. The registered manager was also the sole director of the provider so if a complaint was made about them, they would be investigating themselves.

## Are substance misuse services well-led?

**Vision and values**

# Substance misuse services

The service submitted a statement of purpose to CQC in 2011. This outlined that the service "provides a care project providing support for single men over 30 years old who have an alcohol misuse problem. The main focus is to provide high quality accommodation and support through an alcohol reduction and abstinence programme. The project's aim is to enable residents to resolve issues that may be obstacles to achieving and maintaining independent accommodation. This is achieved by providing a comprehensive, bespoke support plan for each individual to enable them to overcome their personal barriers."

We found that there were clients who had been admitted four years ago and who were funded for long term care. We observed some clients being prompted to complete personal care tasks. There is a concern that this service was providing a regulated activity that they were not registered for. We found some clients had been admitted following long periods of abstinence and it was not clear what the purpose of admission was. We saw no evidence of comprehensive bespoke care plans for clients.

The two managers were heavily involved in the running of the service, they were often the only point of contact that referrers or care managers had with the service.

**Good governance**

This service did not have adequate governance in place. There was no governance framework in place. The registered manager told us that there was not enough time to monitor quality.

Staff had been employed and were working with vulnerable adults without adequate safeguards in place. There were not sufficient staff with skills or training working within the service.

Staff were not receiving supervision or appraisals.

Staff had not received any training in the last twelve months, including mandatory training. The support worker had been employed for three months and received no initial training or induction.

There was no knowledge of relevant legislation by staff, for example, the Mental Capacity Act.

The service was not registered with the local environmental health department despite cooking food on the premises for clients.

The provider had not applied to register with the information commissioner's office, despite the service dealing with confidential information and using an intrusive close circuit camera recording system.

All policies and procedures had been written in 2013 and 2014, with none having been reviewed since. Policies were not being followed and the registered manager told us that there was no programme of audit in place to check how policies worked and whether they were followed. There was a sign sheet for staff to record when they had read policies: the current staff had not signed to confirm they had read policies.

Safeguarding policies and procedures were not adequate and staff were not aware of what safeguarding was, what to report or how. This included the registered manager who told us they had not reported an allegation made by a client as the client did not wish to pursue this.

We saw restrictive practices around medication, finances and use of curfew arrangements with no reference to the legality of these arrangements and no evidence of client consent. Clients told us they were unsure what forms or paperwork they had signed when admitted.

There were no policies or procedures describing the alcohol reduction plans, emergency situations, for example withdrawal seizures, or any treatment programme in place for alcohol use. There was no evidence of regular group work or individual sessions being offered to clients in line with the statement of purpose and best practice for people to support people with substance misuse.

Alcohol reduction was not being managed safely for the client we reviewed. This was the only client of 23 receiving alcohol reduction.

Medicines management practice was unsafe and this had not been identified or addressed.

We saw a task based approach to care, with the use of recording books noting money, medicines and clients whereabouts. There was no daily recording records used for clients and when entries were made in the electronic records these often recorded attendance at an activity or tenancy warnings. Some clients had no individual entries for a number of months.

We were concerned that several clients were living in dirty and unhygienic environments and the provider was not addressing this.

The service used both paper and electronic records. Electronic records were spreadsheets stored on a physical network drive. We were told by managers that there had been a data loss of several months of records earlier in the year as the external drive had stopped working. The business contingency policy referred to regularly backing up data but this had not happened.

There was no monitoring of incidents or accidents. When incidents occurred, there was no investigation process or learning apparent from these. The service had no risk register. There were no audits undertaken. Outcomes were not monitored.

The registered manager told us that the poor record keeping was the result of constrained finances and a lack of time available. This was also the explanation for the lack of audits of the service's performance.

Prior to the announced inspection, we sent a provider information request to the registered manager. This asked for information relating to the service including how they were ensuring good governance and plans for service improvements. Despite repeated email prompts, this was not returned and the requests were never acknowledged.

The registered manager wrote to CQC asking to postpone the planned inspection in November 2016 citing a number of reasons including staff shortages and a need to complete a commissioning tender.

The registered manager was not present during the planned inspection due to sickness. In the absence of the registered manager no-one else had access to personnel files, supervision files and appraisals, referral information, training records and documentation and minutes of commissioner meetings.

The registered manager was present on 12 December 2016. They were unable to find the keys for their locked cabinet which contained personnel documents and two hard drives containing electronic data.

The registered manager was aware of many of the concerns reported but had failed to act. Their response to this inspection has been to make plans to close the service. They have failed to respond to requests relating to the proposed sale of the service and in relation to discharge plans for the clients currently residing in the service.

**Leadership, morale and staff engagement**

We have not been able to access any sickness or absence figures for this service.

We were not aware of any bullying, harassment or whistleblowing reports.

There were no staff surveys or meetings and no way for staff to formally feedback.

Staff we spoke to felt well supported by managers. However, we did not feel that managers displayed sufficient skills or knowledge to adequately support staff.

**Commitment to quality improvement and innovation**

There was no participation in outcome measurement or audit within the service.

There was no involvement in research.

# Outstanding practice and areas for improvement

## Outstanding practice

## Areas for improvement

**Action the provider MUST take to improve**
We used our enforcement powers to take urgent action and prevent the provider from admitting any more people to the service. We did this to ensure that people received safe care and treatment. We also required the provider to send us a weekly summary of the care and treatment provided to people using the services.

Full information about our regulatory response to the concerns we have described in this report will be added to a final version of this report we will publish in due course.

- The provider must ensure that a fire safety risk assessment is completed.
- The provider must ensure that personal emergency evacuation forms are completed for individuals who require them.
- The provider must complete a ligature risk assessment and provide guidance to staff of how to mitigate risks.
- The provider must ensure they complete a legionella risk assessment and provide guidance for staff.
- The provider must ensure the infection control policy is followed in the event of body waste spillages.
- The provider must ensure there is a clear procedure for sharps disposal and that bins have the dates recorded on them as to when they were opened and locked.
- The provider must ensure mandatory training is provided for all staff.
- The provider must ensure that all relevant pre employment checks as specified in Schedule 3 are completed for all staff prior to employment.
- The provider must ensure that risk assessments are completed for clients at admission, and regularly updated as per the policy.
- The provider must complete accident forms when an accident occurs.
- The provider must implement a procedure for reporting incidents and develop a policy to guide staff.
- The provider must ensure that there is an effective system to monitor incidents and accidents which includes analysis and sharing learning.
- The provider must ensure that staff have an understanding of safeguarding.
- The provider must update the policies to ensure there is safeguarding guidance available to staff including the local authority contact details and how to report with reference to the Care Act 2014.
- The provider must review restrictive practices relating to client finances, medication and freedom of movement referring to relevant legislation around consent and capacity.
- The provider must ensure that each client is given a breakdown of contribution costs and what this money is for.
- The provider must review medicines management practice including storage arrangements, administration practice and recording and policies and procedures.
- The provider must ensure staff receive training in medicines management.
- The provider must record medicines errors, for example those relating to paracetamol.
- The provider must develop a policy to guide staff in relation to duty of candour.
- The provider must ensure that they introduce contemporaneous records for individuals.
- The provider must ensure that a pre-admission assessment is completed as per the referrals policy.
- The provider must develop pre-admission information about the service as outlined in the statement of purpose.
- The provider must ensure that individual care plans are developed for each client to guide staff involved in their care.
- The provider must complete physical health monitoring plans for clients who need them.

# Outstanding practice and areas for improvement

- The provider must produce guidelines to assist staff in ensuring that alcohol reduction plans are carefully planned and adhered to.
- The provider must ensure staff are aware of and able to recognise and respond appropriately to complications arising from alcohol reduction, for example, seizures.
- The provider must incorporate recognised assessment tools and rating scales into the alcohol reduction procedure.
- The provider must develop a treatment programme which includes a psychosocial component.
- The provider must ensure staff receive a comprehensive induction to the service as per the policy and induction package.
- The provider must ensure staff are regularly supervised and maintain written records of this.
- The provider must ensure that staff receive an annual appraisal.
- The provider must ensure that staff working within the service from a security agency have been appropriately recruited to work with vulnerable adults.
- The provider must ensure that staff are aware of the Mental Capacity Act and it's applicability to this setting.
- The provider must ensure that capacity assessments are carried out where required
- The provider must ensure that the policy in relation to the Mental Capacity Act is updated to provide clear, practical guidance to staff.
- The provider must ensure that clients and visitors are aware of the closed circuit cameras in use around the building.
- The provider must ensure that care plans are developed with clients.
- The provider must ensure that information is available to clients about how to complain.
- The provider must ensure that the complaints policy is followed.
- The provider must ensure they register with the information commissioner's office given that they are storing confidential information and have an extensive closed circuit camera recording system.
- The provider must develop a policy for the use of closed circuit camera use and must ensure that signage is displayed wherever there are closed circuit cameras within and outside the building
- The provider must review all policies and procedures regularly and set review dates for these to be kept up to date, and monitor their use and effectiveness.
- The provider must review data protection policies and procedures in light of the data loss this year.
- The provider must put in place a system to back up confidential data.
- The provider must develop an audit schedule relating to relevant policies and legislation.
- The provider must develop a system to accurately record outcome data, including unexpected exit from treatment.
- The provider must develop a system for evaluating and improving care which includes gathering and acting on feedback from clients, staff and other relevant people.

### Action the provider SHOULD take to improve

- The provider should endeavour to provide a gender mix of staff given that all care staff employed in a male service are currently female.
- The provider should ensure that there are opportunities for clients to feedback on the service, for example by regular community meetings, feedback cards or a survey.
- The provider should ensure that the lift is repaired.
- The provider should ensure that an activity programme be developed as outlined in the statement of purpose.
- The provider should ensure regular booking of interpreter services for clients who do not speak English and that written information is available in their primary language.
- The provider should develop a vision and values which is shared with clients and staff.

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.

This section is primarily information for the provider

# Enforcement actions

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require treatment for substance misuse | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require treatment for substance misuse | Regulation 11 HSCA (RA) Regulations 2014 Need for consent |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require treatment for substance misuse | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require treatment for substance misuse | Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require treatment for substance misuse | Regulation 17 HSCA (RA) Regulations 2014 Good governance |

| Regulated activity | Regulation |
|---|---|

This section is primarily information for the provider

# Enforcement actions

| | |
|---|---|
| Accommodation for persons who require treatment for substance misuse | Regulation 18 HSCA (RA) Regulations 2014 Staffing |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require treatment for substance misuse | Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require treatment for substance misuse | Regulation 20 HSCA (RA) Regulations 2014 Duty of candour |