

Turning Point - Croydon

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

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 the following issues that the service provider needs to improve:

- Clients risk assessments were not detailed. Clients risk management plans were basic. Risks of abuse to clients or to children were not always recognised and acted on.
- Clients did not have a physical examination before medicines were prescribed. Information was not requested from clients' general practitioners before medicines were prescribed. This was a risk to client's health.

- Clients assessments were not comprehensive. Clients medical assessments were inconsistent and dependant on who assessed the client.
- Complaints from clients were not always acknowledged or investigated.
- The management team did not have appropriate oversight of incidents, complaints and safeguarding referrals.

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

- Clients in the service were very positive regarding staff. Some clients linked their reduction in substance misuse directly to the support staff had provided.

Summary of findings

- Following an increase in people from eastern Europe seeking treatment, the service had employed two Polish speaking staff. Clients in the service had diverse ethnic and cultural backgrounds reflecting the local population.
- The service worked effectively and productively with a range of other agencies.
- The management team were aware of most areas requiring development and were committed to improving the service. They were keen to develop a positive working environment.

We issued the provider with a Warning Notice for a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act (Regulated Activities) Regulations 2014. We also took other action which is at the end of the report.

Summary of findings

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Turning Point - Croydon

Services we looked at

Substance misuse services

Summary of this inspection

Background to Turning Point - Croydon

Turning Point - Croydon provides advice, support and treatment for young people and adults with drug and alcohol problems within the London Borough of Croydon. The service had been operating for just over eighteen months. Prior to this there had been five separate services operated by different providers. The service has the following teams:

Recovery team – The largest part of the service providing substitute opiate prescribing, community alcohol detoxification, key-working, counselling, alternative therapies, benefits and housing advice, a needle exchange, blood borne virus testing and vaccinations.

Young person's team – Provides support for young people using alcohol or drugs.

Engagement and outreach team – Engages with 'hard to reach' clients such as people who are homeless. Provides harm minimisation advice, support and access to substance misuse treatment.

Criminal justice team - Provides assessments to people in custody, prepares reports for the court, and provides key-working, support and treatment to clients who are subject to court orders with a substance misuse requirement.

All adults using the service are also able to access a psychosocial group programme operating six days per week. Young people access their own programme.

Turning Point – Croydon is registered to provide:

Treatment of disease, disorder or injury.

The service was commissioned by the London Borough of Croydon and Croydon Clinical Commissioning Group.

There was a registered manager for the service.

The Care Quality Commission had not previously inspected this service.

Our inspection team

The team that inspected the service comprised of a lead CQC inspector, five other CQC inspectors, a CQC pharmacist inspector, a CQC assistant inspector, a specialist advisor who was a consultant psychiatrist in

addictions 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.

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?

Summary of this inspection

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- visited the service, looked at the quality of the physical environment and observed how staff were caring for clients
- spoke with five clients using the service
- spoke with two peer mentors and one volunteer
- spoke with the registered manager and the provider's senior quality advisor
- spoke with 16 other staff members employed by the service provider, including managers and team leaders, nurses, recovery workers, a doctor, a counselling co-ordinator and a data manager.
- received feedback about the service from commissioners of the service
- attended and observed a clinical team meeting and a care managers meeting
- collected feedback using 19 comment cards from clients
- looked at 23 care and treatment records
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

Clients in the service were very positive regarding staff. Clients reported that they did not feel judged because of their substance misuse. Some clients linked their reduction in substance misuse directly to the support staff had provided. Clients were concerned about other clients congregating outside of the service and drinking alcohol. Three clients had made complaints about the service and had not received a response.

Before the inspection, a comment box had been placed in the service. We received 19 comment cards from clients

using the service. Twelve of the comment cards were positive. These praised the staff as being caring and clients felt listened to. Five comment cards were mixed with positive and negative comments. Comments were about caring staff but also the turnover of staff and other clients using alcohol use outside the service. The two negative comment cards concerned frequent staff changes and the lack of a specific men's group.

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 issues that the service provider needs to improve:

- Client risk assessments were not detailed. Most clients did not have risk management plans.
- The potential risks of abuse to clients, or children they were in contact with, were not appropriately explored. Clients or children were not always referred to safeguarding services when this was appropriate.
- Clients did not have a physical examination before medicines were prescribed. Information was not requested from clients' general practitioners before medicines were prescribed. This was a risk to client's health.
- Not all incidents in the service were reported as an incident by staff. Feedback from incident investigations to staff was inconsistent.
- Medical equipment used in the service had not been calibrated. It may have recorded inaccurate measurements.

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

- Staff absences were covered effectively. The duty worker system was well organised and staff could respond effectively to urgent situations.
- There were good medicines management practices and procedures in the service.

Are services effective?

We do not currently rate standalone substance misuse services.

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

- Clients' assessments were not comprehensive. Clients' medical assessments were inconsistent and dependant on which staff member assessed the client. Assessments did not take account of client's culture or religion. This was a breach of a regulation. You can read more about it at the end of this report.
- Staff in the service did not have a good working knowledge of the Mental Capacity Act.

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

Summary of this inspection

- Medicines were prescribed in accordance with national guidance. All clients were offered testing for blood borne viruses.
- There was an extensive group programme for clients. Clients could also access individual counselling.
- The service worked effectively and productively with a range of other agencies.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Clients in the service were very positive about staff. They said that staff supported them with all of their needs and listened to them. Some clients linked their reduction in substance misuse directly to the support staff provided.
- Clients were involved with planning their care. Clients were given copies of their care plans.
- Clients could provide feedback to the service in a number of ways.

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

- Clients' family members or carers were not consistently offered support by the service. Family members and carers' needs were not regularly assessed.

Are services responsive?

We do not currently rate standalone substance misuse services.

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

- Clients' complaints were not always investigated. Complaints were dealt with informally and clients did not receive a written outcome to their complaint.
- Client information leaflets regarding culture and diversity and in different languages were not available.

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

- Following an increase in people from eastern Europe seeking treatment, the service had employed two Polish speaking staff.
- Clients in the service had diverse ethnic and cultural backgrounds reflecting the local population. Clients attending the service were from all ages groups.

Summary of this inspection

- The service operated two evenings per week and on Saturdays. Emergency assessments appointments were available every weekday.
- The service had a well-developed programme for clients to become volunteers and peer mentors. Clients had to have stopped using drugs and alcohol for these roles.

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 quality of client's assessments, risk assessments and risk management plans was not monitored. Risk assessment forms did not aid staff to identify all potential risks.
- The service did not notify the Care Quality Commission of all notifiable incidents. When incidents were notified there was a delay.
- The management team did not have appropriate oversight of incidents, complaints and safeguarding referrals.
- The medicines policy provided information which explicitly contradicted national guidance. Policies were not reviewed when they should have been.

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

- The service was implementing the provider's enhanced quality improvement programme. The programme was designed to improve the quality of the service provided to clients.
- The management team were aware of most areas requiring development and were committed to improving the service.
- The management were keen to develop a positive working environment.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

MCA training had been undertaken by 75% of staff. Some staff we spoke with had not received MCA training. Other staff did not have a good understanding of the MCA. They

did not know when it may be appropriate to undertake a capacity assessment. We identified one client who had not had a capacity assessment regarding their substance misuse treatment when this was clearly appropriate.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

- The entrance to the service was locked. Reception staff controlled access to the building. Funding had been obtained for renovation work in the reception area.
- Alarms were placed at the reception desk to enable staff to summon assistance. Every interview room, except one, had an alarm for staff to summon assistance. The interview room did not have an alarm and did not have a spyhole at the door. Staff were unable to see into the room. However, this room had a telephone and was monitored by closed circuit television.
- There were three clinical rooms in the service. Two rooms had an examination couch, weighing scales and a sphygmomanometer (blood pressure machine). One room had a height measure.
- The weighing scales, sphygmomanometer and breathalyser used in the service had not been calibrated. The weighing scales had been due to be serviced over a year previously, and had not been. Blood glucose monitoring equipment had not been calibrated. When equipment is uncalibrated, it can produce inaccurate readings about clients' physical health. Medical devices were not maintained in accordance with national guidance (Managing medical devices: guidance for healthcare and social services organisations, Medicines and Healthcare products Regulatory Agency, 2015). Disposable urine dip stick tests had expired the previous year. Urine dip stick tests assist with the identification of people's health problems. The dip sticks may have given inaccurate results. Kits for testing for illicit drugs in a client's urine were within their expiry date.

- All areas of the building were visibly clean and well maintained. A cleaner attended the service every evening.
- Alcohol gel was available to staff. Medical equipment was disinfected regularly. Sharps bins were used to dispose of needles and other sharp objects. However, the date staff started using each sharps bin was not recorded. National guidance states sharps bins should be closed and disposed of after three months (Safe management of healthcare waste, Department of Health, 2013). Handwashing posters were on the wall at each sink in the building. These showed staff how to wash their hands thoroughly. Clinical waste bags were available in all of the clinical rooms. Staff gave clients injections and vaccinations at the service. Blood spillage kits were available. However, there were no red bags for items contaminated with body fluids. This was not in accordance with the provider's policy or with national guidance.

Safe staffing

- Two nurse prescribers were employed by the service. The nurse manager was also undertaking training to become a nurse prescriber. There were three doctors working part time at the service. This meant there were five staff that could assess clients and prescribe medicines. At least two of these staff members were always available when the service operated. The recovery team had 11 staff and no vacancies. The criminal justice team had eight staff and the engagement team five staff. Neither team had vacancies. We were told that the young person's team consisted of two staff with two vacant posts. Following the inspection, the provider stated that there was only one vacancy in the young persons' team. All of the teams had team managers or team leaders in post.

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- The service had one vacant post for a nurse prescriber. A long-term agency nurse prescriber worked in this post. In a three month period before the inspection 160 shifts required agency cover. All of the shifts were filled. The service had a 17% turnover of staff in the previous year. However, this included staff leaving as a result of the reorganisation of the service. Staff sickness in the previous year was 1%.
- When the provider had taken over all of the services from other providers, staffing levels were reviewed. This led to a reduction in the number of staff in the service. It was unclear how staffing levels had been assessed during this time. After several months staffing levels were increased.
- Staff in the recovery and engagement and outreach teams had a caseload of 45 to 50 clients. The recovery worker providing shared care with general practitioners (GPs) had a caseload of approximately 95. Staff in the criminal justice team had caseloads between 24 and 50. In the engagement team staff had a caseload of 30 to 35 clients. Staff in the young peoples' service had a caseload of 10 clients each. Staff caseloads were reviewed on a regular basis.
- Staff leave was managed to ensure that there were sufficient staff in the service at all times. When staff were on leave or sick they informed managers of their planned appointments. Other staff and managers would undertake the appointments. If necessary, one of the duty workers would attend the appointment. When a nurse prescriber was absent the service used a regular locum nurse prescriber.
- During the week, staff were always able to speak with a staff member who could prescribe medicines. This would be the consultant psychiatrist, a general practitioner, or a nurse prescriber.
- Managers and staff were required to undertake 15 types of mandatory training. Almost all of the managers and staff had undertaken all types of mandatory training. However, 75% of staff had undertaken Mental Capacity Act (MCA) training. Safeguarding adults level 2 training had been undertaken by 79% of staff. Almost all of the staff due to undertake these types of training had been booked onto training. This was due to take place shortly after the inspection. Staff and managers were required to undertake mandatory training on first aid awareness.

This was delivered by e-learning and included the use of cardio pulmonary resuscitation (CPR). CPR consists of breathing and chest compressions to a person whose heart has stopped. This training was scheduled to be undertaken every three years. This was not in accordance with Resuscitation Council (UK) guidelines which state training should be undertaken annually.

Assessing and managing risk to clients and staff

- Staff carried out a risk assessment when clients were first assessed by the service. The risk assessment was a checklist of 37 specific areas of potential risk. This included risk areas regarding substance misuse, mental health, housing and neglect. Staff completed the assessment by ticking a box next to each area of risk. This indicated if the risk was a current risk, past risk or had never been a risk. The risk assessment form did not include any risk areas relating to clients driving vehicles. There was a potential risk to the client and others if they were driving and using drugs or alcohol. During clients' initial and medical assessment, there was no record that staff asked clients whether they drove a vehicle. Clients were not advised of their responsibilities to report their circumstances to the Driver and Vehicle Licensing Agency (DVLA). This was not in accordance with the provider's policy or national guidance. The risk assessment form had an area to record details of clients' risks and to document a risk management plan.
- We reviewed eleven risk assessments. Some clients had previous suicide attempts, dangerous injecting practices and accidental overdoses identified. One client had a history of deliberate overdoses immediately before entering treatment. When risks were identified, they were not always explored in further detail. The circumstances regarding risk incidents and when they happened was not recorded. Two clients did not have a risk management plan addressing the identified risks. When there was a risk management plan this did not always provide details of how to manage all of the potential risks. This was not in accordance with the provider's policy. Risk assessments were updated every three months or following risk incidents. However, when risk assessments were updated only the risk checklist was used. There was no explanation of how or why clients' risks had changed. There was no updated risk management plan. Staff discussed an incident which

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had involved two clients. One of the clients had also taken an overdose several days before the inspection. Neither of the clients' risk assessments or risk management plans had been updated.

- When clients first attended the service they had a medical assessment. During the medical assessment clients had their pulse and blood pressure taken. Three clients had not had their weight recorded. Measuring client's weight during assessment is needed to assess the doses of some medicines, and is considered best practice (Drug misuse and dependence: UK guidelines in clinical management [orange book], Department of Health [DH], 2007). Clients were asked if they had any physical health problems. However, clients did not have a physical examination before medicines were prescribed. This was not in accordance with best practice (DH, 2007). This meant that clients may have had physical health problems which could be undetected. A client's physical health could be affected by medicines. A client did not have their injecting sites checked during the medical assessment. Shortly after the assessment the client had a deep vein thrombosis. This is a potentially serious blood clot. Examination of the client's injecting sites may have identified this at an early stage. A further client was assessed as drinking very high amounts of alcohol. The effects on the client's liver were unknown as no physical examination was undertaken. Prescribed medicines could not be adjusted to take account of any potential liver problems. A further client did not have a GP and had multiple and serious physical health problems. They did not have a physical examination.
- Clients undergoing alcohol detoxification attended the service each day to be administered two doses of their detoxification medicine. During this time, staff assessed clients for alcohol withdrawal symptoms. Clients pulse and blood pressure were checked and clients used a breathalyser to detect if they had drunk alcohol.
- The service did not consistently communicate with clients GPs. Clients could have been receiving medicines from their GP, which interacted with the medicines prescribed by the service. We heard that one client had been prescribed the same medicine by the service and a GP. The service became aware of this when the client's chemist informed the service. Communication with clients GPs did not happen frequently when clients were in treatment or their medicines were changed.
- Some clients were aggressive in the reception area of the service. This happened frequently. Staff were able to verbally defuse the situation. Clients waiting long periods for their appointment were identified as one of the causes for these incidents. The service was working towards reducing the amount of time clients waited for their appointments. A small number of clients were repeatedly verbally abusive and aggressive. These clients were restricted to visiting the service only when they had appointments. Clients signed a contract with the service agreeing not to engage in aggressive behaviour. However, the contract was not enforced, and the service had not excluded any clients due to aggressive behaviour.
- The service had a duty worker system. Each day two members of staff would be duty workers. These staff members did not have appointments booked and were available to speak with or see clients urgently. There was always a duty manager in the service to respond to urgent situations.
- All staff had undertaken safeguarding adults and safeguarding children training. Thirty eight staff (79%) had undertaken safeguarding adults level 2 training. The remaining staff were due to attend this training following the inspection. Clients risk assessment forms asked if they were at risk of sexual exploitation or neglect. It also asked if clients were at risk of, or had been, the victim of violence. However, the risk assessment did not include clients being at risk of financial or emotional abuse. There was no record that these potential risks had been explored with clients. The assessment form for clients in the service had recently been changed. The previous assessment form had included specific questions regarding risk to children. The new assessment form and risk assessment forms asked for details of any children clients had contact with. There were no questions or indicators to guide staff to identify potential risks to children. The service had a safeguarding register. This recorded all safeguarding adult and safeguarding children referrals. It also recorded when the service had discussed a particular client with a safeguarding team. At the time of

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the inspection the register recorded 12 adult safeguarding referrals or contacts. There were 20 child safeguarding referrals or contacts. However, we identified in the records of two clients where their children were potentially at risk. None of the children had been discussed with, or referred, to safeguarding children services. We reported our concerns to the manager. In both cases, the client's initial assessment and medical assessment had not explored the potential risks to the children in accordance with national guidance (DH, 2007; Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence, National Institute of Health and Care Excellence [NICE], 2011). During an assessment, one client reported being repeatedly assaulted. There had been no referral to the safeguarding adults team. We informed the manager of our concerns. Two care managers were due to start working in the service shortly. One would be the lead for safeguarding adults and the other the lead for safeguarding children.

- The provider had a lone working policy for staff. When staff undertook home visits or outreach work they always followed the lone working policy. Staff visited clients in pairs or with a staff member from another agency.
- The service prescribed medicines to almost all clients. A system was in place for the storage and processing of prescriptions. A number of checks were made to minimise the risk of handing an incorrect prescription to clients. The service did have a small number of medicines in stock. These were within their expiry dates and appropriately stored. Where medicine was kept in a refrigerator, temperature checks were recorded daily. Staff in the service administered hepatitis vaccines. The medicine adrenaline was available for injection should clients have an extreme reaction to the vaccine. When clients were required to take medicine to their home at weekends, the service provided them with locked boxes. This was so that children, or others, could not access their medicines. The service had guidelines for prescribing each of the medicines used for treating clients. Seven pregnant women were being treated by the service. There were specific prescribing guidelines for pregnant clients.
- All clients with heroin addiction took their medicine at their local chemist for the first three months of

treatment. They were observed taking their medicine by a pharmacist. This is known as supervised consumption and is best practice (DH, 2007). When clients attended the service to pick up their next prescription staff contacted the chemist. This was to establish if the client had been attending and taking their medicine. The client would not receive their prescription if they had not been attending. This process was to prevent clients having an overdose on prescribed medicines if they had a break in their treatment. When clients had a break of three days treatment or more, they were restarted on a lower dose of medicine. Clients who socialised with other heroin users were provided with naloxone. This is a medicine which reverses the effects of an overdose. Clients had information on when and how to use naloxone. This was best practice.

Track record on safety

- The service reported no serious incidents requiring investigation in the previous year.

Reporting incidents and learning from when things go wrong

- Staff described how they had, or would, report a range of incidents. These included medicine or prescription errors, clients making violent threats and clients expressing suicidal thoughts. However, when clients were abusive towards staff this was not always recorded as an incident. Clients reported that staff were often subject to verbal abuse from clients. One prescription error was not reported as an incident, and another was reported one week after the incident. Staff did not report 'near misses'. A 'near miss' is when an incident has been narrowly avoided.
- Staff reported 56 incidents in the service in the six months before the inspection. During that time six clients had collapsed or became unconscious in the service. An ambulance was called on each occasion. Other incidents included clients who expressed suicidal thoughts and clients who were threatening and abusive. Two errors regarding prescriptions were recorded as incidents.
- Staff reported that they received feedback from incidents only when changes were necessary. The management team were aware of the need to improve feedback from incidents.

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- Staff received debriefing following incidents. Incidents were reviewed at the end of each day during a feedback session with all staff.
- The management team identified long waiting times as a contributing factor to incidents of aggression from clients. The service had improved waiting times to reduce the number of aggressive incidents.

Duty of candour

- The management team were aware of their responsibilities to apologise to clients when the service had made a mistake. When the service did so this was reported in the service clinical governance meeting.

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)

- We reviewed 23 care and treatment records. Staff assessed each client when they first attended the service. Each assessment form contained details of the client's GP if they had one. It also recorded if the client was in contact with mental health services. The client's current drug use was assessed. However, the client's history of drug use, and all of the drugs they had previously used, was not recorded for six clients. When clients used drugs and alcohol their alcohol use was not always assessed. For clients with alcohol misuse there was no record that a motivational intervention was undertaken as part of their initial assessment. This was not in accordance with national guidance (NICE, 2011). The assessment form included a 'body map'. This is a picture of a body where scars and injecting sites can be recorded. The initial assessment included other areas such as client's housing and family circumstances. Clients' education and training, physical health, mental health and history of offending were also on the assessment form. However, for five clients these areas were not completed. Clients' assessments did not include details regarding their religion or culture. Clients seeking treatment provided a urine sample. This was tested for the presence of drugs. Clients had an assessment with a doctor or one of the nurse prescribers following their initial assessment. The quality of the client's medical assessment depended on the staff member undertaking it. A detailed history of the client's substance misuse was not always recorded. A client's personal, family and social history was recorded in some medical assessments and not others. The Alcohol Use Disorders Identification Test (AUDIT) was used to assess the degree of a client's alcohol dependency. This is recommended best practice (NICE, 2011). However, the AUDIT was not used to assess eleven clients with suspected alcohol dependency. Client's alcohol dependency was not routinely assessed using the Severity of Addiction Questionnaire (SADQ) in accordance with national guidance (NICE, 2011). During clients' medical assessment they did not have a brief cognitive assessment if they misused alcohol. National guidance recommends the use of a standard tool to assess client's cognition (NICE, 2011). This is important as clients with alcohol dependency are at risk of severe and chronic memory problems. Clients received medicine to minimise memory problems. However, without a brief cognitive assessment it was unclear if the dose or type of medicine was effective. Clients using opiates reported their drug use during the medical assessment. However, a full history of the client's drug use was not always recorded. Staff did not seek confirmation of clients' drug use by physical examination or from friends and carers. This was not in accordance with national guidance (DH, 2007). Clients' initial treatment was based solely on their self-report and urine drug screen results, when clients had screen tests.
- Validated opiate withdrawal scales such as the Clinical Opiate Withdrawal Scale (COWS) or the Short Opiate Withdrawal Scale (SOWS) were not used during assessments. This meant clients withdrawal symptoms could not be consistently assessed and monitored over time. Six clients did not have breath alcohol measurements taken during the assessment. Clients with mental health problems did not have their mental health symptoms assessed in detail. The young person's service had developed a new assessment form specifically for their client group. Young people preferred the new assessment form.
- There were several types of care plans in use. Some care plans were specifically tailored for clients who spent a significant amount of time intoxicated. There were

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symbols for clients to understand the care plan more easily. These care plans were also used for people who had difficulties reading. Two care plans did not have specific timescales.

Best practice in treatment and care

- Clients in the service were prescribed medicines recommended by national guidance (Methadone and buprenorphine for the management of opioid dependence, NICE, 2007; DH, 2007; NICE, 2011). A small number of clients were prescribed high doses of methadone. Staff arranged for these clients to have an electrocardiogram (ECG). The ECG was to monitor potential heart abnormalities due to their dose of medicine. This was in accordance with national guidance (DH, 2007; Guidance for the use of substitute prescribing in the treatment of opioid dependence in primary care, Royal College of General Practitioners, 2011).
- When clients were abstinent from alcohol they were also prescribed medicines to assist with their abstinence. This was in accordance with national guidance (NICE, 2011). Very few clients in the service undertook a community alcohol detoxification. When they did, a client's family or friend would remain with them throughout the detoxification. The client, and their family or friend, were provided with important information concerning detoxification, including safety information. This was best practice. During clients' alcohol detoxification, they attended the service each day. Clients' blood pressure and pulse were recorded. Clients were also asked about any withdrawal symptoms. However, no specific withdrawal tool was used to assess clients' withdrawal symptoms policy. The providers' policy stated that the Clinical Institute Withdrawal Assessment – Alcohol, revised (CIWA-Ar) scale should be used. This is also recommended best practice (NICE, 2011).
- When clients prescribed opiate substitution medicines requested an increase in their medicine this was provided. Clients were not always required to provide a urine drug test and were not assessed using a validated withdrawal tool. This meant increases in doses were based on clients' self-report only. Clients were not consistently asked to provide samples for drug tests. This meant the service could not check if clients were using other non-prescribed drugs.
- None of the clients in the young person's service were prescribed medicines. This was in accordance with national guidance (DH, 2007, NICE, 2011).
- The psychologist in the service co-ordinated a range of groups and psychological interventions for clients. These included mindfulness, recovery skills, drama therapy and SMART recovery. SMART recovery is one of the interventions recommended for treatment of alcohol misuse (NICE, 2011). There was a specific group using relapse prevention principles for clients who had become abstinent from drugs or alcohol. An education, training and employment group supported clients with job applications and interview skills. There was also a specific group for clients who had alcohol misuse. Eleven counsellors undertook voluntary work in the service and offered individual counselling for clients. Smoking cessation treatment was also available in accordance with national guidance (DH, 2007).
- All clients were offered blood borne virus testing for Hepatitis and HIV. This was in accordance with best practice (DH, 2007). The service also offered clients hepatitis vaccinations.
- Clients in the service were supported with employment, housing and benefits advice and assistance. Staff in the service addressed clients social care needs in addition to their treatment needs.
- Client outcomes were recorded using the Treatment Outcome Profile (TOP). Outcomes were measured when clients entered treatment and every three months. A final outcome measurement was undertaken when clients were discharged from the service. The service also provided information to the National Drug and Treatment Monitoring Service (NDTMS).
- The service conducted a prescribing audit every three months. This identified the type and dose of medicine being prescribed for each client. The service could monitor that medicines were prescribed in accordance with the provider's policy and national guidance. A care plan and risk assessment audit was also undertaken. This was used to monitor that care plans and risk assessments were updated at regular intervals. However, the audit did not measure the quality of care

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plans and risk assessments. Infection control audits were undertaken regularly. An audit to measure treatment against NICE guidelines was being planned, but no dates for this had been arranged.

Skilled staff to deliver care

- A consultant psychiatrist in addictions and two general practitioners worked in the service part-time. Two nurse prescribers were also employed at the service. A psychologist worked two days per week in the service. They developed and organised client groups and supervised the counselling co-ordinator.
- The consultant psychiatrist and general practitioners were substance misuse specialists. Nurse prescribers had previously worked in substance misuse services and had undertaken additional education and training. Managers and team leaders in the service had significant experience in substance misuse services. Senior recovery and recovery workers had previously worked in substance misuse services, counselling or probation. Some recovery workers had successfully completed treatment for substance misuse problems.
- Staff had supervision every four to six weeks. In the previous six months the supervision rate was 64%. Of three staff files we reviewed, two contained brief supervision notes from the consultant psychiatrist. There were no records of management supervision in any of the staff files. All staff had received an appraisal. However, there were no appraisal records in staff files. The provider had introduced a staff competency assessment. The process of staff meeting with managers to undertake the competency assessment started shortly after the inspection.
- Risk assessment and risk management training was not scheduled as mandatory training. However, 86% of staff had completed this training. Harm minimisation and needle exchange training had been undertaken by 12 staff. Training in mindfulness had been undertaken by 66% of staff, and 61% of staff had undertaken recovery skills training. Less staff had undertaken training on motivation to change (55%), the community reinforcement approach (33%) and group work skills (34%). Just over a quarter of staff had undertaken recovery interventions training (28%). Four staff (12%) had undertaken suicide and self harm training and one staff member had attended domestic abuse training.

Three staff had received benefits advice training. One member of staff was trained in acupuncture and smoking cessation. No members of staff had undertaken training in motivational interviewing or motivational enhancement therapy. However, a large number of staff had transferred to the service from other organisations. Only the training staff had received with the provider was recorded.

- When staff were not performing to expected standards this was addressed. A range of informal and formal measures were used to ensure staff recognised their responsibilities.

Multidisciplinary and inter-agency team work

- Each week the service had a clinical team meeting which all staff attended. Staff raised the care and treatment of specific clients for the team to discuss. The meeting had a standard agenda and discussed safeguarding, clients' medical reviews and their mental and physical health problems. The team discussed clients' needs, psychosocial interventions and social issues, such as housing difficulties. The staff team offered each other guidance on how best to support clients. However, whilst incidents involving clients were discussed there was little discussion regarding future risk management and incident investigation findings. Every two weeks there was a complex cases meeting. These meetings had started just before the inspection and the service were beginning to identify criteria for clients to be discussed at this meeting.
- Team meetings were held at the beginning and end of each day for staff to handover to each other information regarding clients. In the engagement and outreach team, staff were often working separately from each other. They telephoned each other regularly throughout the day to handover information.
- The service had strong links with a range of organisations. The service was part of 'Croydon safer streets' with the police, housing services, mental health services and the local authority. The services met monthly to discuss concerns and share information. Monthly meetings also took place with the drug and alcohol teams in the two local acute hospitals. The service was represented at the monthly vulnerable adults meeting with the local authority. This local authority was able to share information regarding

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people they were concerned about. The service was also able to discuss clients who required local authority services. The service also worked with the local authority drugs and alcohol team and an organisation providing homeless outreach. Staff in the engagement and outreach team conducted joint visits with them. The service was part of the adult advice network. This was a network of agencies which provided specialist advice. Advice included legal, benefits and housing advice. On one occasion the network was used to obtain advice from a Macmillan nurse for a client with cancer. The service also had links with an organisation, which provided internet equipment and training for clients. This was to encourage clients to communicate with specific people electronically. Staff also worked with the local acute hospital maternity services. They provided a service at the hospital for expectant mothers with substance misuse problems. The service also undertook work with pregnant clients at the family justice centre. The young person's service worked with another organisation which undertook sports activities with young people. Staff in the young person's team used sport as a way to engage with young people about their drug or alcohol use. Staff in the service undertook joint working with the probation and child and adolescent mental health services.

Good practice in applying the MCA

- MCA training had been undertaken by 75% of staff. Some staff we spoke with had not received MCA training. Other staff did not have a good understanding of the MCA. They did not know when it may be appropriate to undertake a capacity assessment. For instance, one client did not believe they were taking drugs anymore. They were not aware of their own drug use. The client had not had a capacity assessment regarding his substance misuse or its treatment.

Equality and human rights

- There were no restrictions on anyone accessing the service. Clients in the service had different ethnic backgrounds and were of different sexual orientation and ages. A specific group was operated for women and there was specific service provision for women who were pregnant. Clients with a disability were able to access treatment at the service or at home. Clients with a learning disability were able to access the service. However, the service did not record clients' religion. It

was not possible for the service to assess that it was accessible to people of all religions. Clients in the service reported that they had not experienced discrimination based on their race or sexual orientation.

Management of transition arrangements, referral and discharge

- A number of clients were referred to the service from other substance misuse services. This happened when clients were moving into the borough. Staff obtained details from the other service, including information regarding the client's prescription and potential risks. The service provided the same information to other services when clients moved out of the borough.
- The service had links with older adults and HIV charities who could advise people of the service. Work was underway to ensure that all local GPs were aware that the service offered community alcohol detoxification.
- Clients in the young person's service had an age range from under 15 years old to 24 years old. Older clients remained with the young person's service if they did not need to be prescribed medicines. The younger person's service was more able to meet the needs of these clients.

Are substance misuse services caring?

Kindness, dignity, respect and support

- Staff were observed to be caring and thoughtful in their approach with clients. Staff listened to clients and displayed warmth and understanding.
- Clients in the service were very positive about staff. Clients reported that they did not feel judged because of their substance misuse. They said that staff supported them with all of their needs and listened to them. Some clients linked their reduction in substance misuse directly to the support staff had provided. They described staff as 'amazing', 'exceptional' and 'excellent'.
- Overall, staff understood client needs. Staff were empathic to clients and supported them with a range of difficulties. However, staff did not always understand the potential risks to or from clients.

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- Clients were asked to provide consent for the service to share information with other agencies. Clients signed a consent form. A recent clinical governance meeting had highlighted that staff should be encouraged not to discuss clients unnecessarily in the staff office.

The involvement of clients in the care they receive

- Clients took an active role in planning their care and had a copy of their care plan.
- Family members or carers were not consistently offered support by the service. Family members and carers' needs were not regularly assessed. This was not in accordance with national guidance (DH, 2007; NICE, 2011). However, the service did offer a carers support group and displayed information for carers in the reception area.
- The service received feedback from clients in a number of ways. The service operated a monthly service user forum. The service also had feedback boxes at reception. Clients could post suggestions on improving the service in the boxes. Clients also provided feedback as part of the service quality audit.

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

Access and discharge

- Clients could refer themselves to the services. Clients were also referred from mental health services, hostels, the courts, social services and acute hospitals. The service accepted referrals from any source as long as the client lived in the borough.
- When clients accessed services, waiting times were monitored. All clients were assessed within three weeks of referral. In the previous year the service had received 1518 referrals including self-referrals. Assessments were undertaken with 1366 (90%) clients following referral. A number of clients who had been referred to the service did not attend their assessment appointments.
- When clients presented themselves to the service an emergency assessment slot was used to assess the

client. Emergency assessment slots were available every day. Some clients who were referred and required urgent treatment were also allocated an emergency assessment slot.

- When clients telephoned the service they received a quick response. However, we observed that clients were often unable to speak with their keyworker immediately.
- The service assessed all people with a drug or alcohol problem. There were no exclusion criteria for the service. When clients requested detoxification from 'novel' drugs, such as gamma-butyrolactone (GBL) they were referred on to a specialist service. A small number of clients were also referred on to residential or in-patient detoxification services.
- When clients were assessed by the service they discussed with staff a re-engagement plan. This identified how the client could be contacted if they did not attend for appointments. However, when some clients did not attend the service, there was no record that staff had used the re-engagement plan. There was no record of attempts to contact the client or of future appointments being arranged.
- The service was able to offer flexible appointment times to clients. Client appointments were not cancelled. When clients missed appointments they were able to see the duty worker in the service. Some client appointments did not run on time and were delayed for long periods. This was due to the level of demand on the service and clients attending outside of their appointment times. Managers considered that this contributed to incidents of aggression. Work had been undertaken to remind clients to attend on time for their appointments and waiting times had reduced. However, some clients continued to miss appointments with their worker and would see the duty worker. Therapeutic boundaries regarding appointments were not consistently enforced.

The facilities promote recovery, comfort, dignity and confidentiality

- The reception area in the service was small for the number of clients attending the service. Some clients said that this affected conversations with staff and confidentiality.

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- The service had a number of individual interview rooms and a large group room. Clinic rooms were used for medical assessments, vaccinations and blood tests. Interview rooms and clinic rooms had sound proofing. Clients could speak with staff in these rooms and would not be overheard.
- A range of information was available for clients. Information leaflets were available regarding opiate treatment, alcohol advice and complaints. Other information leaflets were for domestic violence, recovery qualifications, lesbian, gay, bisexual and transgender services and sexual abuse. However, there were no information leaflets concerning safer injecting or chemsex. Chemsex involves people taking drugs just prior to having sex.
- A number of clients would attend the service and leave cans of alcohol outside whilst they attended their appointment. Staff removed alcohol containers on a daily basis. However, some clients spoke of other clients congregating outside of the service and drinking alcohol. They considered that this was not helpful for their recovery.
- Clients who had stopped using drugs and alcohol could become volunteers or peer mentors in the service. The service had two volunteers and six peer mentors. Volunteers and peer mentors roles were different. Volunteers assisted staff at reception and preparing for groups. They could then progress to become peer mentors, supporting clients. The role of peer mentors was clearly defined. The peer mentor and volunteer co-ordinator provided ongoing support to volunteers and peer mentors. Peer mentors had successfully applied for employment with the service.
- discussed how this may affect clients' treatment. However, there was no information for clients regarding possible changes to their medicine during this period, to accommodate clients' fasting.
- The engagement and outreach team regularly visited five homeless hostels in the borough. They worked to engage homeless people into substance misuse treatment. Following an increase in clients from Poland, two Polish speaking workers were employed in the service. These staff worked with the Polish community to encourage people to enter into treatment. The service also had links with street pastors and faith groups. Some female clients had appointments in separate premises belonging to other agencies. The women's group also operated in another agencies' premises. This was to ensure females felt safe as a number had been abused by other clients in the service.
- Clients with restricted mobility or wheelchairs could access the service. Toilets suitable for disabled clients were available. When clients were unable to attend the service due to their disability, staff conducted home visits.
- Information for clients concerning methadone was available in a number of languages. There were no other leaflets available in different languages for clients. Services for Polish people were advertised on a poster. The poster was written in English. We were informed that a number of leaflets in different languages had been ordered.
- A resource file contained information to support clients with diverse cultural needs. However, this information was not available in the reception area. Access to this information relied on staff members being aware of clients' cultural needs.

Meeting the needs of all clients

- The local population was diverse; 42% were from black, minority and ethnic communities. There was also a large homeless population. The service celebrated cultural events such as black history month. Information was displayed in the service regarding various religious festivals. However, this information was written in English and was not prominently displayed. A religious celebration was taking place during the inspection. Staff
- Staff in the service could speak a number of languages. When required, an interpreter was obtained for client appointments.
- The service had a vehicle to undertake outreach work. Due to the geographical size of the borough, this vehicle was taken to areas which were distant from the service. Staff in the vehicle provided advice and information and attempted to engage people into treatment.
- In the six months prior to the inspection, 1053 clients were treated by the service. Two thirds of clients were

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male, and almost 80% of clients were aged 25 to 54. However, 5% of clients were over 60 years of age, and seven clients were over 70 years of age. Most clients' ethnicity was white British or white Irish. However, 39% of clients were from a range of different ethnic backgrounds.

- The service operated until seven pm two nights per week. The service was also open on Saturdays. One of the Saturday activities was to develop and grow vegetables in the service garden.

Listening to and learning from concerns and complaints

- In the 12 months before the inspection the service had received seven complaints. These complaints were addressed informally with the client. None of the clients received a formal written response to their complaint. Following the inspection, the provider informed us that the service had received two formal complaints. These complaints led to a written response including details of how the client could appeal against the findings.
- Clients knew how to complain about the service. Complaints leaflets were available and clients felt confident to make a complaint. However, three clients reported having made a complaint in the previous year. They were told they would be contacted regarding their complaint, but had not been contacted. The system for managing complaints was not effective.

Are substance misuse services well-led?

Vision and values

- The provider had a clearly defined vision for services. Service objectives reflected this vision.

Good governance

- Governance processes were in place. However, they did not provide robust assurance that all the systems in the service were operating effectively. This affected the services' ability to maintain the safety of patients and to ensure staff had the necessary support to carry out their roles to a consistently high standard. For example the quality of clients' assessments, risk assessments and risk management plans were not monitored effectively.

- The management team attended a clinical governance meeting. However, the clinical governance meeting minutes showed complaints, incidents and safeguarding referrals were briefly reviewed, or not reviewed at all. The management team did not have appropriate oversight of these areas. Themes and trends were not monitored and service-wide lessons and action plans were not developed.
- The service had key performance indicators. These indicators were available on an electronic dashboard. Each staff member also had their own electronic dashboard. This allowed the manager to monitor each staff members' performance and the service performance.
- All services registered with the Care Quality Commission are required to notify the Commission of certain incidents, without delay. In the previous year the Commission received four notifications from the provider. Three notifications were in relation to safeguarding adults and safeguarding children. At least four safeguarding matters had not been referred to the Commission. One incident involving the police was not notified to us. Of the three notifications received, one was five months after the incident and another was four months after the incident. The third notification was received one month after the incident.
- A service risk assessment was carried out the month before the inspection.
- The provider's needle exchange policy was dated 2009. There was no record that this policy had been reviewed and remained up to date. The provider's incident and accident policy had a review date five months before the inspection. There was no record that it had been reviewed. The language used in the policy was not clear that verbal abuse should be recorded as an incident. The provider's medicines policy stated that the content was in accordance with national guidance. However, the policy stated that clients prescribed high doses of methadone did not require routine ECGs. National guidance (DH, 2007) recommends that such clients are closely monitored for heart abnormalities. The service arranged routine ECGs for clients on high doses of methadone. Staff in the service followed national guidance and not the providers' policy. The medicines

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policy did not recommend routine use of validated opiate withdrawal tools to support the assessment of clients. A new draft medicines policy had been circulated for comment just prior to the inspection.

Leadership, morale and staff engagement

- A staff survey had been undertaken for the service but the results were not yet available.
- Sickness and absence rates in the service were low.
- Staff felt able to raise concerns with management. Staff were aware of the provider's whistleblowing procedure.
- Staff morale had been affected by the reorganisation of services and staff changes. Staff morale had been low. Discussions regarding these changes were ongoing at the time of the inspection. However, staff morale was improving. Once a week staff brought in home cooked food to share with colleagues. The service had an area where staff could observe their religion. The management team were keen to develop a positive working environment.
- The reorganisation of different services to one provider had resulted in significant disruption to the staff team

and the service. A significant proportion of management time had been taken up with implementing changes. This had affected service development. At the time of the inspection, there were no longer any vacant management posts. The management team were aware of most areas requiring development and were committed to improving the service. However, growing demand for the service limited the pace at which the service could develop.

- The staff team were supportive of each other. Staff worked together to provide support, care and treatment to clients.
- Staff were able to provide feedback to the management team and to offer ideas for service improvement.

Commitment to quality improvement and innovation

- The service was implementing the provider's enhanced quality improvement programme. This programme involved a range of audits and subsequent action plans. The programme was designed to improve the quality of the service provided to clients.

Outstanding practice and areas for improvement

Outstanding practice

- Following an increase in people from eastern Europe seeking treatment, the service had employed two Polish speaking staff.

Areas for improvement

Action the provider **MUST** take to improve

- The provider must ensure that potential risks to clients and others are appropriately assessed. Clients must have risk management plans addressing identified potential risks.
- The provider must ensure that staff are able to identify all clients at risk of abuse and that appropriate action is taken. The provider must ensure all children at risk of abuse are identified and appropriate action is taken.
- The provider must ensure that a physical examination takes place before commencing clients' treatment.
- The provider must ensure that clients having community alcohol detoxification have their withdrawal symptoms assessed consistently.
- The provider must ensure that all complaints made about the service are investigated. People who complain must receive a written response including how they can appeal against the complaint response.
- The provider must ensure that all clients have a comprehensive, detailed, assessment. Assessments must identify client's religious and cultural needs.

- The provider must ensure that all medical devices are calibrated in accordance with best practice.
- The provider must ensure that all incidents are reported and recorded. The provider must ensure that all incidents which should be notified to the Care Quality Commission are notified, without delay.
- The provider must ensure a system is operated effectively to monitor the quality of assessments, risk assessments and risk management plans.

Action the provider **SHOULD** take to improve

- The provider should ensure that infection control procedures are undertaken in accordance with best practice and national guidance.
- The provider should ensure that all appropriate staff understand when and how to use the Mental Capacity Act.
- The provider should ensure that client's family and carers are consistently identified and offered support.
- The provider should ensure that information for clients is available in a range of languages reflecting the local population. Information leaflets should reflect the diverse cultural needs of the client group.

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
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The care and treatment of service users was not always appropriate and did not meet their needs. Service user assessments were not comprehensive. Service users' medical assessments were inconsistent and dependant on who assessed the person. Assessments did not take account of services users' culture or religion. This is a breach of Regulation 9(a)(b)
Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person did not ensure that equipment used by the service provider was safe to use. The weighing scales, sphygmomanometer, breathalyser and blood glucose monitoring equipment used in the service had not been calibrated. This is a breach of Regulation 9(e)
Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The systems and processes established to prevent abuse and to investigate, immediately upon becoming aware of, any allegation of such abuse, were not effective

This section is primarily information for the provider

Requirement notices

Clients did not have potential risks related to financial or emotional abuse explored during assessment. The circumstances of a service user indicated that they were at risk of physical abuse. The service had not taken appropriate action to safeguard the service user.

This is a breach of Regulation 13(2)(3)

Regulated activity

Regulation

Treatment of disease, disorder or injury

Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

The registered person had established a system for identifying, recording and responding to complaints but this was not fully effective.

Three service users had made a complaint and had not received any response.

This is a breach of Regulation 16(2)

Regulated activity

Regulation

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Systems and processes were not operated effectively to enable the registered person to assess, monitor and improve the quality and safety of the services provided, or to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk.

Children at risk of potential abuse were not always identified as such. Action to safeguard children was not always taken. The assessment and risk assessment forms did not include some important areas of potential risk. The service did not monitor the quality of client assessments, risk assessments and risk management plans. The service risk assessment and some policies had not been reviewed when they should have been.

This section is primarily information for the provider

Requirement notices

Complaints, incidents and safeguarding referrals were not reviewed in sufficient detail by the management team. The medicines policy provided information which contradicted national guidance.

This is a breach of Regulation 17(1)(2)(a)(b)

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 18 CQC (Registration) Regulations 2009
Notification of other incidents

The registered person did not notify the Commission without delay of incidents of abuse or allegations of abuse in relation to a service user, or of incidents reported to, or investigated by, the police.

The service did not notify the Care Quality Commission of all incidents it was required to. When notifications were made these notifications were delayed.

This is a breach of Regulation 18(2)(e)(f)

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
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person did not always assess the risk to the health and safety of service users receiving care or treatment and did not do all that was reasonably practicable to mitigate any such risks. The assessments of potential risks to service users were not detailed enough. All areas of potential risk were not assessed. Risk management plans did not address all potential risks. Service users did not have a physical examination before treatment commenced. Withdrawal tools were not used for clients undergoing alcohol detoxification. There was a lack of correspondence with service users' general practitioners. This is a breach of Regulation 12(1)(2)(a)(b)(i)