Yeldall Manor

Quality Report

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Date of inspection visit: 21 May to 22 May 2018
Date of publication: 30/07/2018

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:

- Since our previous inspection, there had been some improvements to medicine management processes but there were still gaps in process and policy around the prescribing and administration of medicines that did not fully assure us that clients would always be kept safe from harm. There were gaps in medicine charts with no explanation recorded. Since our previous inspection the service stocked take-home naloxone medicine but staff were not trained to advise the client in its safe use.
- Staff training was not always adequate to enable them to carry out their roles safely. Staff competency was not regularly reviewed in respect of medicine administration or in the completion of withdrawal assessment and measuring tools in line with provider policy. We saw evidence of tools used to assess withdrawal symptoms not being used in line with clinical guidelines.
- Since our previous inspection, client care records remained separate and did not cross-reference each other. However, the provider had made progress in addressing this and had a test site in place for a new electronic case management system.
- Since our previous inspection staff now completed risk assessments after admission, however, these did

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not always reflect health or risk information contained in the pre-admission risk assessment. Care plans did not consistently reflect physical health needs.

- Prescribing doctors completed a medical assessment on admission for detoxification clients only, but this was not holistic and did not include questions on safeguarding, mental health, capacity, social care needs or a full injecting history. The service received a lot of key information pre-admission from GPs and other relevant health, probation and social care bodies.
- There was no multi-disciplinary team meeting in which all staff could review and discuss patient care.
- The service had not audited infection control, prescribing, medicine charts or care records. Yeldall Manor commissioned external quality inspections and sought to drive improvement based on these recommendations.

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

- Clients told us the care they received was exceptional and gave them opportunities to rebuild their lives. The programme included a wide range of employment training and volunteering opportunites in the local community and through small business enterprises on the same site. Clients completing the programme also had access to move-on accommodation.
- Peer support was included in the structure of the programme. Clients were assigned another client to help them settle into the programme and there were opportunities to make changes to the service through community meetings.
- The service was part a group of independent rehabilitation centres where clients could be placed as an alternative to Yeldall Manor if the placement broke down.
- Yeldall Manor fundraised and offered a bursary to financially support clients.
- Outcomes for clients were good. In the 12 months prior to our inspection, 16 of 17 clients had successfully completed detox treatment with the 17th client undergoing detoxification treatment at the time of the inspection.
- There was a clear exclusion criteria and the service did not accept clients that would not benefit from the ethos of the service or where staff could not ensure a safe environment.
- Since our previous inspection, Yeldall had instigated quarterly governance meetings and two new posts had been developed to recruit two staff members to focus on governance, policies and audits.
- Staff felt happy working at Yeldall and felt there had been a recent improvement in their feeling able to give feedback and input into service development.
- Storage and disposal of medicines was well-managed and doctors prescribed and managed detoxification medicine safely and followed national guidance. Since our previous inspection the service had processes in place to report, record, act on or monitor significant events, incidents and near misses in relation to medicines.
- The service ensured that all clients accessed physical health care via a local GP practice and a sexual health nurse visited the service regularly to provide blood borne virus testing and treatment.
- Since our previous inspection the service had set up policies and an internal system to record any incidents or safeguarding concerns. Staff understood when and how to report incidents or safeguarding concerns.
- Staff provided a range of care and treatment interventions suitable for the patient group. These included medicines and detox treatment, therapeutic interventions, mutual aid access and opportunities for training and employment. These followed guidance from the National Institute for Health and Care Excellence.
- Staff received regular supervision with 100% of staff having a named supervisor. Staff were able to access

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specialist training courses in addiction. Mandatory training attendance was good overall. All staff were trained in first aid and received Safeguarding and Mental Capacity Act training via a local authority.

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Background to Yeldall Manor

- Yeldall Manor is a 25-bedded male only Christian residential rehabilitation centre, set in 38 acres of Berkshire countryside near Reading. The service is a charity organisation operating under the provider Yeldall Christian Centres, and has operated as a rehabilitation centre for 40 years. It receives referrals from local authorities across the UK and also self-funded clients. The provider also offers a bursary, funded by Yeldall Manor via fundraising, for people unable to secure local authority funding.
- There are two prescribing doctors employed via sessional contracts to provide opiate and alcohol detoxification. The abstinence-based programme consists of four phases. Phase one offers detoxification and stabilisation and is 12 weeks in duration. Phase two includes additional counselling and group work and is 12 weeks in duration. Phase three is 18-24 weeks and offers recovery support with the availability of two self-contained flats. Phase four is for 12 months and community based where clients are supported to explore training and employment. The service also offers five move-on houses for clients who reach phase four, and aftercare for 12 months following completion.
- Yeldall Manor's counselling model is integrative and the service provides one to one therapy and interactive group work with trained or trainee counsellors and teaching groups. In addition to counselling, clients have access to recreation facilities, a work-based programme and additional training opportunities.
- As a Christian centre, Yeldall Manor has a religious focus and clients are encouraged to attend church as part of their recovery. Christian religious beliefs are not part of the entry criteria and church attendance is not mandatory after phase one. The service welcomes clients of different faiths and backgrounds and ensures their cultural needs are met.
- The service has a clear exclusion criteria and does not accept clients who are at particularly high risk or would not find benefit from the structure and ethos of the service.
- Yeldall Manor is registered with the Care Quality Commission to provide the regulated activity 'Accommodation for persons who require treatment for substance misuse' and there is a registered manager in place.
- We last inspected this service in November 2016. The service met most of the essential standards at that inspection. However, there were gaps in process and policy that did not fully assure us that clients would always be kept safe from harm. We issued Requirement Notices under Regulation 12 HSCA (RA) Regulations 2014 Safe Care and Treatment and under Regulation 17 HSCA (RA) Regulations 2014 Good Governance.
- On this inspection we found that the provider had addressed all of the MUST improvement requirements but that client care records remained separately located.

The provider had addressed two SHOULD improvement requirements. There was a system to monitor fridge temperatures where medicines were stored and an external audit was carried out to review policies, protocols and procedures relating to the safe administration of medicines.

However, the following SHOULDs had not been addressed:

- That missed doses on medicine charts were recorded and investigated
- That medicine charts, prescribing and infection control were regularly audited
- That use of naloxone was in line with national guidance
- That all clinical decisions were recorded in the clients' care records.

Summary of this inspection

Our inspection team

The team that inspected the service comprised two CQC inspectors, a specialist advisor nurse and a specialist advisor doctor.

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. We also inspected the service to assess how the provider had taken action to address requirement notices applied following the previous inspection in November 2016.

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 reviewed information that we held about the location and asked other organisations for information.

During the inspection visit, the inspection team:

- looked at the quality of the physical environment, and observed how staff were caring for clients
- spoke with eleven clients in a focus group setting
- spoke with the registered manager and the operational manager
- spoke with three other staff members employed by the service provider, including counsellors and admission staff
- spoke with three staff members who worked in the service but were employed by a different service provider, including doctors and a sexual health nurse
- received feedback about the service from two commissioners
- attended and observed one client morning meeting and a client 'catch up' group
- collected feedback using comment cards from two clients
- looked at seven care and treatment records, including all available medicines records, for clients
- observed medicines administration
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

All clients we spoke with spoke highly about the programme and told us there was very little they would want to change. They liked getting involved in practical pursuits and taking responsibility for chores. They said the service was exceptional and gave them opportunities to rebuild their lives, especially by offering support to find accommodation and work and that recovery had changed their lives. They told us they felt welcomed, accepted and supported by staff and peers in calm and peaceful surroundings. They said they would have liked

Summary of this inspection

the swimming pool to be back to working order. Clients were supported to look after their physical health by visiting the local GP practice and dentist and to maintain relationships with family, children and friends.

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:

- There was no call alarm system at the service. There was no procedure evident that described how clients would contact the duty worker in the event of an emergency, with one member of staff on duty to cover evenings and nights.
- Since our previous inspection staff now completed risk assessments after admission and we saw that these were in place and reviewed monthly. There was a large amount of risk information obtained pre-admission and the service did not accept high risk clients. However, risk assessments did not always reflect information contained in the pre-admission risk assessment, such as physical or mental health needs.
- Since our previous inspection, there had been some improvements to medicine management processes but there were still gaps in process and policy around the prescribing and administration of medicines. The service had not ensured that missed doses on medicine charts were recorded on the chart and an explanation given. Since our previous inspection the service stocked take-home naloxone medicine but staff were not trained to advise the client in its safe use.
- Staff competency was not regularly reviewed in respect of medicine administration or in the completion of withdrawal assessment and measuring tools in line with provider policy. We saw evidence of the tool used by the service to measure withdrawal symptoms being used for a shorter period than that recommended in clinical guidelines.
- There was no documented evidence that risks of detox were explained to clients individually. The service's detoxification policy did not demonstrate how the risk of accidental overdose during detox from opioids was managed.
- Key procedures around risk were clearly displayed for staff in the clinic room. However, these did not always reflect policy or practice. In case of seizures, there was no policy in place and medicine to be used in the case of seizures named on the procedure was not stocked. Equipment for monitoring physical health was either not working or had not been checked or calibrated.
- Since our previous inspection, client care records were accessible to staff but remained separate with little evidence of

cross-referencing. Medical notes were kept in a different room to clients' risk assessments and care plans. There were no progress notes for all staff to input into but separate methods of recording daily medicine concerns and general concerns for handover.

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

- The clinic room was clean and tidy and since our previous inspection had running water. Fridge and room temperatures were monitored and recorded. Staff adhered to infection control principles.
- The service had low incidents of sickness and vacancy rates. Plans were in place to recruit and train additional staff to facilitate external activities and offer support to clients. The service did not use temporary or agency staff.
- There was an appropriate detox reduction regime in place for both alcohol and opiates and doctors followed National Institute for Health and Care Excellence (NICE) and national guidance for best practice. Both prescribing doctors were able to cover each others work in the event of unplanned absence. The prescribing doctor for alcohol detox stayed on site for the first 48 hours of an alcohol detox and the service ensured that blood tests had been completed for clients prior to acceptance for admission for detoxification. The admission team requested GP summaries and key risk information prior to admission, and we found comprehensive medical information for clients in all care records we reviewed.
- All medicines, including emergency medicines were checked and in date and there was an up to date stock list. All medicines were stored securely in locked cabinets and there was a good process in place for controlled drugs.
- Since our previous inspection the service had processes in place to report, record, act on or monitor significant events, incidents and near misses in relation to medicines. The service also had an incident control and reporting policy in place and an electronic system to capture reported incidents.
- Since our previous inspection the provider had introduced a procedure to record and monitor safeguarding incidents. The service had made no safeguarding notifications to the Care Quality Commission.
- The service had a process in place to ensure clients leaving treatment prematurely received harm reduction advice, including information on the risk of overdose. Staff ensured support services or the referring agency in their home location were informed that they had left the programme, and where possible encouraged the client to return.

Summary of this inspection

Are services effective?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- There were good links with the local GP practice and all clients were registered there within 24 hours of admission. A sexual health nurse visited the service regularly to provide blood borne virus testing and treatment for some sexually transmitted diseases.
- Care plans were present, up to date, personalised, holistic and recovery oriented. However, where relevant, these did not always include a plan to manage clients' physical health needs.
- The service promoted mutual aid and hosted groups like Alcoholics Anonymous. All counsellors at the service were registered with the BACP (British Association of Counsellors and Psychotherapists). Counsellors and trainee counsellors offered one to one therapy, group therapy and family interventions.
- Six social enterprise businesses were based in the grounds of the service and offered work experience in areas like guitar making, landscaping and woodwork. Several companies offered Yeldall clients voluntary work. Clients moving through the four phases at the service had opportunities for training, employment and housing.
- Staff received regular supervision with 100% of staff having a named supervisor. Staff were able to access specialist training courses in addiction.

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

- The service did not complete an holistic, comprehensive assessment for clients after admission. Prescribing doctors completed a medically focussed assessment of clients admitted for detoxification with no evidence of questions around safeguarding, mental health, capacity or social care needs or a full injecting history documented.
- There were no regular multi-disciplinary team meetings at the service for all staff to review clients' care or share information.
- Since our previous inspection, the provider had not ensured that staff received regular appraisals, as only 62% of staff had been appraised in the previous 12 months. However, the provider told us that the appraisal rate was low partly due to staff having left the organisation or on long term leave.
- Staff only assessed clients' capacity on admission. Staff told us that clients who lacked capacity would not be admitted to the service. Staff received Mental Capacity Act training but there was no standalone Mental Capacity Act policy in place.

Summary of this inspection

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Clients had opportunities to feedback to staff at the daily morning house meeting and via the weekly client board meeting. Yeldall asked residents to complete feedback questionnaires.
- There was a strong sense of community; staff and residents ate together and went on joint holidays. Clients told us that they were supported by their peers, which we observed during groups during the inspection. The food was of a good quality and portion size.
- On admission clients received a handbook, attended orientation groups and were assigned another client as a "shadow" during the first week to ensure that they settled onto the programme. Clients told us the care they received was exceptional and gave them opportunities to rebuild their lives.

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

- As there was no examination couch in the clinic room, staff asked clients to use the couch in communal areas for these interventions. This might have a potential impact on clients' privacy and dignity.

Are services responsive?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- The service was part of the Choices Loop, a group of independent rehabilitation centres where clients could be placed as an alternative to Yeldall Manor if the placement broke down.
- Yeldall Manor offered a bursary to financially support clients and staff took part in fundraising events for this.
- Of 17 clients who had received a detox in the 12 months prior to our inspection, 16 had successfully completed the treatment with the 17th client undergoing detoxification treatment at the time of the inspection.
- The service had a clear exclusion criteria and would not accept clients that would not benefit from the ethos of the service or where staff could not ensure a safe environment. This was

Summary of this inspection

determined by historical risk information obtained pre-admission and through well documented discussions with the client, referring agencies and sponsors. Exclusions included complex or severe physical or mental health needs.
- Since our previous inspection, two group rooms had been renovated to give the service additional space to operate concurrent larger groups. Clients had access to an onsite gym and bicycles.
- There were a low level of complaints and the service had a system to manage these effectively.

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

- Some clients on phase one of the programme were required to share a bedroom with another client. However, clients were made aware of this prior to starting the programme.

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:

- Policies did not clearly indicate how staff would access occupational therapy themselves to support their own physical and emotional health needs.
- The service had not audited infection control, prescribing, medicine charts or care records. Yeldall Manor commissioned external quality inspections and sought to drive improvement based on these recommendations.
- Medical, counselling and care records were kept separately from each other and were not triangulated. However, the provider had a test site in place for a new electronic system.
- Since our previous inspection, the service had completed an external audit on policies, protocols and procedures relating to the safe administration of medicines. However, policies were not always in place and did not always correspond with written procedures.

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

- The Yeldall Manor board of trustees included people with personal experience of addiction and recovery and the Yeldall Manor programme.
- Since our previous inspection, Yeldall had instigated quarterly governance meetings and two new posts had been developed to recruit two staff members to focus on governance, policies and audits.

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- Staff felt happy working at Yeldall and felt there had been a recent improvement in their feeling able to give feedback and input into service development. Coaching had been made available to some key staff, to help to develop their leadership skills or to assist with identified capability issues.

Detailed findings from this inspection

Mental Health Act responsibilities

The Mental Health Act is not applicable at this location.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff assessed capacity on admission but staff told us that clients who lacked capacity would not be admitted to the service. Staff were confident that they would know what to do should someone's capacity change and had received Mental Capacity Act training, provided by the local authority. There was no Mental Capacity Act policy in place at the service. However, there was a Deprivation of Liberty Safeguards policy that included mention of the act.
- Care records evidenced consent to treatment and sharing of information.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

- Yeldall Manor is a large building dating back to the 1890's set in large, well-maintained grounds. The furnishings appeared to be in good repair and all areas were clean.
- Following our previous inspection, the clinic room had since been connected to running water. The clinic room had 24 hour CCTV installed and was clean, tidy and functional.
- Yeldall staff checked the fire alarms regularly and recorded this. Just prior to our inspection, the service had commissioned fire safety specialist to carry out a fire risk assessment. The assessment identified Yeldall as at a moderate risk level and included recommendations that Yeldall produced a fire safety checklist. The assessment noted that although staff were trained on induction there were no fire wardens identified in the building. Fixed wire testing was three years overdue.
- The provider's most recent ligature risk assessment identified where the potential ligature risks were and what level of risk they presented. The ligature risk assessment also identified what they would do if a client's risk changed and included contacting the local mental health crisis service or moving client to a twin room. Potential risks were also managed in part by the provider's exclusion criteria of not accepting a client with complex mental health needs or who had attempted suicide in the previous six months. Staff told us that a client presenting with very low mood or who was potentially suicidal would be supported intensively by the staff team.
- There was no call alarm system at the service. There was no procedure evident that described how clients would alert staff in the event of an emergency. The gates to the Yeldall estate were locked each night to deter unauthorised access.
- There had been no infection control audits completed since our previous inspection. The service's Infection Control policy included a brief procedure in the event of an injury with a used or contaminated needle that included attendance at A&E. Staff wore gloves to administer medicine as per the service's Medicine Policy and there were hand washing facilities available.
- Since our previous inspection, and in response to a previous incident, the service stocked take-home naloxone medicine. However, staff would give take-home naloxone to clients leaving the programme but were not trained to administer it or advise clients of its use. Naloxone is an emergency medicine used to treat an opioid overdose.

Safe staffing

- In the 12 month period of March 2017 to February 2018 there were 26 members of staff at Yeldall Manor. For the same period, total vacancies were at 3.5% and total permanent staff sickness at 2.0%. Vacancies data related to one intern post and included maternity cover. Sickness calculation included two periods of compassionate leave. Yeldall did not use agency staff but were recruiting additional staff to work alongside core staff in evenings. These additional staff would be trained by Yeldall to facilitate external activities and offer support. Annual leave was planned six weeks in advance.
- Staff were on duty 24 hours a day, seven days a week with one duty staff member who slept on site to cover weekends, evenings and nights. A senior member of

staff was "on call" at all times. There was a lone worker policy in place and a risk assessment with a procedure for staff actions should an incident occur. Sleep over shifts were covered by male staff.

- The prescribing doctor for opiate detox attended Yeldall Manor one morning a week whether or not an opiate detox was taking place. The prescribing doctor for alcohol detox stayed on site for the first 48 hours of an alcohol detox. Detoxes were arranged in advance and prescribing doctors were able to cover each other's work in the event of an unexpected absence. Both prescribing doctors were available by telephone to support staff.
- Staff received mandatory training that included Safeguarding Adults and Children, First Aid, Care of Medicines, Mental Capacity Act, Fire Safety, Infection Prevention and Control, Violence and Aggression, Health and Safety, Conflict Resolution. Equality and Diversity training had been arranged by the service for later in the year.
- All of the staff at Yeldall had Disclosure and Barring Service (DBS) checks or the relevant national criminal records checks appropriate for their country of origin. Staff awaiting DBS clearance did not work with clients unsupervised.

Assessing and managing risk to clients and staff

- Since our last inspection the service had not ensured that missed doses on medicine charts were investigated and recorded where appropriate. We looked at all of the clients' medicine charts, including those on critical medicines, and saw examples of gaps in the charts where medicine should have been given, with no reasons for non-administration recorded.
- 'As and when' medicine was not clearly identified as such on medicine charts and where medicine was identified to be prescribed by local GP practice, there was no copy of the prescription in the medical files. Medicines such as Thiamine, Omeprazole and Vitamin B were prescribed to be taken twice daily but had been given three times a day with no explanation recorded or medicine incident logged.
- Since our previous inspection the provider had commissioned an independent external audit of medicine charts. This led to an improvement in spaces to record comments on the reverse side of the medicine charts. Allergies and adverse reactions were clearly recorded on the front of the medicine charts along with photographs of clients. However, one medicine chart did not indicate an allergy to penicillin despite this being recorded in the medical assessment. As per policy, two staff members checked and countersigned the medicine charts against the medicine packaging on a weekly basis.
- There were good systems in place for the storage and disposal of medicines. Since our previous inspection, there was a system in place to monitor fridge and room temperatures where medicines were stored. Temperatures were checked daily and were within recommended range. All medicines were checked and in date and there was an up to date stock list. Clients' medicines were stored with their names clearly displayed and medicines such as creams and eye drops were labelled with client details. Staff did not log unused medicines before storing them internally in the medicine cupboard, but these were logged when they were returned to pharmacy. There was a system in place to safely dispose of medicines and a sharps bin.
- As part of their risk mitigation, the provider had installed CCTV in the clinic room and the room was kept locked at all times. All medicines were stored securely in locked cabinets and there were two controlled drug cabinets that housed controlled drugs and prescription pads which senior staff had access to only. The service did not have a Controlled Drugs Accountable Office in place as this was not required, however the service did not have a controlled drugs lead in place in case escalation was required. The controlled drugs register was completed appropriately with two signatures when administering these and other critical medicines. Critical medicines included anti-depressants and anti-epileptic medicines for epilepsy and staff were required to record their administration in a critical medicine file that was checked daily.
- There was an electro-cardiograph machine but it was not working and there was no record of it being checked. Blood pressure machines were in place but there was no record of calibration. A defibrillator was also in place but was not in use, the service had contacted St John's Ambulance for advice on staff training.

Substance misuse services

- The service was supplied by two community pharmacists but pharmacists did not visit the service. Pharmacy contact details were displayed in the clinic room. Medicines for on-going physical and mental health conditions unrelated to substance misuse were prescribed by the local GP practice and reviewed.
- Since our previous inspection, the service had ensured that there were processes in place to report, record, act on or monitor significant events, incidents and near misses in relation to medicines. Staff recorded medicine errors in the medicine handover diary, these were reviewed in the team handover morning meeting then a senior manager recorded these on a spreadsheet. During our inspection a medicine error occurred and the service sought medical advice and took appropriate action to ensure the client's safety which was then recorded as a medicine incident on their internal system. Staff competency to administer medicines was not reassessed following incidents and there was no process in place to ensure this took place.
- Staff carried out weekly and monthly medicine audits that cross-checked the number of tablets against the medicine charts and identified any unreported issues, incidents or expired medicines. Any discrepancies were recorded along with a reason and then taken back to the quarterly governance meeting. The Medicines policy explained the process of who to contact if a medicine error occurred.
- Key procedures with staff instructions were clearly displayed on the clinic room wall. These included the management of epilepsy, medical emergencies, alcohol and opiate detox, analgesic and anti-inflammatory medicines, allergies, mental health contact and referral to crisis along with duty staff signatures. However, the epilepsy procedure stated that Midazolam should be used in the event of a seizure but this not was kept in stock. In practice intravenous diazepam was available for use but non-medical staff were not trained to administer this.
- There was an appropriate detox reduction regime in place for both alcohol and opiates. Prescribing doctors followed National Institute for Health and Care Excellence (NICE) and national guidance that described best practice in detoxification or withdrawal. Prescribing doctors were qualified and competent to assess and prescribe for addiction issues. Clients were detoxed on the same medicine they had been maintained on. Prescribing doctors used medicines recommended by NICE as the first line of treatment such as methadone for opiate detox and diazepam for alcohol detox. Prescribing doctors used intravenous diazepam for any emergency complications during alcohol withdrawal and this followed NICE guidelines.
- The service used formal measures of withdrawal symptoms including the Clinical Opiate Withdrawal Scale (COWS), Clinical Institute Withdrawal Assessment Of Alcohol Score (CIWA-Ar) and the Benzodiazepine Withdrawal Scale (CIWA-B). However, staff were not completing the CIWAs consistently. The service's alcohol withdrawal procedure stated that the CIWA should continue for the entire alcohol detox, however care records we viewed showed that CIWA stopped after 72 hours despite the continuation of diazepam and also 'as and when medicine'. However, the use of the CIWA for 72 hours followed national guidance and the service's use of medicine to provide symptomatic relief was appropriate and based on low CIWA readings. There were no reported incidents related to inconsistent CIWA completion.
- Yeldall offered medically monitored detoxifications and since our previous inspection a medical doctor was on site for the first 48 hours of an alcohol detoxification when the risk to the client was highest. Clients were offered a choice of detox medicine with diazepam being the service's preferred choice. There were brief protocols in place for both alcohol and opiate detoxification. Medical entries documented the progress of a client on alcohol detox but only for the first two days when the prescribing doctor was on site, no further entries were made. There was no documented evidence that risks of detox were explained to clients individually, however there was a disclaimer that stated that opiate assessment risks had been discussed. Prescribing doctors were contactable by telephone for advice when not present at the service.
- The service's detoxification policy did not demonstrate how the risk of accidental overdose during detox from opioids was managed and did not cite examples of a detox regimen. There was no benzodiazepine detox

policy despite the service carrying this out, either as a standalone detox or part of an opiate detox. There were no policies on epilepsy, delirium tremors or drug overdoses.

- The service's Medical Emergency policy listed examples of emergencies and what staff were expected to do. There was a qualified first aider on site at Yeldall Manor 24 hours per day as all staff were trained in first aid. Staff would call 999 or 112 in the event of an emergency.
- Since our previous inspection, the service had ensured that clients were not admitted for detoxification without baseline blood tests completed. Clients admitted for detoxification had their health status monitored and recorded regularly. Regular and random drug and alcohol testing took place.
- Since our previous inspection the provider had introduced a procedure to record and monitor safeguarding incidents. In the 12 month period April 2017 to March 2018 the Care Quality Commission received no safeguarding data relating to Yeldall Manor. There was a safeguarding policy in place and staff were aware of what constituted a safeguarding concern, of safeguarding procedures and who to contact at the local authority. Staff were trained to Safeguarding Level One, Managers trained to Level Two and the Registered Manager was trained to Level Three. However, prescribing doctors at the service did not routinely assess clients' safeguarding needs on admission. Children visiting the service were supervised by a responsible adult .
- Since our previous inspection staff now completed risk assessments after admission and we saw that these were in place and reviewed monthly. However, there were gaps in risk assessments that did not include clients' physical health care, such as epilepsy, and there were no management plans for clients with physical health needs. Just under half of the risk assessments we saw did not reflect clients' current or historic mental health issues that had been documented in the pre-admission risk assessment. However all of the information was accessible to staff in the same care record folder. There was no assessment of injecting history but there was assessment of previous drug use. Clients were risk assessed prior to any unsupervised leave.

Track record on safety

- The service reported two serious incidents in the 12 month period April 2017 to March 2018 relating to disruptive, aggressive or violent behaviour and slips, trips or falls.

Reporting incidents and learning from when things go wrong

- Since our previous inspection, the service had an incident control and reporting policy in place and an electronic system to capture reported incidents.
- The service learned that a client fatally overdosed shortly after leaving the service. Since then the service stocked take-home naloxone. However, learning from incidents had not included the need for staff to be trained to advise clients how to administer naloxone safely before they left the service. Yeldall Manor had updated the leavers checklist to be completed by all premature leavers. This was then discussed at a staff meeting to consider whether there was anything more that could have been done to prevent the resident leaving prematurely, or if any changes to work practices are necessary.
- Incidents that occurred in the evening or night were logged into handover book. Learning was fed back during staff meetings and briefings.

Duty of candour

- Duty of candour is a legal requirement that means providers must be open and transparent with clients about their care and treatment. This includes the duty to be honest with clients when something goes wrong. Yeldall Manor had a duty of candour policy that listed the actions staff would be expected to take with an emphasis on the need to remain open and transparent.

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

Assessment of needs and planning of care

- The service did not carry out an holistic, comprehensive assessment for clients following admission. Prescribing doctors completed a medical assessment on admission for clients admitted for detoxification that included urine testing. However, there was no evidence of

questions around safeguarding, mental health or social care needs. The medical assessment did not include a plan to manage any apparent mild to moderate mental health symptoms. Unmanaged mental health symptoms could potentially lead to premature exit from treatment. Mental capacity was considered but not consistently.

- The admission team requested key health and risk history information prior to admission and alerted the prescribing doctors to any information of concern but the conversation was not documented. Nutritional status was assessed and Vitamin B prescribed where necessary. Clients were required to complete a medical questionnaire prior to using the onsite gym.
- Clients who were at Yeldall for rehabilitation and not detox, did not receive a medical examination on admission but were registered at the local GP practice. The GP practice carried out investigations and tests as needed and was accessible throughout the clients' stay at Yeldall.
- The service's procedure for unplanned exit was included in the Discharge of a Service User Policy. Apart from clients referred to Yeldall from prison, there were no individual unexpected exit from treatment plans. However the service had a clear protocol and procedure and was included in the client's handbook.
- Care plans were present, up to date, personalised, holistic and recovery oriented but did not always include a plan for clients' physical health care needs. Care plans included SMART goals and outcomes (Specific, Measurable, Attainable, Realistic, Time bound).
- The rehabilitation programme was structured with firm boundaries, however the staff team considered all requests for variation on a case-by-case basis, taking into consideration a client's personal needs and circumstances.

Best practice in treatment and care

- Six social enterprise businesses were based in the grounds of the service and offered work experience in areas like guitar making, landscaping and woodwork. Several companies offered Yeldall clients voluntary work. Clients moving through the four phases at the service had opportunities for training, employment and housing.
- The staff at Yeldall included British Association for Counselling and Psychotherapy registered counsellors and trainee counsellors. The Counselling Ethical Framework supported care in the therapeutic aspects of the programme. Clients had weekly one to one counselling sessions as well as group work. Some counsellors offered family interventions which could be facilitated remotely.
- The service had an agreement with an NHS in reach nurse to attend Yeldall Manor twice a month to provide blood borne virus testing and sexual health checks for clients. If a client tested positive, the nurse was able to offer treatment for some conditions, otherwise Yeldall would then refer the client to the local GP practice for onward referral.
- Clients were registered with the same local GP practice. Any changes to clients' developing needs was communicated to the GP practice and onward health referrals made via the GP.
- Yeldall promoted mutual aid links and hosted groups that included 12-step fellowships such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Cocaine Anonymous (CA) and Al-Anon. The ethos was to help clients recognise and explore the core reason behind their addiction.

Skilled staff to deliver care

- Staff identified to administer medicines all received 'Care of Medicines' training and received certificates. This was an online course followed by one nurse-led training session. Senior staff had amended shift patterns to ensure that at least one staff member trained in medicines was on duty during the day. However, staff competency to administer medicines was not assessed on an on-going basis or after medicine errors. Staff competency was not reviewed in relation to the completion of withdrawal measuring tools.
- The prescribing doctors engaged with continued professional development. Both had completed Royal College of General Practitioners training certificates for 'alcohol and drug management'. Both doctors were

appropriately registered, revalidated and received annual appraisals. The prescribing doctor for opiates had provided tutorials to staff on using withdrawal symptom assessment tools.

- Since our previous inspection, the provider had not ensured that staff received regular appraisals. In the 12 month period March 2017 to February 2018, 62% of staff had had an appraisal. However the provider told us that the appraisal rate was low partly due to staff having left the organisation or on long term leave.
- In the 12 month period March 2017 to February 2018, 100% of staff had a named person who provided supervision. Staff we spoke to told us they received supervision every 4-6 weeks as per the supervision policy. British Association for Counselling and Psychotherapy Registered counsellors met registration requirements and had supervision with accredited supervisors and weekly group supervision with other counsellors. They also supervised trainee counsellors at the service.
- Staff had opportunities for specialist training at Yeldall, some staff had completed a ten month 'understanding addiction' course.

Multidisciplinary and inter-agency team work

- There were no regular multi-disciplinary team meetings at the service to review and discuss clients' care. When not present at Yeldall Manor, prescribing doctors were accessible by telephone.
- Staff attended a morning handover meeting to plan for the day and weekly briefing meetings. Minutes of these meetings were circulated to staff. The service also held a therapeutic team meeting which served as a forum for programme issues to be discussed and changes proposed.
- Staff knew how to refer clients for mental health input and had accompanied clients to mental health appointments.
- We saw successful examples of staff engagement with local debt agencies to assist clients with debt relief.
- Yeldall admitted clients from across the UK and liaised with respective local authorities and social service departments. The service had developed good working relationships with local probation services when clients were admitted under Drug or Alcohol Rehabilitation requirements.

Adherence to the MHA

- The service was not registered to accept clients detained under the Mental Health Act. If a client's mental health were to deteriorate, staff were aware of who to contact.

Good practice in applying the MCA

- Staff assessed capacity on admission but staff told us that clients who lacked capacity would not be admitted to the service. Staff were confident that they would know what to do should someone's capacity change and had received Mental Capacity Act training, provided by the local authority. There was no Mental Capacity Act policy in place at the service. However, there was a Deprivation of Liberty Safeguards policy that included mention of the act.
- Care records evidenced consent to treatment and sharing of information but there was no documented evidence that capacity was assessed while clients were at the service.

Equality and human rights

- The programme at Yeldall is Christian-based and staff were Christian. However, the service had admitted clients who subscribed to other faiths or had no faith, and they had successfully completed the programme. The staff team and service literature showed a clear commitment to not impose one religious viewpoint on clients and to support freedom of choice in spiritual and religious matters.
- The renovations to one of the groups rooms included sound boards to dampen sounds designed to make it easier for clients with a hearing impairment to participate fully in groups. The service placed walking frames and crutches around the building for use by a client who needed support while walking and adjustments were made to enable him to use the toilet facilities in his room and in the main building.

Substance misuse services

Are substance misuse services caring?

Kindness, dignity, respect and support

- Clients told us the care they received was exceptional and gave them opportunities to rebuild their lives.
- Clients were made aware prior to admission that they would be expected to relinquish their mobile phones and these would be posted to family or friends. If the client left treatment early, they would not have access to a mobile phone.
- When a new client arrived, they were assigned another client as a "shadow" during the first week to ensure that they settled onto the programme, became familiar with the rules and timetable and ask questions.
- The sense of community was evident at Yeldall Manor; staff and clients ate lunch together, with evening duty staff sharing dinner with the clients too. They shared other leisure activities such as days out and holidays.
- As there was no examination couch in the clinic room, staff asked clients to use the couch in communal areas for these interventions. This might have a potential impact on clients' privacy and dignity.

The involvement of clients in the care they receive

- The admissions team liaised with family members of clients pre-admission and assisted them to access support groups such as Al-Anon.
- Clients had opportunities to feedback to staff at the daily morning house meeting. Yeldall asked residents to complete feedback questionnaires by week four and at approximately 16 weeks into the programme. The weekly client board meeting was chaired by clients who then attended the staff meeting weekly to feedback. We observed a client 'check-in' meeting chaired by a client who invited feedback and was facilitated by a counsellor. We observed good mutual support between peers and each client had an opportunity to speak.
- Clients were supported to self-advocate with support from peers and staff. There was also access to a local peer mentoring service, some of Yeldall Manor's ex-clients were engaged with this service. Some ex-clients provided support for current clients and their details were displayed in communal areas.
- Clients were supported to complete an induction checklist on admission and received a handbook that included information on house rules, orientation groups, the buddy system, and how to complain.

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

Access and discharge

- Prior to admission clients were interviewed by the admission co-ordinator who had obtained pre-admission information related to the client's previous physical health, mental health and forensic history, parole board reports, solicitor information, community mental health team involvement. This information included blood test results if for detox and scores for Severity of Alcohol Dependence Questionnaire (SADQ); a short questionnaire to measure severity of dependence on alcohol. The admission information included a critical information sheet with personalised information such as important contact numbers. The admissions team followed the service's exclusion criteria and when admission was agreed, flagged issues of concern for doctors attention, however prescribing doctors did not access the pre-admission pack until after clients were admitted. The service did not hold a multi-disciplinary team meeting to routinely discuss clients care or needs.
- The service was part of the Choices Loop, a group of independent rehabilitation centres where clients could be placed as an alternative to Yeldall Manor if the placement broke down. Yeldall Manor offered a bursary to financially support clients and staff took part in fundraising events for this.
- In the 12-month period March 2017 to February 2018 all 17 clients admitted for detox completed the detox. Over the same period 49 clients were discharged from the service, all of these were still engaged with Yeldall and were followed up within seven days. The service communicated with the community service prior to clients' planned departure. Over the same time period four clients did not attend. All four clients were due to come to the service directly from prison.

- The service had a clear exclusion criteria and all of the clients denied admission to the service over the previous 12 months had severe or complex mental health or behaviour difficulties. Other reasons for exclusion included physical health needs that would make Yeldall Manor an unsuitable environment.
- The building's structure meant that access for clients with physical disabilities was limited. The service did not accept clients whose physical disabilities would prevent them from accessing all parts of the building or engage in work-based activities.

The facilities promote recovery, comfort, dignity and confidentiality

- Some clients on phase one of the programme were required to share a bedroom with another client. However, clients were made aware of this prior to starting the programme. The service had 11 single ensuite rooms, and seven twin rooms, five of which were ensuite and two had their own private bathroom.
- Since our previous inspection, two group rooms had been renovated to give the service additional space to operate concurrent larger groups, these rooms were newly furnished, spacious and bright.
- Among other activities, clients had access to an onsite gym and bicycles. Staff and clients ate together and the food was of a good quality and portion size.
- The content of groups was to be updated by the newly developed 'programme development role' when that person was recruited.

Meeting the needs of all clients

- Clients admitted to Yeldall were aware of the restrictions on outside contact for the initial phase of the programme. Once clients had successfully moved through the first phase, staff supported clients to maintain contact with their family and carers and family support and interventions were available onsite. The service provided bicycles for clients to use to access the nearest town.
- Referrals for people with physical disabilities that would prevent them from accessing the building or the physical elements of the programme were not accepted by the service. The service ensured that everyone referred understood the physical demands of the programme.

Listening to and learning from concerns and complaints

- There were a low level of complaints about the service. In the 12 month period March 2017 to February 2018 there were three complaints from two clients, one of which was upheld. One was subsequently withdrawn, one was settled in a meeting and one was related to an infringement of a rule that was contested by the client and upheld. The service captured informal complaints on a spreadsheet with subsequent actions and whether closed or open. There were 22 compliments received by the service over the same time period.
- Complaints were on the agenda at each governance meeting which included participation by trustees. This meant that any concerns would be raised at the next full board meeting. Any changes as a result of complaints were disseminated to staff through updated policies or procedures with relevant training if required.
- The complaints procedure was contained within the client handbook given to each client on arrival, discussed at the initial orientation groups and copies were sent to families members on request. The service's complaints policy stated that there would be an acknowledgement of all complaints within 24 hours and a response within 14 days.

Are substance misuse services well-led?

Vision and values

- The service had a clear vision, of men finding freedom from addiction to go on to live life to the full. The service stated clearly in its publicity and within the service that all staff and volunteers have a Christian faith and believe that the best means of achieving true freedom is through a relationship with God.
- The Yeldall Manor board of trustees included people with personal experience of addiction and recovery and

the Yeldall Manor programme, a medical doctor, people trained in counselling and substance misuse work, people with business experience, charity leadership experience and a family member of the founders.

- The service's sickness and attendance policy included a section on staff attendance as required to see an occupational health provider appointed by the provider. However, the policy did not make it clear how staff would access occupational therapy themselves to get support for their own physical and emotional health needs

Good governance

- Since our previous inspection, the service undertook a monthly medicine audit that counted and accounted for medicines but there were no regular audits for medicine charts or care records. The service did not audit prescribing to ensure the doctors they contracted with followed established best practice. There was no evidence that an infection control audit had been carried out since our previous inspection. Where audits were completed, outcomes were emailed to staff and the service was recruiting to two new posts to focus on governance, policies and audits. Yeldall Manor commissioned external quality inspections and sought to drive improvement based on these recommendations.
- Since our previous inspection, Yeldall held quarterly governance meetings to review policies, procedures and data governance with a focus on quality, safety and compliance. We saw minutes from these that included actions and named individuals but these did not have a time-frame. Incident reviews and complaints were standing agenda items but safeguarding was not.
- Since our previous inspection, care records remained separate; pre-admission, care plans and risk assessments were kept together while medical notes were kept in a different room. Due to client confidentiality counselling notes were also kept separately. There was evidence of a lack of cohesive working between recovery staff and medical staff and there was no multi-disciplinary team meetings to discuss client care holistically. Medical staff did not attend staff training and were not conversant with Yeldall Manor policies and safeguarding procedures. Patient care and medicine records were not triangulated and did not cross-reference each other. There were separate handover diaries for medicines and generic issues. Client information such as history of mental health issues in pre-admission paperwork was not always transferred to risk assessments and care plans. However, the provider had progressed their plan to integrate all information onto an electronic system and had the test site for this in place.
- Since our previous inspection, the service had completed an external audit of policies, protocols and procedures relating to the safe administration of medicines. During our inspection, we found that policies did not always exist where there was a procedure in place and these did not always correspond with each other. Clients with epilepsy were accepted by the service, however there was no policy on the management of epilepsy. All staff were trained in first aid which included a component on the management of epilepsy. Policies had minimal content and did not include references to national policies or guidance. There was no named author or date when the policy should be reviewed by and no system of ensuring that staff had read them. The service planned to introduce a system to ensure that staff had read and understood policies.
- Senior staff engaged with external stakeholders including commissioners. Commissioners we contacted were very satisfied with the service.
- The service did not have a specific information governance policy but we saw the record keeping and confidentiality policy which contained sections on the data protection act 1998 and a policy on confidentiality. The service was in the process of changing their training provider to offer data protection training for staff and planned to implement new data protection policies.

Leadership, morale and staff engagement

- Staff felt happy working at Yeldall and enjoyed their work. They felt that it was a safe, therapeutic environment with good boundaries. Where staff had concerns they felt able to raise them without fear of victimisation and felt supported by senior management. They felt there had been a recent improvement in their feeling able to give feedback and input into service development.

- Coaching had been made available to some key staff to help to develop their leadership skills or to assist with identified capability issues.

Commitment to quality improvement and innovation

- Where specific skills or experience were not available at board level or within the senior leadership, Yeldall Manor sought outside support where necessary to improve the service. Over the past 12 months they had engaged support related to health & safety, human resources, financial management, pensions, trust fundraising, coaching, tendering, social impact, medication and detoxification and the CQC's key lines of enquiry.
- The results of client feedback questionnaires were collated by the chief executive officer to identify trends. The information was fed back to staff either directly to the individual manager, through the senior leaders' meeting or the governance meeting.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must put in place robust polices, protocols and procedures relating to the safe administration of prescribed medicines. This includes the need to ensure that all missed doses on medicine charts are investigated and recorded, that allergies are recorded on the medicine chart if known and that appropriate medicines must be on site as per policy or procedure.
- The provider must ensure that staff consistently use withdrawal measuring tools in line with clinical guidelines.
- The provider must ensure that risk assessments and care plans reflect key risk and health information acquired pre-admission.
- The provider must ensure staff are trained to advise clients in how to use take home naloxone, and ensure that clients being offered take home naloxone are trained to administer it safely.

Action the provider SHOULD take to improve

- The provider should ensure that the premises used are safe to use for their intended purpose and are used in a safe way. This includes meeting fire safety requirements and ensuring that there is a system in place for clients to alert staff members in the event of an emergency.
- The provider should ensure that clients receive an holistic, comprehensive assessment on admission and that there are regular multi-disciplinary meetings in place for all staff to share information and discuss client care.
- The provider should implement and record audits to enable staff to learn from the results and make improvements to the service.
- The provider should ensure that there is a system in place to ensure equipment used to monitor physical health interventions is regularly calibrated and in working order.
- The provider should ensure that privacy and dignity is maintained for clients undergoing physical observations or examinations.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The provider must ensure that staff consistently use withdrawal measuring tools in line with clinical guidelines. • The provider must put in place robust polices, protocols and procedures relating to the safe administration of prescribed medicines. This includes the need to ensure that all missed doses on medicine charts are investigated and recorded, that allergies are recorded on the medicine chart if known and that appropriate medicines must be on site as per policy or procedure. • The provider must ensure that risk assessments and care plans reflect key risk and health information acquired pre-admission.

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 18 HSCA (RA) Regulations 2014 Staffing • The provider must ensure staff are trained to advise clients how to use take home naloxone, to ensure clients being offered take home naloxone are trained to administer it safely.