ASANA Healthcare Ltd

Asana Lodge

Inspection report

48 Moorend Road
Yardley Gobion
Towcester
NN12 7UF
Tel: 01908543251

Date of inspection visit: 27 May 2021
Date of publication: 09/07/2021

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Summary of findings

Overall summary

This was an unannounced focused inspection, undertaken due concerns about the quality of risk assessments, the safety of clients, the quality and outcome of investigations and the overall management of governance systems.

We did not look at all key lines of enquiry during this inspection. However, the information we gathered provided enough information to make a judgement about the quality of care. We have reported, but not rated on the following domains:

• Safe

• Effective

• Well Led

Asana Lodge was registered by the Care Quality Commission on 20 April 2020. New services are assessed to check they are likely to be safe, effective, caring, responsive and well-led. The Care Quality Commission has not carried out any previous inspections at Asana Lodge.

We did not rate this inspection. However, we found the following areas of concern:

- The provider had not ensured staff were adequately trained to provide safe care and treatment to clients. Staff had not received adequate training, supervision, appraisal or induction. Staff were not trained in Mental Capacity Act and did not discuss or check capacity to consent to treatment with clients on admission.
- Leaders did not have the skills, knowledge or experience to perform their roles, or have a good understanding of the service they managed. The provider did not have systems and processes in place to manage risks to both staff and clients. The provider did not complete regular audits of care provided to clients and had no way to monitor the effectiveness of the service. The provider did not effectively or robustly investigate poor staff performance. The provider had not reported incidents that were notifiable to the Care Quality Commission in a timely manner. Systems and processes for the management of complaints was not effective.
- Ligature risk assessments were not being completed in line with the providers' policy.
- Staff did not adequately assess and manage client risk. Unexpected exit from treatment and crisis plans had not been completed. Staff did not work with clients to develop individual care plans.
- The service did not have systems and processes to safely prescribe, administer, record and store medicines.
- The service did not have processes in place to monitor the security of the information being sent to clients from staff members personal mobile phones.

However;

- All premises where clients received care were clean, well equipped, well-furnished and well maintained.
- Staff completed routine monitoring of clients' physical healthcare and regular observations of clients. Staff had completed a comprehensive pre-admission and post admission assessments with all clients. Staff undertook a range of physical health assessments and completed exit questionnaires on discharge.
- Staff felt respected, supported and valued. Staff felt positive and proud about working for the provider.

This inspection took place on the 27 May 2021. Following our inspection, because of the serious concerns we had about client's safety, we served an urgent Notice of Decision. We told the provider they must not admit any new clients without

Summary of findings

the prior written agreement of the Care Quality Commission. We told the provider they must ensure that all incidents, past and present are reviewed and investigated and all notifications requiring submission to the Care Quality Commission are completed in full. We told the provider they must undertake a review of all clinical records, such as care plans and risk assessments for all clients, they must complete a review of all ligature risk assessments and complete an action plan to mitigate all risks identified. We told the provider they must carry out a review of staff qualifications and they must submit evidence of their application for a Home Office Stock license. We also told the provider they must undertake a review of all governance systems and processes at Asana Lodge and devise appropriate policies.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Residential substance misuse services	Inspected but not rated	We did not rate this inspection. However, we found the following areas of concern: • The provider had not ensured staff were adequately trained to provide safe care and treatment to clients. Staff had not received adequate training, supervision, appraisal or induction. Staff were not trained in Mental Capacity Act and did not discuss or check capacity to consent to treatment with clients on admission. • Leaders did not have the skills, knowledge or experience to perform their roles, or have a good understanding of the service they managed. The provider did not have systems and processes in place to manage risks to both staff and clients. The provider did not complete regular audits of care provided to clients and had no way to monitor the effectiveness of the service. The provider did not effectively or robustly investigate poor staff performance. The provider had not reported incidents that were notifiable to the Care Quality Commission in a timely manner. Systems and processes for the management of complaints was not effective. • Ligature risk assessments were not being completed in line with the providers' policy. • Staff did not adequately assess and manage client risk. Unexpected exit from treatment and crisis plans had not been completed. Staff did not work with clients to develop individual care plans. • The service did not have systems and processes to safely prescribe, administer, record and store medicines. • The service did not have processes in place to monitor the security of the information being sent to clients from staff members personal mobile phones. However;

Summary of findings

- All premises where clients received care were clean, well equipped, well-furnished and well maintained.
- Staff completed routine monitoring of clients' physical healthcare and regular observations of clients. Staff had completed a comprehensive pre-admission and post admission assessments with all clients. Staff undertook a range of physical health assessments and completed exit questionnaires on discharge.
- Staff felt respected, supported and valued. Staff felt positive and proud about working for the provider.

Summary of findings

Contents

Summary of this inspection

Background to Asana Lodge

Asana Lodge opened in June 2020 and is a 22 bedded residential drug and/or alcohol medically monitored, detoxification and rehabilitation facility based in Yardley Gobion, Towcester. The service provides care and treatment for male and female clients. Asana Lodge provides ongoing abstinence-based treatment, which integrates cognitive behavioural therapy and dialectical behaviour therapy alongside 12-step treatment.

Asana Lodge is registered to provide:

- Accommodation for persons who require treatment for substance misuse.
- Treatment for disease, disorder or injury

At the time of inspection there was no registered manager in post. However, a registered managers application had been submitted by the provider.

At the time of inspection 15 people were accessing the service for treatment. Average length of stay for treatment was approximately 28 days. The service provides care and treatment for male and female clients, Asana Lodge takes self-referrals from privately funded individuals.

The Care Quality Commission has not carried out any previous inspections at Asana Lodge.

Prior to our inspection Asana Lodge had been issued an enforcement notice by South Northamptonshire Council as there had been unauthorised change of use of the land from a nursing home to a rehabilitation centre without the benefit of planning permission. This was still ongoing at the time of our inspection.

What people who use the service say

We did not speak with clients during this inspection. This was a focused inspection to review specific concerns.

How we carried out this inspection

Three inspectors conducted this inspection; one of whom had a background in substance

misuse.

During the inspection, our inspection team undertook the following activities:

• spoke with five staff members

• undertook a tour of the ward and the clinic room

• looked at medicine's management

• reviewed staff personnel files

Summary of this inspection

• reviewed six clients care records looking at incidents, risk assessments and risk management plans.

We also reviewed a range of information including:

• policies and procedures

• minutes of meetings

• client documentation including daily clinical notes, risk assessments and risk management plans, and physical healthcare documentation, and

• data held by the management team and the Care Quality Commission.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

We told the service that it must take action to bring services into line with legal requirements.

- The provider MUST ensure care plans are completed with all clients and that care plans meet client's individual needs and preferences. (Regulation 9 (1) (a)).
- The provider MUST ensure ligature risk assessments are updated in line with the provider policy. (Regulation 12 (2) (a)).
- The provider MUST ensure that clients risk assessments, risk management plans and unexpected exit from treatment plans are completed in full, kept up to date to reflect client risks, and that they are personalised to each individual clients (Regulation 9 (1) (a)) and (Regulation 12) (1)(2)(a)(b)).
- The provider MUST ensure that Incidents that affect the health, safety and welfare of clients must be reported internally and to relevant external bodies. They must be reviewed and thoroughly investigated by competent staff and monitored to make sure that action is taken to remedy the situation, prevent further occurrences and make sure that improvements are made as a result. (Regulation 12 (2) (b)).
- The provider MUST ensure the correct licence is in place to hold medication in stock. (Regulation 12 (2) (g)).
- The provider MUST ensure that all staff are up to date with all aspects of their mandatory training. (Regulation 12(1) (2)(a)(b)(c)).
- The provider MUST establish and operate effectively an accessible and robust system for identifying, receiving, recording, handling and responding to complaints by clients and other persons. (Regulation 16 (2)).
- The provider MUST ensure it has adequate systems in place to monitor the security of staff personal mobile phones being used to share client information. (Regulation 17 (2) (d)).
- The provider MUST ensure that the risk register is updated to reflect current concerns relating to client risk. The provider MUST ensure that staff have access to the risk register and is aware of its contents. (Reg 17(1)(2)(a)).

Summary of this inspection

- The provider MUST ensure there is governance and oversight to highlight issues of non-compliance in all aspects of care and treatment. (Regulation 17(1)(a)(b)(c)).
- The provider MUST ensure they have an effective audit and governance system in place. (Regulation (17) (2) (f)).
- The provider MUST ensure that all staff have the necessary skills and competencies to meet the need of clients. (Regulation (18)(1)(2)(a)).
- The provider MUST ensure that all staff receive appropriate ongoing or periodic supervision and appraisal in their role to make sure competence is maintained. (Regulation 18 (2) (a)).
- The provider MUST ensure that they have an induction programme that prepares staff for their role. (Regulation 18 (2) (a)).

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Residential substance misuse services	Inspected but not rated	Inspected but not rated	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated
Overall	Inspected but not rated	Inspected but not rated	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated

Inspected but not rated

Residential substance misuse services

Safe	Inspected but not rated
Effective	Inspected but not rated
Well-led	Inspected but not rated

Are Residential substance misuse services safe?

Inspected but not rated

The provider had not ensured staff were adequately trained. We found gaps in the skills and competencies of staff. The provider told us there were 22 mandatory training modules. Overall compliance was low at 38% completion. This meant staff did not have a full understanding of how to treat clients with complex drug and alcohol needs.

Staff had not completed training that showed they knew how to protect clients from abuse. Overall, safeguarding adults training compliance was low at 40%. The service did not provide safeguarding children training.

The ligature risk assessment was out of date by two months, it was last updated in March 2020. This was not in line with the providers policy which stated to update annually or when risks change.

Staff did not adequately screen clients risk levels prior to admission and some clients were admitted unsafely. Staff did not assess and manage risks to clients and themselves well. client's files did not contain plans for unexpected exit from treatment or crisis plans. Following our inspection, the provider developed crisis plans. However, they were not personalised to each client and contained standard statements.

Staff had not completed risk reviews in two of the six of the client's treatment files reviewed. Following inspection, the provider sent updated copies of twelve out of 15 client's risk assessments. Four clients who had an overall risk score indicating they were medium or high risk had no ongoing risk management plan in place. All other eight clients had an overall risk score of low.

The service was not always sufficiently staffed. We looked at staffing rotas from 01 – 16 May 2021; the provider was short staffed on three occasions. Two of the occasions being overnight when the service only had one staff member supporting clients.

The service did not have systems and processes to safely prescribe, administer, record and store medicines. The service did not have a home office stock licence for holding stock medication at the time of inspection. The Registered Provider had been administering controlled drugs for alcohol detoxification from stock medication since it opened on 22 June 2020. This meant the Registered Provider was not following national guidance for safe administration of medication.

The provider had not reported incidents that were notifiable to the Care Quality Commission in a timely manner. Overall, we reviewed the submission of 12 notifiable incidents between 08 December 2020 and 20 March 2021. Seven out of 12 notifications (58%) had a delay of over eight days. Six of these notifications were only submitted following a request from CQC. The longest delay in submitting a notification was 108 days for a client who required hospital treatment for a fractured arm. Notifications were not completed adequately or thoroughly.

Inspected but not rated

Residential substance misuse services

However;

All premises where clients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose. Staff followed infection control policy and COVID-19 guidance, including hand washing. Staff and visitors had their temperature recorded on entry to the building. The provider had ensured that staff had access to personal protective equipment (PPE).

Staff completed routine monitoring of client's physical healthcare. Staff had completed thorough recordings of enhanced observations which had been put in place to keep clients safe.

Are Residential substance misuse services effective?

Inspected but not rated

Staff did not work with clients to develop individual care plans. Four out of six client treatment files reviewed did not have a care plan in place. However, the two care plans that had been completed were personalised, recovery orientated, holistic and looked at strength areas for each client.

Between 01 January 2021 and 18 March 2021, the Care Quality Commission received four complaints from discharged clients regarding the lack of aftercare support. However, the provider showed us aftercare attendance registers to show that aftercare support was available to clients post treatment and was well attended.

Managers had not ensured that staff had the range of skills needed to provide high quality care. Managers did not support staff with appraisals, supervision and opportunities to update their training and further develop their skills. Managers could not evidence they provided an induction programme for new staff.

The provider had joint working arrangements with mutual aid groups who attended the service. However, there were no other joint working arrangements in place such as safeguarding or sexual health services. The service did not have a programme of audit to review the effectiveness of the service, and so staff could not participate in clinical audit, benchmarking and quality improvement initiatives.

Staff were not trained in Mental Capacity Act. Overall, 33% of staff had received Mental Capacity Act training. Staff told us that all clients had capacity. However, no consideration had been taken into clients' capacity being reduced if they were admitted whilst under the influence of substances. Staff did not discuss or check capacity to consent to treatment with clients on admission. This meant staff did not know what to do if a client's capacity to make decisions about their care might be impaired.

However;

The provider advocated health promotion. Clients were supported to have access to yoga sessions and mutual aid groups. The provider had an on-site gym and supported smoking cessation.

Staff had completed a comprehensive assessment of patients on admission in a timely manner. Pre-admission assessments had been completed thoroughly by the admissions team prior to accepting clients for treatment.

Staff used recognised rating scales to assess and record severity and outcomes.

Inspected but not rated

Residential substance misuse services

Staff completed exit questionnaires with clients on discharge, the majority of which were positive.

Are Residential substance misuse services well-led?

Inspected but not rated

Leaders did not have the skills, knowledge or experience to perform their roles, or have a good understanding of the service they managed. Senior managers were unclear how many clients were in treatment and how many staff were employed by the provider at the time of inspection. Since the service opened in June 2020, there had been a high turnover of managers. As a result, there had been several changes to systems, processes and ways of working within the organisation.

Staff used personal mobile phones to contact clients. The service did not have processes in place to monitor the security of the information being sent to clients or staff safety.

Our findings from the other key questions demonstrated that governance processes were not operated effectively, and that performance and risk were not managed well. The provider did not have systems and processes in place to manage risks to both staff and clients. The service was not holding regular staff team meetings.

Audits were not carried out regularly and were not sufficient enough to provide assurance. The last audit of client care plans and exit plans was completed on 16 January 2021, we received no other records of completed audits.

The provider did not investigate incidents thoroughly or keep full written records of investigations. The provider did not learn from themes of incidents. We reviewed four investigations and were not satisfied the provider had taken appropriate action to safeguard clients or staff.

The provider had not reported incidents that were notifiable to the Care Quality Commission in a timely manner. Following guidance from the Care Quality Commission, notifications were still delayed and not completed adequately.

The provider did not effectively or robustly investigate poor staff performance. We found a misconduct case where staff performance required investigation and required police involvement. However, we found the same staff continued to work in the service with no formal evidence from the investigation recorded in their personnel file.

The Manager maintained the risk register and told us that this was being reviewed regularly. However, we requested a copy of the risk register which we did not receive.

We found the system and process for the management of complaints was not effective. Between October 2020 and March 2021, we received six complaints from discharged clients who were unhappy with the way their complaint had been handled by Asana Lodge. The complaints log did not contain all complaints that had been submitted and were held on file. The complaints file did not contain copies of the complaint, the providers response, or the date the complaint was resolved meaning learning from complaints could not take place to minimise the risk of re-occurrence.

However;

Staff felt respected, supported and valued. They felt able to raise concerns without fear of retribution. Leaders were visible in the service and approachable for clients and staff.

Inspected but not rated

Residential substance misuse services

Staff felt positive and proud about working for the provider, their team and the organisation's future direction.

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

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **The provider did not have an established or effective system for identifying, receiving, recording, handling and responding to complaints by clients or other persons. (Regulation 16 (2)).**

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider did not have adequate systems in place to monitor the security of staff personal mobile phones being used to share client information or to contact clients outside of treatment times. (Regulation 17 (2) (d)).** **The provider did not have an up to date risk register reflecting current concerns relating to client risk. Staff did not have access to the risk register and were not aware of its contents. (Reg 17(1)(2)(a)).** **The provider did not have sufficient oversight of governance to highlight issues of non-compliance in all aspects of care and treatment. (Regulation 17(1)(a)(b)(c)).** **The provider did not have an effective audit and governance system in place. (Regulation (17) (2) (f)).**

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

This section is primarily information for the provider

Enforcement actions

Treatment of disease, disorder or injury	The provider had not ensured that all staff had the necessary skills and competencies to meet the needs of clients. (Regulation (18)(1)(2)(a)). The provider had not ensured that all staff received appropriate ongoing or periodic supervision and appraisal in their role to make sure competence was maintained. (Regulation 18 (2) (a)). The provider did not have an adequate induction programme that prepared staff for their role. (Regulation 18 (2) (a)).

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care • The provider had not ensured care plans were completed with all clients or that care plans met client's individual needs and preferences. (Regulation 9 (1) (a)).

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not updated ligature risk assessments in line with the provider policy. (Regulation 12 (2) (a)). The provider had not ensured that clients risk assessments, risk management plans and unexpected exit from treatment plans were completed in full, kept updated, or were personalised to each individual client (Regulation 9 (1) (a)) and (Regulation 12) (1)(2)(a)(b)). The provider had not reported internally and to relevant external bodies all Incidents that affect the health, safety and welfare of clients. Incidents had not been reviewed and thoroughly investigated by competent staff and

This section is primarily information for the provider

Enforcement actions

monitored to make sure that action was taken to remedy the situation, prevent further occurrences and make sure that improvements were made as a result. (Regulation 12 (2) (b)).

The provider did not have the correct licence in place to hold medication in stock. (Regulation 12 (2) (g)).

Staff were not up to date with all aspects of their mandatory training. (Regulation 12(1) (2)(a)(b)(c)).