

Bosence Farm

Quality Report

Bosence Road
Townshend
Hayle
Cornwall
TR27 6AN
Tel: 01736 850006
Website: www.bosencefarm.com

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location

Are services safe?

Are services effective?

Are services caring?

Are services responsive?

Are services well-led?

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.

Summary of findings

Overall summary

We do not currently rate independent standalone substance misuse services.

We found the following areas of good practice:

- The environment was clean, welcoming and fit for purpose. Clients felt safe and well cared for.
- Medicines were managed safely. At our previous inspection we found not all staff administering medicines had received training. At this inspection we found that all staff involved in medicines administration had received suitable training. Medicines policies and procedures had been reviewed by the clinical lead and updated. Medicines were stored and administered safely.

- All treatment at the service followed National Institute for Health and Care Excellence (NICE) guidelines in both the prescription of medicines and the delivery of psychological therapies.
- Clients risk and treatment needs were assessed prior to admission and care was planned and delivered in line with this assessment.
- The provider recorded incidents and was able to demonstrate learning from these. Staff we spoke with understood safeguarding and we saw that relevant referrals had been made to the safeguarding team.

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

- Staff had not always completed mandatory training.
- The dates of opening of liquid medicines had not been recorded.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Substance misuse services		Inspected but not rated

Summary of findings

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Bosence Farm

Services we looked at

Substance misuse services;

Summary of this inspection

Background to Bosence Farm

Bosence Farm Community Limited is a provider of residential treatment for substance misuse. The service provides a residential detoxification service 'Boswyns' for up to 16 clients and a 'second stage' residential service 'Bosence Farm' for up to 15 clients and the Young People's service. The Bosence Young People's service was opened in April 2017 and provides treatment and support for up to eight young people who are experiencing substance misuse problems but whose complexity requires a more intensive treatment approach that cannot be met in their communities. All three services are located on the same site, a short walk from each other along a private driveway. At the time of inspection, there were 10 clients at Boswyns, two at the young person's service, and 11 at Bosence Farm. Both adult services accept male and female clients. The young person's service accepts either all male or all female groups of

young people. The services are situated in a rural location between the towns of Camborne and Hayle in West Cornwall. This service is registered by the CQC to provide the following services:

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

There was a registered manager.

The provider has been inspected four times previously, in 2011, 2013 and 2014 the service was compliant. At the inspection in 2016 a requirement notice was issued and we told the provider they must ensure that all staff who administer medication or who observe the administration of medications, including controlled drugs, have been trained and assessed as being competent to do so. This requirement notice had been met at our inspection.

Our inspection team

The team that inspected the service comprised CQC inspector Lesley Whittaker (inspection lead), a pharmacist inspector and a non-medical prescriber specialising in substance misuse.

Why we carried out this inspection

We carried out a focussed follow-up inspection and looked at the safe and effective domains.

We inspected this service to check that improvements had been made to medicines management. We also visited the new young person's service.

How we carried out this inspection

This was a focussed follow up inspection to check the service was safe and effective.

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

During the inspection visit, the inspection team:

- visited the detoxification unit and the young person's unit, looked at the quality of the physical environment, and observed how staff were caring for clients
- spoke with four adult clients and two young people
- spoke with the registered manager and the lead nurse
- spoke with five other staff members employed by the service provider, including nurses and support workers

Summary of this inspection

- looked at eight medicines records for clients
- looked at nine client care records
- looked at policies, procedures and other documents relating to the running of the service

What people who use the service say

Clients spoke very positively about the service. They told us they felt safe and well cared for. The clients we spoke with were confident in the abilities of staff and felt that

they worked with clients best interests at heart. Clients in the detoxification unit told us they thought it was very positive that some staff had a history of substance misuse.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- The environment was welcoming, clean and well-maintained.
- All staff involved in medicines processes had the required training.
- Clients could be treated for minor ailments because a list of homely remedies (medicines that people might purchase for treatment of minor ailments) was available and agreed by the doctor on an individual client basis.
- Medicines were ordered, supplied, prescribed, administered and disposed of safely.
- There was evidence of good safeguarding procedures and learning from incidents.
- Clients were positive about their care and treatment and felt safe on both units.

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

- Opening dates of liquid medicines were not recorded.
- Not all staff had completed mandatory training

Are services effective?

We found the following areas of good practice:

- Staff assessed and planned clients' care thoroughly.
- Staff were following National Institute for Clinical Excellence (NICE) guidelines for detoxification and psychological therapies.
- Staff liaised with the relevant external agencies.

Are services caring?

We did not inspect this domain at this inspection.

Are services responsive?

We did not inspect this domain at this inspection.

Are services well-led?

We did not inspect this domain at this inspection.

Substance misuse services

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

Are substance misuse services safe?

Safe and clean environment

- The clinic room at Boswyns was visibly clean and suitably equipped. There was equipment available to carry out general medical observations. Staff checked medical equipment weekly and kept a record of checks.
- We observed staff adhering to infection control principles whilst administering medicines. Bathrooms throughout the unit had suitable handwashing facilities.
- The young people's unit was clean and in good condition. The unit was self-contained with separate entrances and a locked door between the adult detoxification unit and the young person's unit. Young people had access to a shared kitchen, bathrooms with disabled access. Young people had their own bedrooms which opened onto the communal lounge. The lounge was decorated in a homely and welcoming manner.

Safe staffing

- Boswyns detoxification unit had 15 whole time equivalent staff and a sickness rate of 4%.
- The detoxification unit had a mixture of registered nurses and support workers. There were at least two registered nurses on each day shift in the detoxification unit. The board had recently agreed to increase the number of registered nurses on night shifts to two per shift from January 2018. This was to reduce reliance on agency staff.
- There was use of regular bank nursing staff and we were told they were valuable members of the team. The service did not use agency support staff.
- The registered manager told us there had been high use of agency nursing staff in the past and that this had an impact on staff morale as the quality of agency nurses was variable. This had been taken to the board and the service was currently recruiting additional nursing staff.

- The service had recently recruited a new clinical lead.
- Medical Cover was provided four half days per week by a combination of a consultant psychiatrist, a psychiatrist (both of whom specialised in substance misuse prescribing), a local GP and a GP with a special interest in substance misuse. There was no prescriber cover on Fridays or weekends. Staff would call an ambulance for a medical emergency. As there was up to an hour response time the service was cautious in admitting clients with high physical risks.
- The service provided figures for staff training which covered staff at all services. Staff compliance with mandatory training was variable but in the majority of the training fell below 80% completion. Only three out of 15 courses had attained 100% completion. Only 50% of staff required to complete a level three multi-agency child protection had done so. Other training with low completion rates included first aid at 47% and Mental Capacity Act training which had only been completed by 39% of staff.
- The young person's unit employed seven whole time equivalent (WTE) staff and had a one percent sickness rate.
- The young person's unit did not yet offer detoxification to young people so did not employ nurses.
- We spoke with the unit team leader who told us the service had recruited staff with experience of working with young people. They had recruited staff with backgrounds in youth work and teaching as they wanted to employ staff who were interested in young people. They explained staff could learn about substance misuse but it was skills in working with young people that were more important.
- All staff on the unit had received up to level two safeguarding children. Three staff had completed level

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three safeguarding and a further three staff were booked to do the course. The service policy was for all staff to be trained to level three. All staff had undergone enhanced checks with the disclosure and barring service.

- We spoke with two staff on the unit and they described their experience of working with young people and told us they enjoyed working on the unit. We spoke with both young people on the unit and they were very positive about staff, describing them as helpful and caring. Young people told us they felt safe on the unit.

Assessing and managing risk to clients and staff

- We looked at seven electronic client records on the detoxification unit and found they contained clear information to guide staff on the care to be delivered to individuals.
- Staff undertook a risk assessment of all clients prior to admission. The assessment included physical and mental health risks. If staff decided they were unable to safely detoxify a client they arranged admission following hospital treatment. On occasion a client would arrive for admission and staff would assess their physical health as too high risk for the service to treat safely. The client would be transferred to hospital and admitted to the service once they were physically well enough.
- Nursing staff were able to give a comprehensive description of potential risks for individual clients and records we looked at confirmed this.
- Nursing staff monitored clients' physical health when they attended the clinic for medicines and also at other times of the day and night if they were concerned. During the early phase of alcohol detoxification staff assessed clients every two hours. This ensured they were able to provide medication for any emerging withdrawal symptoms and reduce the risk of seizures. Nursing staff told us that it was rare for anybody to experience a withdrawal seizure.
- Each client had a contingency plan should they leave early which included community service contact details. If clients left the service before completing treatment they would be offered naloxone (a medicine to reverse the effects of an opioid overdose). Clients were never given any controlled drugs to take away. Clients assessed as at risk of self harm would only be given 48

hours' worth of non-controlled medication. Staff would contact the client's care coordinator in the community and their GP who would be able to arrange for any ongoing medication.

- Staff we spoke with demonstrated a clear understanding of safeguarding processes and procedures. Records held by CQC demonstrated that where appropriate staff had notified both the relevant local authority safeguarding team and CQC. Client records at the service demonstrated appropriate safeguarding referrals.
- The young person's service worked with the relevant young peoples' community services prior to admission to ensure there was a comprehensive assessment of risk and clear management plans. We looked at the records of both young people currently at the unit and saw all the relevant assessments from involved professionals were in place and accessible to staff.
- There was clear documentation of all risks, and evidence of liaison with children's services.
- The service had clear plans in place should a young person leave the unit or decide to leave treatment early which included a risk assessment in the event of early discharge. This included information about who to contact, how the young person should be helped to travel and the address they would be travelling to.

Medicines management

- All medicines were stored in locked cupboards in the clinic room, which was locked when not in use. All medicines were administered here. All supplies were kept at this location.
- Oxygen, defibrillator, naloxone, adrenaline and diazepam for rectal use were available. Medicines and emergency equipment were checked once a week.
- There was a locked medicines refrigerator whose temperature was monitored on a daily basis. All recorded temperatures were within the required range of between two to eight degrees centigrade. The temperature of the room where medicines were stored was recorded on a daily basis. There was an air conditioning unit in use.
- Controlled drugs were stored safely and the balances were checked daily with appropriate records in place. When new bottles of liquid medicines are opened the volume was checked and recorded in the controlled drug register. Controlled drugs were destroyed on site by the clinical manager and a visiting pharmacist.

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- All medicines were prescribed by a doctor and supplied as either stock or on a named client basis from a local community pharmacy.
- Medicines for disposal were recorded on duplicate stationary and taken to a community pharmacy for disposal.
- All medicines were administered by nurses. When controlled drugs were administered this was checked by a second member of staff who had received training and been assessed as competent.
- All medicines were administered to clients. Inhalers were self-administered under supervision. Clients could self-administer creams and other external preparations.
- The homely remedies list was agreed with doctors for each individual client, these medicines were available and their use recorded on the medicines administration record.
- As much information as possible about medicines use and illicit drug use was gathered before admission. The client's GP was contacted to confirm regular prescribed medicine use and the clients were asked to bring at least a two week's supply of prescribed medicines with them.
- Client identification photos were on prescription/ medicine administration records.
- Appropriate monitoring such as regular physical observations was in place during detoxification.
- Clients told us that they felt safe during their treatment, that they felt their physical health was monitored and staff explained their medication to them.
- Staff told us there was a 'no blame' culture, they felt confident to report incidents and errors. Staff were able to debrief and get support following incidents.
- A new clinical lead had been employed who overhauled all medicines procedures at the service. They identified where errors were occurring and their causes. In respect of the inconsistent amounts of methadone they realised staff were not measuring the amount in a new bottle when it was opened which led to later discrepancies. The procedure was changed to ensure nursing staff now measured all newly opened bottles of methadone.
- In the young person's unit the majority of incidents on the unit concerned young people testing the rules within the unit. Staff explained that this was an expected part of treatment and that it was how young people started to learn more positive ways of relating to both their peers and the staff team. Records showed this was recorded in a running log and discussed at handover. Young people were encouraged to identify when things were getting difficult and to engage in activities designed to manage their difficulties in a more positive way. We saw an example of this in records.

Duty of candour

- The service was able to demonstrate duty of candour. A mistake was made which resulted in a client leaving early. The service identified the cause as a lack of communication and admitted this and apologised to the client. A new procedure was put in place to improve recording at assessment.

Track record on safety

- There had been a series of incidents regarding controlled drugs errors within the last year. The service had reported these incidents to the local controlled drug oversight board as required by legislation.

Reporting incidents and learning from when things go wrong

- Staff knew what to report and how to report it. Medicine incidents were reported to the registered manager and recorded on the computerised central document store. They were reported via the governance system to commissioners and CQC. Trends were analysed and action taken, for example changes to staffing structures to reduce the use of agency staff. Incidents were discussed at staff meetings and on an individual basis during supervision.

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

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

- We looked at seven care records and observed a telephone assessment.
- Prior to admission the service obtained as much information as possible. Staff contacted the client's GP to request liver function tests (essential in alcohol detoxification) and any other relevant health information. This included all current prescribed medication. Clients were asked to bring all their medicines with them.

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- Staff liaised with the client's community drug and alcohol treatment team and with the community mental health team if appropriate.
- The service was able to arrange for the local district nursing team to come in to deliver any wound care. For example, the team were needed regularly to dress leg ulcers and open wounds caused by injecting drug use.
- Staff told us it was rare that someone was too complex to be cared for. The whole team was as accommodating as possible. In terms of severe and enduring mental health problems, they service would admit people who were stable. There was a psychiatrist available three days a week and the majority of the nurses were mental health trained so were able to assess this on an ongoing basis. Staff told us they would be checking for risks of self-harm, suicidal ideation, delusions and aggression towards others.
- The assessment included capacity to consent to treatment as the service was only able to admit clients who had capacity. Confidentiality was explained to clients during the assessment process.
- One member of the nursing team had recently completed a study of the admission process for their master's degree in clinical effectiveness and risk management. They had identified how long the admission should take and what should be part of the assessment and the procedure had been updated.
- Care records in the detoxification unit contained up to date, personalised, holistic care plans. We saw that care and treatment plans had been devised with the client to meet their assessed needs. Physical health needs were included along with a plan for detoxification. Clients told us they were fully consulted about the plans and that advice received from staff about treatment was effective.
- Clients received a copy of their plan within the first week and sign it once staff had ensured they understood it. Care and treatment plans were updated following any significant changes.
- Paper records were stored in a locked clinic room or locked office. Electronic records were accessible by all staff who had password access to the system.
- In the young person's unit the young people told us they had been informed about the service prior to admission. Young people were able to visit the service before admission. One young person told us they had been offered an admission to the service on a number of occasions over a three month period but initially had refused. However, the service had kept the option of a place open and continued to work with them.
- Records showed there had been an assessment carried out with the involvement of the young person and services who supported them. Records held on the unit contained appropriate details about the young person's assessed physical, psychological and emotional needs. The assessment included their wider family and social context and the young person's views.
- The care and treatment plans were holistic and centred on each young person's needs. They included interests and activities, educational and psychological needs.
- Plans were updated regularly and the service carried out regular audits with each young person to determine the effectiveness of the program. Following each face to face meeting young people scored the session to determine if it had been helpful. Young people also filled out a strengths and difficulties questionnaire on admission and four weeks into the program. This was used to determine if the young person had made progress in reducing their difficulties.
- Paper records were stored in a locked clinic room or locked office. Electronic records were accessible by all staff who had password access to the system.

Best practice in treatment and care

- We looked at eight medicines records.
- Prescribing and treatment at the detoxification unit adhered to the latest Department of Health (DoH) guidelines (known as the 'Orange Book'). The clinical lead had updated the unit's policies to reference National Institute for Clinical effectiveness (NICE) guidelines CG115, CG 100 and NICE clinical knowledge summary of opioid dependence, revised 2015.
- Methadone liquid and buprenorphine tablets were used for opiate stabilization and detoxification.
- Chlordiazepoxide was used for alcohol detoxification or oxazepam for clients with compromised liver function.
- When the clients left the service following opiate detoxification they were given overdose advice and, if appropriate, supplied with naloxone if they had completed a training course. Naloxone is a medicine which reverses the effects of opioid overdose.
- The detoxification unit offered psychological therapies recommended by the DoH in the Orange Book. There

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was a group work programme run by keyworkers that included a morning check in. There was a daily structured programme with time allocated to provide one to one sessions.

- Staff worked with clients and funding agencies to organise aftercare where none had been arranged. One client told us staff had facilitated aftercare for them as they had been unable to do it on their own. They said they were worried they would have had to leave without going to anything but now felt really optimistic as a plan was in place.
- Another client, who was homeless, said staff were trying to get funding for an aftercare placement. They told us the service had some beds in their rehabilitation unit for homeless people and they hoped to go into one of these.
- Clients in the detoxification unit completed an outcome rating scale after each keyworker one to one session to rate the effectiveness of the session and we saw examples of these. Clients were asked to complete a survey of their treatment on the day of discharge and this was sent to the registered manager. Surveys were available to read. However, there was no process in place to collate the results.
- The clinical manager carried out regular audits and issues identified in the audits had been acted on. For example, following issues with the controlled drug records new procedures had been implemented and these were monitored.

In the young person's unit

- Staff delivered psychological therapies. They used a model developed by a consultant in substance misuse and young people based on brain development. Young people were taught this model to help them identify behaviours linked to different parts of their brain, which helped them begin to understand their behaviour and how to make changes. The two young people on the unit told us this had helped them understand what was going on for them.
- The young person's unit offered a rolling program so that new admissions could join at any point. However, the service had a cut-off point where the program would be too short so new young people would have to wait until the beginning of the next program. The unit only worked with single gender so would have either all females or all males attending.

- Staff were also able to do family therapy work to help young people improve their relationships with families and carers. Work was also focussed on what was to happen on discharge.
- In addition to therapy and psychological work young people were encouraged to help prepare meals on the unit. One of the young people told us they enjoyed cooking.
- Staff supported young people to continue interests they had before coming to the unit and try new things. There were frequent trips out of the unit which included trips to the beach and gym.
- The staff used the strength and difficulties questionnaire (SDQ) developed by child and adolescent mental health services to assess emotional difficulties, conduct, hyperactivity, peer problems and prosocial behaviour. Young people self scored on admission and after four weeks. Staff were able to use this to assess any changes in these areas.

Skilled staff to deliver care

- The detoxification service had a suitable mix of staff. Medical Cover was provided by a combination of a consultant psychiatrist, a psychiatrist (both of whom specialised in substance misuse prescribing), a local GP and a GP with a special interest in substance misuse. Support was available from an on-call psychiatrist. The detoxification service employed registered nurses and keyworkers. A number of the keyworkers had lived experience of, and were in recovery from, substance misuse.
- Staff received induction on joining the service and there was a short induction available for agency staff.
- Staff received both line management and clinical supervision and records were kept of the frequency. Staff told us about the appraisal process and they could set development goals.
- There was training available for staff, with in house training being delivered. In addition to this members of staff had undertaken external training such as counselling and motivational interviewing. All staff involved in administering medication had received suitable training.
- The registered manager addressed poor staff performance. We discussed an example of this, the action taken and expected outcomes.

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- The young person's service had recruited staff who had experience in, and enthusiasm for, working with young people. The team leader told us this was the most important quality for the staff team. They had recruited staff with a youth work or teaching background.
- Staff we spoke with told us they loved their job, and had received training in basic drug awareness, safeguarding, child protection and food hygiene. They were due to undertake motivational interviewing in the new year. One member of staff had started a degree in child and adolescent mental health.

Multidisciplinary and inter-agency team work

- The service held multidisciplinary meetings but the staff survey indicated staff would like to meet more often. The nursing team now met on a regular basis. Handovers between shifts were effective and the handover to support workers had been improved. There was a communication book which was used effectively.
- Staff at the detoxification unit liaised effectively with both local community services and service further away who had clients at the unit. Additionally they worked with Royal Cornwall Hospital to admit clients directly from the hospital or to follow up clients they had sent to hospital.
- On the young person's unit staff coming onto the shift received a handover and could also access the handover online on the electronic records system. Staff said they were always updated about any issues or any incidents they needed to be aware of.
- The service liaised regularly with children's services, families and any other professionals involved in a young person's care.

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

- Only 39% of staff across all services had undertaken training in the mental Capacity Act. However, capacity was always assumed and clients were only admitted if they had capacity to consent to treatment. The assessment was carried out by a registered nurse who checked capacity and on admission the client was seen by a doctor.

- Staff were able to contact the on-call psychiatrist if they had any concerns about capacity.

Equality and human rights

- The service had some blanket restrictions in place which were intended to protect clients from harming themselves or others. For example clients could not have visitors who were assessed as at risk of attending intoxicated. Staff explained this to clients before admission and also following admission.
- Both the detoxification unit and the young person's unit were accessible for clients with disabilities and had suitably adapted bathrooms available.

Management of transition arrangements, referral and discharge

- Clients were assessed before admission. The service was able to fast track referrals from Royal Cornwall Hospital.
- All clients had discharge plans in place should they leave before treatment was completed. Staff gave overdose advice and naloxone if necessary. Staff also contacted the client's referrer and GP.
- Some clients were admitted to the detoxification unit without any planned aftercare. Clients told us that staff worked hard to access funding for rehabilitation or to arrange community support for them on discharge.

Are substance misuse services caring?

We did not inspect this domain

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

We did not inspect this domain

Are substance misuse services well-led?

We did not inspect this domain

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

The provider should ensure that the dates when liquid medicines are opened are recorded.

The provider should ensure all staff complete mandatory training.