# Tower Hamlets Community Alcohol Team

## Quality Report

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

## Overall summary

We do not currently rate independent standalone substance misuse services.

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

- The home detoxification programme was unsafe. Clients detox for alcohol at home and come to the community base for therapy and activity. We subsequently asked the provider to cease admitting clients to the home detoxification programme due to the concerns we had which included, little clinical oversight of the home detoxification programme, the service did not have effective arrangements in place to assess, monitor and improve the quality of the community alcohol detoxification programme and ensure that this was carried out safely and in line with national guidance.
- The provider has provided CQC with an action plan to improve the safety and quality of the home alcohol detoxification programme in the future.
- The service had not completed an infection control risk assessment of the service or conducted an audit of infection control arrangements.
- The premises were not secure to keep clients and staff safe. Once a client or visitor was buzzed into the building, clients and visitors were able to roam free. Therefore, if someone was intoxicated then it was difficult to manage them and escort them off the premises.
- Letters to the client's general practitioner were not sent out after a home detoxification was completed.
- Care records of clients who had undergone home detoxification were stored on paper and in two different electronic records systems. Some staff did not have access to all the available information to be able to carry out detoxification safely. Alcohol detoxification regimes were left blank in client's care records.
- There was little management or clinical oversight of the way the detoxification was carried out to make sure it was safe. The nurse in the service had only received clinical supervision twice and no management supervision since April 2015.
- The provider had not carried out checks with the disclosure and barring service in relation to the manager at the service before they started work in the service.

# Summary of findings

- Staff had not received training in the duty of candour and the service did not provide a policy or guidance for staff on what the duty meant.
- The service did not risk assess their rationale for not keeping emergency equipment on site.

Please see end of this report for requirement notices that have been issued to the provider.

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

- Staff had a good understanding and knowledge of safeguarding adults and children. Staff were able to identify the risks that the clients faced and the people in their networks.
- Staff were very passionate about the work they did and this was reflected in client feedback about the service.
- Staff were happy working at the service and felt supported by their manager.

# Summary of findings

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# Tower Hamlets Community Alcohol Team

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Substance misuse/detoxification

# Summary of this inspection

## Background to Tower Hamlets Community Alcohol Team

Tower Hamlets Community Alcohol Team (THCAT) provides services ranging from education and brief intervention for non-problematic drinkers, to community detoxification and pathways into residential rehabilitation for dependent drinkers. This service is provided by Rehabilitation for Addicted Prisoners Trust (RAPt)

This service is registered with the CQC to provide the following regulated activities:

- Treatment of disease, disorder or injury.

At the time of the inspection the service was commissioned by the London Borough of Tower Hamlets. However, the service is to be decommissioned and the provider reported that the contract was due to end on 30 September 2016. On the same day the lease expires for the premises. The London Borough of Tower Hamlets have since extended the contract until 31 October 2016 so the provider will be providing regulated activity from another premises during this time. The new location will be in the same borough but using a local NHS trust's premises whilst the provider carries out their regulated activity.

There was a registered manager for this service but the provider informed us that they had left the service in 2014. However, there was a service manager in post who had day to day oversight of the service and had applied to become the registered manager.

We last inspected this service in 2013. At that time the service was meeting essential standards, now known as fundamental standards.

## Our inspection team

The team that inspected the service comprised two inspectors, an inspection manager, and a psychiatrist specialising in substance misuse.

## Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme to make sure health and care services in England meet the Health and Social Care Act 2008 (regulated activities) regulations 2014.

## How we carried out this inspection

To understand the experience of people who use services, we ask the following five questions about every service:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well led?

Before the inspection visit, we reviewed information that we held about the location and asked other organisations for information:

During the inspection visit, the inspection team:

- visited the service, looked at the quality of the physical environment, and observed how staff were caring for clients
- spoke with three clients.

# Summary of this inspection

- looked at six client care records.
- spoke to the manager of the service, the head of governance and quality and the service manager.
- attended and observed a group therapy session.
- spoke with five other staff members who were community alcohol workers and a nurse.
- looked at policies, procedures and other documents relating to the running of the service.

## What people who use the service say

We spoke with three clients. They spoke positively about the staff at the service and the treatment they were receiving. Clients felt able to voice their feelings with the staff.

We also looked at two feedback forms completed by clients using the service. They were both positive, with the clients feeling generally happy and enjoying the programme.

# 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:

- The home detoxification programme was unsafe. Staff did not consistently record physical health checks on clients during alcohol detoxification.
- Not all equipment on the premises was serviced or calibrated.
- Risk assessments were not carried out in relation to the decision to keep no emergency equipment on site.
- The provider did not provide any mandatory training for the nurse who had worked at the service since April 2015
- The building security was inadequate. Most internal offices and rooms could not be locked There was no way of physically restricting people's access to other parts of the premises, staff offices and counselling rooms, once they had entered the building. This potentially put staff and clients at risk of avoidable harm.
- The service did not have appropriate arrangements in place to assess and manage infection risks.
- We found in four out of the six care records that we looked at, clients did not have letters sent to their general practitioner after they had completed alcohol detoxification.
- The necessary pre-employment checks had not been undertaken for the current manager.
- The service did not have a duty of candour policy or provide guidance and training for staff on what it means.
- There were no handwashing facilities in the clinic room.

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

- Staff had a good understanding and knowledge of safeguarding vulnerable adults and children
- Staff reported incidents appropriately and effectively.

### Are services effective?

We do not currently rate standalone substance misuse services.

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

# Summary of this inspection

- The monitoring of physical health and withdrawal symptoms during home detoxification was not consistently recorded by the nurse using the recognised tool used by the service to assess these symptoms.
- Client care records were stored in three different systems. Staff had different levels of access to records which meant that there was a risk; key information was not being shared appropriately.
- The service had one registered nurse working at the service. They had only provided the registered nurse with supervision twice since they joined the service in April 2015 and they had not had an annual performance appraisal in that time.
- Audits were not carried out on the community detoxification programme to determine whether it was being completed effectively or safely.
- There was no evidence that the registered nurse had a been provided with any specialist training by the provider. However, the registered had relevant experience in the field.
- All detoxification regimes in the clients' care records were blank and staff confirmed they were not stored electronically.
- There was limited clinical input into case management meetings.

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

- Care plans were holistic and used appropriate tools to assess clients' alcohol intake and use.
- Staff recorded outcome profiles for clients. This showed a focus on recovery.
- Staff assessed the physical health needs of clients and signposted them to other health services when needed.
- The service worked closely with other local agencies

## Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Staff were very passionate about the work they did and the clients they worked with. Staff were caring and understood the needs of clients and their recovery.
- Clients were involved in the care they receive. Welcome packs were given to clients on joining.
- Staff supported the relatives of clients and hosted support groups for them on the premises
- Staff asked for and listened actively to feedback from clients and made changes to the way the serviced was delivered.
- The service supported user-led recovery groups

# Summary of this inspection

## Are services responsive?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- The service was flexible and adapted to clients' needs. For example, staff facilitated an outreach service and a regular drop in service.
- Interview rooms promoted privacy for clients to have one to one sessions with members of staff.
- The service worked with local Bangladeshi and Somali community groups to meet the needs of people from those communities.

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

- Information was not provided in languages other than English. Clients came from a range of communities and some did not have English as a first language.

## 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:

- There was no overall clinical or managerial oversight of the home detoxification programme. As a result, managers had not identified shortfalls in the way it was delivered and several serious safety concerns.

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

- Senior managers were visible onsite regularly and knew the staff and the environment.
- Staff felt well supported by managers and colleagues and described good team work.

# Detailed findings from this inspection

## Mental Capacity Act and Deprivation of Liberty Safeguards

The service did not provide specific training in the Mental Capacity Act or the Mental Health Act. Staff learnt about these acts as part of other training. Staff had an understanding of capacity and that it is relevant with the client group. If staff identified that clients had mental health issues or capacity needed to be assessed they could seek advice from the consultant psychiatrist visiting the service once a week.

# Substance misuse/detoxification

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

## Are substance misuse/detoxification services safe?

**Safe and clean environment**

- Tower Hamlets Community Alcohol Team was a community service where clients received support and treatment around their alcohol misuse. The service had interview rooms, communal rooms, a clinic room and visitors toilets.
- All interview rooms were fitted with alarms. Staff could sound the alarm if they needed assistance.
- The premises were not secure and these security arrangements left clients and staff at risk. People wishing to enter the building rang a bell. The receptionist looked through the window in the door before opening the door to visitors. Once visitors were inside they had access to all areas within the building including some counselling rooms which were not locked. Several staff described the premises as unsafe. They described serious incidents where people under the influence of alcohol had been let into the service and then become very aggressive, putting others at risk of avoidable harm.
- The clinic room was clean and tidy. However, the blood pressure machine and weighing scales had not been serviced or calibrated so there was a risk they may not have given accurate readings. No emergency equipment was held on site. Staff were not trained to carry out emergency procedures. However, we found no risk assessment detailing this. It was therefore unclear as to how this decision not to keep emergency equipment in the service was taken.
- We observed that the building appeared clean. However, we found no cleaning records for the building. Staff told us a cleaner attended twice a week, but there were no records of this. This meant that there was a risk that some areas of the building would not be cleaned consistently. The clinic room had no handwashing facilities. There was a risk that infection could be spread if clinical procedures were being carried out.
- A breathalyser was frequently used at the service to measure clients' blood alcohol concentration. It was calibrated every month, certificates were available for June and July 2016 but not for May 2016. This meant that incorrect breath alcohol level readings could have been given.
- The service had an infection control policy. However, the service had not conducted an infection control risk assessment or audit of infection prevention and control arrangements. This meant any potential infection risks to clients and staff were not identified and there were no plans in place to protect staff and clients from any risks.

**Safe staffing**

- The service had a manager, one nurse, nine community alcohol workers and a consultant psychiatrist providing support and advice to staff on the care of complex clients one day a week. The service also had an administrator and volunteer alcohol workers.
- As of May 2016 one member of staff had left the service and there was a staff sickness level of 12% in the last 12 months. The majority of staff at the service had worked there for several years.
- Community alcohol workers had caseloads of between 30 and 50 clients. One community alcohol worker was on long term sick leave and their case load had been divided amongst the other staff. Community alcohol

workers who had other duties, such as running the drop-in service and facilitating court ordered groups, had smaller caseloads. This meant they were able to see their clients regularly.

- The community alcohol workers were all permanent staff. The nurse carrying out the home detoxification programme was supplied by an agency and had worked at the service since April 2015. Agency staff were not used to cover staff sickness or leave. Staff said they covered each other's shifts where needed. If there were not enough staff available to facilitate groups then they would cancel them as soon as possible, as a last resort.
- Staff were up to date with mandatory training including safeguarding vulnerable adults and children, first aid, personal safety and care planning. Staff were trained how to use assessment tools such as the alcohol use disorders identification test (AUDIT) and severity of alcohol dependence questionnaire (SADQ). New community alcohol workers worked their way through a set of competencies that equipped them for their role and enabled them to provide safe and effective care.
- The nurse had undertaken training prior to working at this service. However, the nurse had not received training from the provider to carry out their role and keep up to date with their clinical practice. The nurse had received no formal mandatory or specialist training from the service and had worked there for over a year. Due to the vulnerability of the client group this puts them at risk, if staff were not able to identify and consistently manage the risks surrounding them.
- The service conducted checks on the suitability of staff to work in the service prior to employment. These included checks with the disclosure and barring service and with previous employers. Volunteers underwent the same level of checks as paid staff. For the agency nurse the service had relied on his agency to carry out the necessary pre-employment checks. The service had not received the managers disclosure and barring service check. They had worked at the service for over a year. The provider explained this was an oversight as they had applied for it but had not received it back yet. We checked this and the application is still in the process and at the final stages. This meant that there was a risk that potential concerns about their fitness to manage and work in the service had not been identified.

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

- Staff undertook an initial risk assessment of clients for group work and one to one therapy. Staff detailed and identified each client's risks in a holistic way and updated them at regular intervals. Risk assessments were recorded on clients' electronic records.
- Home alcohol detoxification was not being provided in a safe way. The service had admitted eight clients onto their community detoxification programme since January 2016 up until our visit. We found inconsistencies in the documentation of physical health checks during the detoxification process including a lack of checks of blood alcohol concentration, blood pressure, temperature and completion of the Clinical Institute Withdrawal Assessment of Alcohol Scale (CIWA-Ar) scores in clients undergoing alcohol detoxification. These were all recommended observations stated in the Rehabilitation for Addicted Prisoners Trust (RAPt) detoxification policy and recommended by the National Institute for Health and Care Excellence (NICE).
- On some of the days that clients were visited at home the nurse assessed them for alcohol withdrawal symptoms. However, four care records we looked at showed that a CIWA-Ar had not been repeated by the nurse at any point during the detoxification. This meant that some key indicators which were necessary to measure the effectiveness of the detoxification were not completed consistently.
- Out of the six care records we looked at two clients had not had a blood alcohol concentration (BAC) reading taken. When commencing an alcohol detoxification, the providers protocol states that clients need to abstain from alcohol the previous day and that a BAC reading should be taken to measure the clients alcohol levels before detoxification commences. Clients are advised to stop drinking the night before. BAC levels need to monitored to check they are below 100mg/dl so that chlordiazepoxide can be commenced. Chlordiazepoxide is administered in alcohol detoxification to manage the withdrawal symptoms.
- The provider's policy on the assessment criteria for clients undergoing a home detoxification stated, that a person must have a relative or carer staying with them at the time of the detoxification so that they could provide support . We found in one client's records that they had no details of a relative or carer staying with

them during the detoxification process. Having a supportive person attending at all times means that they could spot the indicators of withdrawal and call the service or an ambulance in an emergency if needed. If a person is on their own this puts them at risk of not being able to seek help in an emergency if they are too unwell.

- The provider's detoxification policy stated that a letter must be sent to the client's general practitioner (GP) once detoxification had been completed, to detail any problems or withdrawal symptoms. We found in four records out of the six we looked at that no letter had been sent to the GP.
- Community alcohol workers had a good understanding of safeguarding vulnerable adults and children. They were aware of the provider's policy and could recognise when vulnerable adults and children were potentially at risk and report appropriately. They all identified occasions when they had needed to make a safeguarding referral to the local authority safeguarding team. The service had a safeguarding lead who was able to provide support and guidance to other staff. A representative from the service attended the local multi-agency risk assessment conference meetings.
- Case management and team meetings were held regularly. Staff discussed their caseloads, safeguarding issues and client risks at these meetings.
- The service had a lone working policy in place to support staff working alone in the community and help ensure their safety. Staff had code words to use to alert colleagues if they needed assistance when on visits, which they used on the telephone. Staff explained the precautions they took to ensure that home visits were safe. Precautions included staff going to assess clients together with a professional from another agency, and calls to the line manager or other staff member on arrival at a client's home and again on departure.
- Staff told us that in an emergency, such as a medical emergency, they would call the emergency services.

**Track record on safety**

- There were seven serious incidents involving client using the service between 28 September and 4 April 2016. All these incidents were related to the unexpected deaths of clients. None of these deaths happened on the premises.

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

- Staff knew how to report incidents and the type of incidents they needed to report. We saw incidents such as calling the emergency services and verbal aggression towards staff or other clients being reported. The provider had an adverse incident policy. This detailed how staff should share learning after incidents and how to deal with an incident.
- Staff told us they received support from the rest of the team after any incident took place. This often took place in team meetings that were held weekly.
- There was evidence of improvements being made as a result of particular incidents. We saw a record of an incident where a client was at risk. The incident record outlined what went wrong and what actions the staff took afterwards to reduce the risk. As a result of this a new standardised document was introduced for the staff to complete before commencing alcohol detoxification treatment on a client.
- The manager shared learning from incidents in team meetings. This included learning from incidents that had occurred in other services provided by Rehabilitation for Addicted Prisoners Trust. The team meeting minutes contained standard agenda items including incidents and review of the operational risk register.

**Duty of candour**

- The service did not have a duty of candour policy or equivalent to provide information and guidance to staff about the duty and when it was applicable. Staff had not received training in the duty of candour and were not aware of it.

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

**Assessment of needs and planning of care**

- We looked at six care and treatment records of clients undergoing home detoxification. Community alcohol workers conducted comprehensive, holistic assessments of clients. They completed an outcome

star chart, which identified areas where clients needed support. The star included assessment of drug and alcohol use, physical and emotional health, accommodation, criminal offences and meaningful use of time. When a client scored five or less for a particular area staff developed a care plan with them to help address the client's needs and set realistic goals. Staff discussed and reviewed clients' goals with them when they met.

- Community alcohol workers used the alcohol use disorders identification test (AUDIT) and severity of alcohol dependence questionnaire (SADQ) to assess patients. They understood the criteria for safe alcohol detoxification in the community. Where they identified that a client was suitable for detoxification in the community they referred the client to the nurse for further clinical assessment. The nurse would then carry out an assessment for a client's suitability for community alcohol detoxification. According to the provider's community detoxification policy the criteria for inclusion were no previous history of seizures, a SADQ with a score of 16-30 and a supportive person available to stay with the client. A SADQ had been completed in four of the six records we looked at. We also saw evidence of a client not having an appropriate history taken of seizures.
- Client care records were stored in three different forms. Client records were stored in paper files and uploaded on the service's electronic record system. Clients undergoing home detoxification also had records kept on the GP's electronic record system, which only the nurse had access to within the service. This meant there was a risk that key clinical information could be lost if only one person had access to this system, which held important client information.

**Best practice in treatment and care**

- The service did not prescribe or administer medication. The GP prescribed medication for clients undergoing home detoxification as part of a shared care protocol. The medication administered for alcohol withdrawal symptoms or the detoxification regime was outlined in the provider's detoxification policy. However, of the six client records we looked at, three had blank detoxification regimes, so we could not see what medication was prescribed and administered. Other staff would not be aware of what medication the client had received from looking at their records. This meant that a consistent approach to the client's care and treatment could not be carried out by all staff involved and treatment may not have been appropriate.
- Community alcohol workers facilitated a range of groups aimed at helping clients prepare for treatment, improve their awareness of the impact of alcohol on their health and well-being and remain abstinent, depending on their needs and goals. The provider had developed manuals for the structure of sessions, which helped group facilitators deliver the programme consistently. Staff were trained in facilitating these groups.
- Staff saw clients on an individual basis to discuss their progress and any changes in their needs. Staff saw clients weekly at first and discussed their triggers, risks and the wider impact of their drinking. As the client progressed they were seen less frequently. Staff used motivational interviewing and cognitive behavioural therapy approaches in their work with clients.
- Staff helped clients who wanted to achieve abstinence apply for places in residential detoxification and rehabilitation programmes and took applications to the local authority funding panel.
- Staff completed treatment outcome profiles (TOPs) forms with clients at the start of treatment and reviewed the scores again after 12 weeks and at exit from the programme. TOPs is the national outcome monitoring tool for substance misuse services.
- Staff considered the physical health needs of clients. Clients were referred for blood borne virus testing when needed. Staff signposted clients to other agencies and their GP for help to stop smoking and for any other physical health concerns identified during assessment. Staff discussed the physical health effects of alcohol in the alcohol awareness group provided by the service.
- If clients had complex needs or a dual diagnosis of a mental health problem and problematic drinking staff could request advice from a consultant psychiatrist, who was seconded to the service one day a week. Community alcohol workers asked GPs to refer clients to the community mental health team when appropriate.
- The service hosted Alcoholics Anonymous meetings.

# Substance misuse/detoxification

- There was no evidence that the service participated in clinical audits. However, the consultant psychiatrist had completed an audit in December 2015 for the dual diagnosis needs of clients within the service.

**Skilled staff to deliver care**

- A consultant psychiatrist in mental health was seconded to the service one day a week. The doctor carried out assessments for clients accessing home detoxification as well as providing mental health support for clients with a dual diagnosis.
- Staff said they received a lot of training in-house as well as being supported to access training provided externally. Most staff were trained in group facilitation and several had considerable experience of leading groups. Staff were trained in motivational interviewing. Staff knew the signs and symptoms of alcohol withdrawal. One community alcohol worker was supported to take a course in cognitive behavioural therapy.
- All community alcohol workers said they received regular supervision from a manager. This took place once a month and they were given copies of the supervision notes. They all said they had received an annual performance appraisal. However, we found that the nurse had only had one management supervision and one clinical supervision since they started employment with the service in April 2015. The nurse had not received an appraisal since starting at the service. This meant that staff performance could not be regularly monitored. The provider's employee handbook stated that employees should receive monthly supervision with their line manager.
- The service used volunteers and peer supporters in the delivery of the service. There were clear criteria around what a volunteer could or could not do. They provided a supportive role, observed groups and sat in on assessments. Several staff told us they had initially been volunteers in the provider's services before becoming paid staff. Two staff had initially been employed as apprentices.

**Multidisciplinary and inter-agency team work**

- Records showed that case management meetings had been held two or three times a month between May and August 2016. These meetings were an opportunity for staff to meet with a consultant psychiatrist and discuss complex clients. However, minutes of the meetings showed that the consultant had been present at only two meetings, two meetings were cancelled and the consultant was not present at seven other meetings. This meant that the clinical input into case management discussions was very limited.
- Community alcohol workers had close links with local GPs. Individual staff took responsibility for groups of GP practices. GPs referred patients to the service and community alcohol workers conducted assessments in the surgeries. Satellite groups were also held at a local acute hospital twice a week.
- Staff worked with other health, social care and third sector agencies to meet the needs of different groups. For example, staff from the voluntary sector came to the service every two weeks and delivered housing and benefits advice sessions for clients. Community alcohol workers also liaised closely with floating support teams, local hostels and probation.
- Staff attended multi agency meetings within the borough, for example, a quarterly hidden harm meeting that discussed substance misuse themes and issues within the borough.
- The nurse who carried out the home detoxification did not always share communication that was had with the clients' GPs. We found in four out of six client records that the nurse did not store written feedback to GPs about clients who had been through a community alcohol detoxification programme on the service's electronic case management system. This meant that information was not shared adequately within the service in order to keep the client safe in the event of a relapse.

**Good practice in applying the MCA and consent**

- Community alcohol workers told us they had received training in the Mental Capacity Act (MCA) and understood the importance of ascertaining clients' capacity to give consent to care and treatment. Team meeting minutes from May 2016 showed that staff had discussed the MCA and five key principles.

# Substance misuse/detoxification

- Staff understood the need to gain clients' consent to take part in groups and to be able to share information about them with others. Records showed that staff made the limits of confidentiality clear to clients at their first assessment.
- Clients completed consent forms during their initial assessments. Consent forms included what the client would like staff to do if they relapsed or did not attend appointments.

**Equality and human rights**

- The service compiled a health needs assessment, outlining the demographics of the borough including gender, ethnicity, disability and religion. Staff had linked in with the local Bengali group where a women only substance misuse group was held. The service did not have a lift and was based over three floors. However, the service had rooms downstairs which could be used for one to one work with clients with mobility or sensory impairments. Staff were provided at GP surgeries throughout the borough.
- An interpreter could be obtained for an assessment if the clients first language was not English. The service's website offered other languages such as Bengali and Polish for further information.

## Are substance misuse/detoxification services caring?

**Kindness, dignity, respect and support**

- Staff were very committed to the service and passionate about their work. They spoke positively and optimistically about the clients they worked with and supported.
- Clients gave positive feedback about the staff, notably that they were committed to the clients and that they were approachable. Some clients attributed maintaining abstinence to the service.
- Staff were empathic towards clients and took a holistic approach to the clients recovery.
- Staff carried out breathalyser tests in a private room to help maintain the privacy and dignity of clients.
- We observed a pre-treatment group whilst onsite. The staff in the group were thoughtful and caring towards people and acknowledged their experiences and feelings.

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

- The service provided clients with a welcome pack when they joined the service. This contained information about group programmes, details for the helpline, a drinking record and carers support.
- The service provided group support for relatives of people with drinking problems.
- The service hosted and supported a client led recovery programme called the SMART group. SMART is a science based recovery model to help people manage their recovery from addiction. This met once a week at the service and used a cognitive behavioural therapeutic approach.
- Representatives of the client group met at a monthly forum and gave feedback to staff about the provision of the service and suggested improvements. Records showed that service user meetings were held monthly. Actions were identified at each meeting and these were followed up. The client representatives attended a monthly borough wide service user group meeting.
- Staff asked for feedback from clients after every group they facilitated. This helped to determine the usefulness of the group and enabled staff to make improvements or changes.

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

**Access and discharge**

- Clients were residents of the local borough of Tower Hamlets. Clients could self-refer, be referred by their GP or local authority.
- There was a waiting list and clients usually had to wait for a week to attend their first group session. If the waiting list was longer then staff would discuss this and offer regular telephone calls to the client.

# Substance misuse/detoxification

- The service was flexible and staff could see clients for assessments and one to one meetings in GP surgeries, in the service or at home, depending on the needs of the client. Staff offered some appointments in the evening when clients worked during the day.
- The service provided a drop-in session twice a week. Anyone could attend the drop-in session and would be assessed by a member of staff.
- Staff were pro-active in advertising the service locally and in encouraging people to take up the services on offer. For example, one staff visited a local acute hospital twice a week. They visited the wards and encouraged referrals from staff as well as self-referrals from patients. They offered brief interventions and harm minimisation advice to patients in the hospital, which involved giving information on the impact of drinking and awareness raising.
- The service had annual targets to meet in terms of the number of new clients they saw (400) and the number of clients undergoing community alcohol detoxification (40). The team received regular feedback on performance against these targets in teams meetings. The service saw more than the target number of clients in 2015-2016 but had conducted less than half of the target community detoxifications, with only eight completed detoxifications since January 2016.
- Staff made repeated attempts to contact and re-engage clients who had left the programme early or relapsed.
- Appointments ran on time and were only cancelled at short notice if staff were sick and there was no one to cover. If groups were changed or stopped due to low attendance then clients were informed before this happened.

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

- The clinic room had an examination couch. There was a group room to hold group sessions in the service.
- The interview rooms were quiet and private for clients' confidentiality.
- There were signs and posters in the service providing information on how to access other services for support groups. There was a poster advertising a recovery walk at the service that took place once a week.
- There were posters on display in the service educating clients about drinking and substance misuse.

**Meeting the needs of all clients**

- Access to the building was on the ground floor level. There was a group room on the ground floor which could be reached by those with limited mobility, otherwise counselling rooms were situated on higher floors. These were accessible by stairs only, there was no lift available. Staff said it was sometimes difficult for patients who had been drinking to climb the stairs.
- Staff told us that the client group using the service was reflective of the local population. The service had Somali and Bangladeshi clients from the two largest minority communities in the London borough of Tower Hamlets. Staff recognised there was a great deal of stigma attached to using alcohol in certain communities, which may have impacted on people's willingness to seek help for problem drinking. The service worked with other culturally based local organisations to raise alcohol awareness among the diverse communities and promote the service they offered. Staff had also attended a young person's forum in the borough to raise awareness of the service.
- The service advertised and encouraged clients and relatives to attend specific local support groups. For example, a group specifically aimed at women and groups for concerned significant others.
- However, there was no information leaflets in languages other than English made available for non-English speaking people at the service, which did not reflect the diverse nature of the borough's population.

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

- Clients could email complaints to a specific email address, although senior managers told us this had not been used to make a complaint.
- All complaints were reviewed by the provider. Senior managers stated that no complaints had been received since April 2016. The service had received two complaints between April 2015 and March 2016. Staff said these were informal complaints and had been handled locally. One complaint related to the late running of a session and the second complainant said

that a staff member had been rude. Both of the complaints were upheld. A three way meeting was held with the second complainant, the manager and the staff member concerned in order to resolve the issues.

- The service manager completed a quarterly performance report for the provider, which included information on all complaints received. This was reviewed by the provider's quality standards group. The manager shared learning from complaints and trends in complaints with staff in supervision or the monthly team meeting. Staff received feedback on compliments as well as complaints.

## Are substance misuse/detoxification services well-led?

### Vision and values

- Staff knew and understood the core beliefs of the organisation. The provider's stated values were being honest, robust, committed, sustained, supportive and respectful. The service was committed to evidence based interventions including the 12 step recovery model.

### Good governance

- The service had their own risk register dated 2016/2017 which they could update. Home detoxification was identified as a risk at the service. The register identified what measures were in place, like a protocol in line with NICE guidelines and all staff to understand the protocol. All staff involved in carrying out the detoxification are to have regular supervisions. The actions for this risk are for these measures to be discussed and reviewed with relevant staff and external providers. There was no responsible person listed or dated for when and how this will happen. Therefore these actions could not be followed up and improvement could not be implemented at the service.
- The provider also had a strategic risk register, dated 2016/2017 for the organisation as a whole. An example of an identified risk was the delivery of unsafe clinical services. Things like recruitment difficulties for clinical staff and poor training and monitoring of clinicians were examples of the risks at provider level. Consequences of these risks were outlined. Actions were identified as improvement for clinical supervision and ensure effective clinical leadership at service level. A timescale was given for each action and a responsible person identified.
- The service participated in a quality improvement plan. This outlined areas for improvement with an action plan to facilitate this. It was observed that care plans needed improvement and to be comprehensive. As a result an audit was carried out at the service in May 2016. They gave feedback to the manager and staff on the completion of assessments and care records.
- The provider colour coded (red, amber and green) all incidents reported to rate whether they were serious and needed immediate action or whether they were non-serious. Incidents were sent to the quality and governance team to produce a thematic report and and see what types of incidents were happening across the services.
- However, although community alcohol workers received regular supervision, training and appraisal the nurse had only received clinical and managerial supervision twice since starting work at the service in April 2015. This had been overlooked by the service manager and senior management within the organisation. The manager did not provide mandatory training for the nurse or ensure that they received regular supervision and appraisal. This put clients undergoing community alcohol detoxification, under the sole supervision of the nurse, at risk.
- Staff or managers had not carried out any audits or monitoring of the home detoxification programme. There was no evidence of any clinical oversight of the programme at a local or provider level. This meant there were no effective arrangements in place to assess, monitor and improve the quality of the community alcohol detoxification programme and ensure that this was carried out safely and effectively.
- Minutes of the service's community detox forum on 20 May 2016 noted that some clients wanted the nurse to make more contact with them during their detox process. There were no proposed actions to address this concern recorded in the minutes. The service did not always learn from feedback provided.
- The service had a receptionist who carried out all the administrative duties to support the team.

# Substance misuse/detoxification

**Leadership, morale and staff engagement**

- Staff were positive about the management of the service and felt well-supported. They said the manager had brought stability to the service. Community alcohol workers said they received great support from their managers and from each other.
- The provider's senior managers visited the service once a month and all staff knew who they were. The governance and quality team would also visit the service to carry out quality performance and development audits.
- The service reported a staff sickness rate of 12% in the past 12 months as of May 2016. Some staff reported that they were leaving the service due to the uncertainty of the future of the service. The service was being taken over by another provider but it was unclear what staff could be employed there or when this was being implemented. this impacted staff and some of them sought out other employment.
- Staff described an open culture where it was possible to ask for help when needed. Staff were encouraged to learn from mistakes.
- Staff were aware of the provider's whistleblowing policy and felt able to raise concerns about the service if they needed to.
- The provider gave staff working directly with clients a monthly financial allowance for their own individual therapy.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the provider MUST take to improve

- The provider must ensure that potential risks to clients and others are appropriately assessed before commencing a home detoxification.
- The provider must ensure that a physical examination of clients takes place and is recorded before commencing clients' detoxification treatment and throughout their treatment.
- The provider must ensure that clients undergoing home alcohol detoxification have their withdrawal symptoms assessed and recorded consistently.
- The provider must make sure there is adequate clinical oversight of the home detoxification programme to ensure that it is safe.
- The provider must ensure that the performance of all staff is consistently and regularly monitored through regular clinical and management supervision and annual appraisal.
- The provider must ensure that they adhere to their own infection control policies, carry out a risk assessment and regular audits and provide handwashing facilities in the clinic.
- The provider must ensure that all staff have training in duty of candour and guidance for staff on the duty is introduced.
- The provider must ensure employees have all the necessary pre-employment checks, including disclosure and barring service checks before starting work in the service.
- The provider must ensure that the premises are properly secure and that staff and clients are protected from avoidable harm.
- The provider must ensure that a risk assessment is carried outlining the rationale as to why emergency equipment is not kept on the premises.
- The provider must ensure that they inform the client's GP when they have completed an alcohol community detoxification regardless of whether they complete it or not.
- The provider must ensure that the appropriate systems are in place to assess, monitor and improve the service overall.
- The provider must ensure that they record all alcohol detoxification regimes for clients undergoing community detoxification.

### Action the provider SHOULD take to improve

- The provider has voluntarily agreed to stop admitting clients onto their home detoxification programme. The provider should not deliver the service in the future until further action has been taken to make the programme safe for clients.
- The provider should ensure that there is clinical input into all case management discussions
- The provider should ensure that all equipment used in the service, including the blood pressure monitors, weighing scales and the breathalyser are serviced and calibrated regularly and this is recorded.
- The provider should ensure that care records are stored appropriately so that all staff can access them if they need to and kept consistently in each format.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>Care and treatment was not provided in a safe way for service users.<br><br>The service did not carry out adequate physical health checks on service users before and during home detoxification.<br><br>The service did not assess the withdrawal symptoms of service users undergoing home detoxification consistently.<br><br>The service did not send out letters to the service users' GPs after a community alcohol detoxification was completed or stopped.<br><br>The service did not assess the risk of infections including those associated with health care.<br><br>The premises were not secure which put staff and clients at risk of avoidable harm.<br><br>This was a breach of regulation 12 (2)(a)(b)(c)(d)(h)(i) |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>The systems or processes established by the service to assess, monitor and improve the service were not effective.<br><br>There was little clinical oversight of the home detoxification programme. |

This section is primarily information for the provider

# Requirement notices

The service did not have effective arrangements in place to assess, monitor and improve the quality of the community alcohol detoxification programme and ensure that this was carried out safely and in line with national guidance.

The service did not maintain an accurate and complete record of all detoxification regimes prescribed to service users.

This was a breach of regulation 17 (2)(a)(b)(c)

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br><br>Persons employed by the service did not all receive appropriate support, training, professional development, supervision and appraisal to enable them to carry out their duties safely and effectively.<br><br>The nurse had only received supervision twice since April 2015 and had not received an annual appraisal.<br><br>The service did not provide the nurse with mandatory or specialist training whilst being employed at the service.<br><br>Staff had not received training in respect of the duty of candour.<br><br>This was a breach of regulation 18 2(a)(b)(c) |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed<br><br>The service did not have the information specified in Schedule 3 (information required in respect of persons employed or appointed for the purposes of the regulated activity) available in relation to each person employed.<br><br>The service had not carried out a check of the service manager with the disclosure and barring service. |

This section is primarily information for the provider

# Requirement notices

This was a breach of regulation 19 (3)(a)

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.