Linwood Park

Quality Report

Wensley Road
Barnsley
South Yorkshire
S71 1TJ
Tel:01226 298910
Website: www.thelinwoodgroup.co.uk

Date of inspection visit: 23 February 2016
Date of publication: 28/07/2016

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

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Overall summary

We do not currently rate independent standalone substance misuse services.

We found the following issues that need to improve:

- The service did not have any lone working protocols in place to ensure the safety of staff when they were lone working on the rehabilitation unit.
- Staff practice in the administration of clients own medication and 'as and when required' medication were not safe.
- Staff were not fully aware of how the Mental Capacity Act related to their role and had not identified when an application for a deprivation of liberty safeguard may have been required.
- The principles of equality and diversity were not fully embedded in the systems and processes within the service.
- The provider had not implemented any key performance indicators to monitor the quality of the service.

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

Summary of findings

- Staffing levels in the service would be increased based on the level of occupancy and the needs of the clients.
- We observed genuine, caring interactions between staff and clients.
- The staff we spoke to demonstrated a thorough knowledge of the clients and their individual recovery plans.
- The service was able to respond promptly to requests for detoxification or rehabilitation, offering clients an admission date and time to suit their needs.

Summary of findings

Contents

Linwood Park

Services we looked at
Substance misuse/detoxification;

Summary of this inspection

Background to Linwood Park

Linwood Park was registered for providing residential alcohol and drug detoxification and residential rehabilitation to adults over 18. The service was provided in a large house over two floors, the detoxification unit on the first floor had 20 bedrooms. The rehabilitation unit on the ground floor had 14 bedrooms. At the time of the inspection there were eight clients on the rehabilitation unit and seven on the detoxification unit. Over the period of the inspection four people were admitted to the detoxification unit.

Clients were able choose whether to have a detoxification only or have rehabilitation as well as a detoxification.

The service was registered to provide the following regulated activities:

- The accommodation for persons who require treatment for substance misuse.
- Diagnostic and screening procedures.
- Treatment of disease, disorder or injury.

At the time of the inspection the service received referrals through several referral agencies or directly from people funding their own treatment.

This was the first CQC inspection at this location

Our inspection team

The team that inspected the service comprised CQC inspector Martin Grinold (inspection lead); two additional CQC inspectors and one advanced nurse practitioner.

Why we carried out this inspection

We inspected this service as part of our inspection programme to make sure health and care services in England meet fundamental standards of quality and safety

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, asked other organisations for information and requested detailed information from the provider.

During the inspection visit, the inspection team:

- Looked at the quality of the physical environment, and observed how staff were caring for people who used the service.
- Spoke with five people who were using the service.
- Observed one therapy session.

Summary of this inspection

- Spoke with the registered manager, the deputy manager and the lead nurse.
- Spoke with 10 other staff members employed by the service provider, including nurses, support workers and therapy staff.
- Looked at six care and treatment records, including medicines records, for people who used the service.
- Observed medicines administration.
- Looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

The people we spoke with all spoke highly of the service, they said they felt safe and that they were treated with respect by the staff. People were aware how to raise concerns and had confidence these would be addressed.

However some people we spoke with felt the restrictions on the use of mobile phones which were in place were too strict and limited the contact they could have with their family during treatment.

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 service did not have any lone working protocols in place to ensure the safety of staff when they were lone working on the rehabilitation unit.
- The admission process was not robust and did not capture enough information from the client or others to enable a robust risk assessment or treatment plan to be completed.
- Staff practice in the administration of clients own medication and 'as and when required' medication were not safe.

This was a breach of a regulation; you can read more about it at the end of this report.

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

- Staffing levels in the service would be increased based on the level of occupancy and the needs of the clients.
- When agency or bank staff were required to cover shifts the manager tried to use the same regular agency staff to maintain consistency.

Are services effective?

We do not currently rate standalone substance misuse services.

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

- The service did not hold multidisciplinary meetings to review the care provided to clients.
- Staff were not fully aware of how the Mental Capacity Act related to their role and had not identified when an application for a deprivation of liberty safeguard may have been required.
- When staff had assessed capacity they did not fully record the rational for their decision

These were a breach of a regulation, you can read more about it at the end of this report.

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

- The service had a process in place to ensure all staff received supervisions and appraisals.

Summary of this inspection

Are services caring?

We do not currently rate standalone substance misuse services.

We found areas of good practice, including :

- We observed genuine, caring interactions between staff and clients.
- Clients spoke highly of all staff including housekeeping and kitchen staff.
- The staff we spoke with demonstrated a thorough knowledge of the clients and their individual recovery plans.

Are services responsive?

We do not currently rate standalone substance misuse services.

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

- Some clients had to wait a long time to see the medical practitioner to complete their clinical assessment on admission.
- The principles of equality and diversity were not fully embedded in the systems and processes within the service.

This was a breach of a regulation, you can read more about it at the end of this report.

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

- The service was able to respond to promptly to requests for support offering clients an admission date and time to suit their needs.
- All clients were aware of how to make a complaint and we saw evidence the management company had investigated all formal complaints.

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:

- Staff were not aware of the providers management structure.
- The providers policies and procedures all related to care homes and were not appropriate for the service. The provider had not addressed this despite being informed by the management company.
- The provider had not implemented any key performance indicators to monitor the quality of the service .

These were a breach of a regulation, you can read more about it at the end of this report.

Summary of this inspection

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

- The manager had implemented a process of medication audits and had identified where further clinical audits were required.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not demonstrate an understanding of the Mental Capacity Act and its application to their role.

Staff assessed clients capacity to consent to treatment on admission and would re-visit this if the client was assessed to not have capacity at the time due to being intoxicated. However, staff did not record the details of the decision in their assessment or make reference to the principles of the act.

We found one client who could at times become confused and wonder; the service had admitted them on to the detoxification unit as there was a locked door. The service had not sought guidance from the local authority regards applying to the court of protection for an authorisation under the deprivation of liberty safeguards.

Substance misuse/detoxification

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse/detoxification services safe?

Safe and clean environment

The service employed both housekeeping and maintenance staff to maintain the environment which was seen to be clean and tidy. There was a daily cleaning rota in place and we saw evidence of domestic staff completing daily cleaning sheets which the service manager checked.

The housekeepers emptied the cleaning trollies daily and all materials were all stored securely in a locked store.

Maintenance staff conduct basic repairs and report more serious repairs to the manager.

The décor was seen to be tired in places and ready for redecoration, the service manager informed us of a 12 month refurbishment plan which the provider had agreed and could demonstrate areas where work had begun, including replacement wall heaters and flooring.

We observed potential ligature points throughout the service, which clients could use to attach a cord, rope or other material to for the purpose of hanging or strangulation. The service did not have a ligature risk assessment. The manager informed us, they mitigate risk through individual risk assessment and the use of enhanced observation. We saw evidence of increased observation records within clients notes; however, there was no written guidance on this process.

Each room had a call button and there were two panels on each unit to identify where the call had been raised.

Safe staffing

- the registered manager
- five nurses, including two vacancies the service was recruiting to.
- eight support staff
- four night support staff
- five therapy staff
- three kitchen staff
- four housekeeping staff
- one maintenance person
- and one administrator

A local medical practice provided medical support through a service level agreement, providing:

- a medical practitioner to clinically assess new clients on admission.
- prescribing to support the detoxification regime.
- ongoing medical interventions to clients.
- provide emergency telephone support or a visit if a practitioner is available.

The service operated a rota based on minimum staffing levels. comprising a nurse and support worker on the detoxification unit and a support worker on the rehabilitation unit. Therapy staff were available on both units between 9am and 5pm. The manager would increase staffing levels as necessary depending on occupancy levels and individual needs of the clients.

The service used agency staff to cover vacant shifts. Where possible the service tried to use regular agency staff to ensure consistency. Where it was identified additional staff were required the extra shifts would be offered to substantive staff first before the use of agency staff.

The average mandatory training rate for staff was 68%. This reflected that six staff had completed first aider and fire marshal training although the majority of staff had completed emergency first aid training.

Substance misuse/detoxification

There were no lone working protocols in place to ensure the safety of staff whilst lone working. Although the service provided call buttons in rooms staff did not have a personal alarm or means of raising an alarm whilst lone working.

Staff we spoke with expressed concerns regards staffing levels, stating they didn't always feel these were adequate especially on the rehabilitation unit at night where there was only one member of staff on duty. In the absence of lone working protocols, it was felt that current staffing levels could place staff and clients in a vulnerable position.

Assessing and managing risk to people who use the service and staff

We looked at six clients' records. These included pre admission information taken by the service and third party information received for funded clients. In all of the detoxification records we reviewed, staff had not fully explored potential risks on admission. The assessment paperwork covered set questions about risk but contained minimal detail necessary to assess them effectively. For example, staff did not explore risks associated with blood borne viruses other than recording the last time the client was tested. The service did not use a recognised risk screening tool and had incorporated risk screening within their assessment documentation.

Where staff had identified risks, there were set pro forma interventions to manage these risks. For example, there were management plans for epilepsy, allergies and diabetes, which contained a set of processes that staff should follow if the risk occurred. We found that staff had recorded concerns in a client's note about high blood sugar levels. They recorded an action plan, which included referring the client to the GP if levels did not fall. A further entry recorded that blood sugar levels were still high despite the client increasing their intake of water. There were no further/subsequent documented notes about the client's blood sugar levels.

We also saw evidence of medication errors including one error where a client taking anticoagulants had been given two doses of aspirin before staff had identified the error.

Staff completed hourly observations of clients as standard regardless of their assessed level of risk. Where higher risks were identified staff would increase observations to half hourly.

We noted that the initial engagement form allowed the client to consent to sharing information with their GP. Two clients had not given their consent. This meant that the GP prescribing the detoxification was fully reliant on the information the client gave them about their medical condition and any prescribed drugs they were taking.

A high number of clients chose to undertake a seven-day alcohol detoxification programme. Staff gave clients a discharge letter to give to their GP advising them of the treatment.

The service advised clients to bring enough medications with them to last through the detoxification period. We saw that this included medication bottles already opened by the client. Staff would then take over dispensing the medication without any assurance that the medication in the bottle was what the client's GP had prescribed. This practice was unsafe, placing clients and staff at risk.

Staff received training on safeguarding adults and all the staff we spoke to were able to outline the procedure they would follow to raise a concern. However staff were not proactive in their approach to safeguarding and would wait for clients to raise a concern with them before taking action in the form of a safeguarding alert. This could result in a client being a risk of harm unnecessarily.

Track record on safety

No serious incidents had been recorded in the previous twelve months.

Reporting incidents and learning from when things go wrong

The management company had introduced the datix incident reporting system. The staff we spoke with knew how to report incidents and we saw examples of completed incident forms. The registered manager was introducing a system for sharing learning following incidents as there was not a robust process in place. We saw evidence of learning from a recent incident which resulted in the service ordering personal alarms for the staff. However we found evidence of incidents including medication errors which had not been reported.

Duty of candour

Substance misuse/detoxification

There had not been any serious incidents in the last twelve months. The incident records we saw did not indicate the service had followed a process in relation to the duty of candour.

We saw records of medication errors however these did not contain any reference to a discussion with the person involved regards the error, this was not in line with the providers responsibilities under the duty of candour.

Are substance misuse/detoxification 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)

Clients were admitted to the detoxification unit in a staged approach; support staff completed the unit admission. The duty medical practitioner would complete a clinical assessment on the day of admission and prescribe the treatment regime to support the detoxification.

Staff relied on the information provided by the client on admission and through the initial enquiry to complete the admission. Where clients did not consent to staff contacting their GP or other third party staff would not seek any further information. The meant some clients did not have comprehensive risk assessments creating a potential risk for staff and clients.

Some staff we spoke with felt the initial admission process was not robust and 1:1 sessions would often identify further risks. all the clients assessment records we reviewed confirmed the current admission process did not adequately identify potential risk issues and relied on information provided by the client during admission.

Staff completed generic care plans and risk assessment which contained prepopulated actions which were not specific to the need of individual clients.

When the client progressed from the detoxification unit to the rehabilitation unit a more thorough comprehensive assessment took place with greater client participation. Each client had a generic care plan, based on the first three stages of the twelve steps programme. Clients had a prescribed course of action to achieve with completion dates.

Clients' daily notes were very brief. For example, therapist notes stated that the client had attended/ not attended group and did not record any details of 1:1 therapy sessions. Nursing notes also lacked detail.

Best practice in treatment and care

The service followed National Institute for Health and Care Excellence (NICE) guidance and the department of health, drug misuse and dependence guidance.

The service provided a range of individual and group therapy sessions based on the twelve step programme. Other therapy options available included life story sessions, cycle of change, red flag to relapse, drama therapy and the Johari window model, a tool for illustrating and improving self-awareness, and mutual understanding between individuals within a group.

Staff used the clinical institute withdrawal assessment of alcohol score to monitor outcomes for clients withdrawing from alcohol.

However when staff dispensed as required medication for symptomatic relief, they always selected the highest dose permitted. They did not relate the client's symptoms to their alcohol withdrawal assessment score before making a decision.

The contracted medical practitioner working for the local medical practice completed clinical assessments and subsequent treatment plans. Detoxification medication and reduction plans were a fixed regime based on the NICE guidelines. Chlorodiazapoxide was used during the alcohol detoxification to manage the withdrawal symptoms. Lorazepam or Oxazepam were not used as an option for patients with liver disease. Oral thiamine was prescribed to reduce the likelihood of alcohol-related brain disease in alcohol dependent patients. However, the service did not prescribe and administer intra-muscular thiamine, recommended by NICE.

Staff supported clients with routine health monitoring including blood pressure and checking blood sugar for diabetic clients.

Staff would seek support via the emergency services for clients suffering with a physical health or mental health crisis.

Substance misuse/detoxification

We saw evidence that the manager completed monthly medication audits on both the detoxification unit and the rehabilitation unit. The nurses on duty also completed medication checks at each handover.

The service did not have any local authority commissioning arrangements, therefore was not required to complete the national drug treatment monitoring system returns and had no other means in place to monitor service outcomes.

Skilled staff to deliver care

The service employed a range of staff including both acute and mental health nurses, support workers and therapists. Therapists were all federation of drug & alcohol professionals or British association for counselling and psychotherapy accredited.

Staff received regular supervision. Clinical supervision was provided through an agreement with a retired GP who had links with the service. The service provided management supervision through a hierarchical structure. Staff we spoke with were happy with the supervision arrangements and felt supported. All non-medical staff had received an appraisal within the last 12 months.

The staff we spoke with informed us the service supported them to access specialist training including health and social care level three and training to take blood samples for non-clinical staff. A member of the therapy team told us the service was supporting them to attend training to maintain their registration.

Team meetings did not regularly take place within either unit or as a service as a whole. Staff shared any relevant information with the nurse in charge or the therapy lead and recorded in progress notes. The manager disseminated key information through the supervision structure or through memos in staff pigeon holes. The lack of team meetings reduced the ability of the team to share information and discuss concerns effectively.

Multidisciplinary and inter-agency team work

Neither medical practitioners nor external agencies had regular input in to the service therefore the service did not hold regular multidisciplinary meetings . However, nurses and therapists held daily meetings with the manager and shared information as necessary between teams or recorded details in progress notes.

Where a client was receiving support from another agency and gave permission for the service to share information staff would involve the third party in the persons care planning and inform them of progress made.

The service had links with the local mental health crisis team and probation services and would seek support as necessary.

There was an agreement with the local GP to register clients admitted on the rehabilitation unit as a temporary resident.

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

The service informed us they had 72% compliance with Mental Capacity Act training, staff we spoke to told us they had had training. Staff understanding of the act and its application was limited. Staff were aware that if a client was intoxicated on admission to the detoxification unit they should seek their consent and obtain a signature when they had 'sobered up' 24 to 48 hours later. However, staff did not demonstrate an understanding of the principles of assessing a client's ability to understand, retain and weigh up information in order to make a decision.

The service did not have access to advocacy support and were unaware of any local advocacy provision.

Where staff made decisions regards a client's capacity there were no detailed recording of this decision. For example where a client had been assessed not to have capacity to sign their treatment contract on admission client notes did not contain details of how the decision was reached.

Staff did not demonstrate an understanding of the Deprivation of Liberty safeguards (DoLS). Staff told us if a client wanted to leave they would not be able to stop them from doing so though would try to persuade them to stay, however they would allow them to leave after signing a disclaimer.

However, one client who was suspected to be suffering with Korsakoff syndrome, and could at times be confused; had been admitted on the detoxification ward for a period of time whilst his family sought an appropriate residential placement. Staff informed us he was on the detoxification ward due to the ward having a locked door and he could wander off should he be confused.

Substance misuse/detoxification

We checked the clients care plan and could not find a clear care plan detailing actions to take should he become confused or any clear recording of a capacity assessment. The service had not sought any guidance from the local authority regards the need to apply to the court of protection for an authorisation under deprivation of liberty safeguards.

The provider has a MCA/DoLS policy though this policy referred to residents in a care home and was not representative of the needs of a drug and alcohol service.

Management of transition arrangements, referral and discharge

Staff worked across both units, this provided continuity as clients transitioned from detoxification to rehabilitation. Staff would have a handover and the clients file would transfer to the rehabilitation ward with them.

When a client transferred to the rehabilitation unit they would receive an induction to the unit from another client on the unit before staff completed the admitted and care plan.

On discharge, staff gave clients a personal recovery plan and a discharge letter to give to their GP advising them of the treatment. Staff informed us that where another service had been involved in the clients care throughout the admission the service would invite them to a discharge meeting prior to discharge.

Staff advised us that should a client wish to leave before the end of their treatment they would encourage them to stay, clients would be asked to meet with a nurse or therapist prior to discharge and be asked to sign a disclaimer stating they were leaving against medical or therapeutic advice.

Where clients had provided consent for staff to contact their GP or other relevant parties, staff would also phone them to advise of the discharge. If a patient had not given consent, the service would not inform anyone of the discharge. This demonstrated a lack of understanding of the principles of information sharing specifically; the duty to share information can be as important as the duty to protect patient confidentiality.

The service did not routinely develop contingency plans for unplanned discharges to include for example guidance on harm minimisation or requesting a welfare check on clients thought to be at risk following discharge.

Are substance misuse/detoxification services caring?

Kindness, dignity, respect and support

We observed one group therapy session and one admission. We saw caring interactions between staff and clients throughout the service, staff engaged clients in a respectful manor. We observed staff empower a client to take a lead within a group session.

We spoke with five clients, all said staff were caring and treated them with respect. Two clients said the staff were 'genuinely interested'.

The staff we spoke with presented to be caring and had knowledge of the individuals they were supporting.

The involvement of people in the care they receive

All of the clients we spoke with felt they had been involved in discussions about their care and support. Clients said staff asked who they wanted to be involved in their care and would involve anyone clients requested.

We observed one group therapy session which staff planned with a client; we observed staff facilitated client' involvement in the session and support clients to take active roles within the session.

We reviewed six care records and saw evidence clients had been involved in their assessment and care plans. We saw evidence of staff obtaining a second signature after clients completed detoxification. However, one client told us they had not felt involved in the choice of treatment plan on the detoxification unit. But they had been more involved in their recovery plan on the rehabilitation unit.

In the rehabilitation unit, clients were allocated weekly coordinator roles to encourage their involvement in the running of the service, for example, the activities coordinator planned the evening activities and the client coordinator helped induct new clients to the unit.

The service held monthly family days on a Sunday where clients' family could visit and take part in activities. Monthly aftercare days were held on one Saturday each month for both current and previous patients to attend.

Substance misuse/detoxification

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

Access and discharge

The bed occupancy rate for the service was low, between 50% and 60%. At the time of the inspection, there were eight clients in the rehabilitation unit and seven in the detoxification unit. Staff were expecting four admissions over the course of the inspection.

The current occupancy rate enabled the service to be responsive in providing clients access to treatment; many clients told us they were admitted the day after making an initial enquiry.

Clients could be admitted at a time which suited them including in the evening. However, due to the contract agreement with the local medical centre to provide clinical assessments on admission clients could have to wait for long periods to see a medical practitioner. One client told us they had 'been left for hours' on their admission and did not know what was happening.

The service was flexible in the treatment options provided; clients could choose to stay for detoxification, rehabilitation or both. Alcohol detoxification was completed over seven days; the average stay for opiate detoxification was three weeks.

The facilities promote recovery, comfort, dignity and confidentiality

Both units provided a lounge area, dining area and a quiet space. Clinic rooms were available on both units and a clinical admission room on the detoxification unit.

On the detoxification unit, the service provided a family room where clients could meet visitors or make phone calls in private. The service provided a smoking room on the detoxification unit for clients as there was no access to an outside space. One client told us that despite the room having extraction you could still smell the smoke from the room when other clients entered or exited the room as it was close to the lounge area.

Clients were unable to have direct access to an outside space during their stay on the detoxification unit which meant some clients on a prolonged opiate detoxification could go a considerable length of time without the opportunity to go outside. if a patient requested access to an outside space staff would assess individual risk associated with facilitating this request and the patient would be supported to access the garden by a support worker or member of therapy staff.

There was space for clients to engage in both group and 1:1 therapy sessions in each unit.

Bedrooms had a wash basin and a toilet; the service provided communal showers and bathing facilities. Bedrooms also had facilities for clients to have a locked cupboard to store personal items.

The layout of the building enabled separate male and female corridors on the detoxification unit however; this was not replicated in the rehabilitation unit, staff managed this through an informal bed management process.

The service provided meals for the clients who could choose from a range of options daily. The service was able to cater for a range of dietary requirements on request. A range of snacks were readily available in both the lounge and dining areas and clients could help themselves to hot or cold drinks at any time.

Clients on the rehabilitation unit were able to access the local community in groups and could plan activities each week through the client activities co-ordinator; this was a client on the ward who took on the role to arrange for the week.

There were three weekly alcoholics anonymous meeting held in the service including one female only meeting. The service supported clients who wanted to attend narcotics anonymous meetings to access these, although the nearest meeting was in Sheffield and required a member of staff to drive the clients. The service provided a car for this purpose.

The rehabilitation unit also provided access to a paved patio area and a large garden.

Meeting the needs of all people who use the service

The service was accessible and had a lift to enable access to the detoxification unit. Bathrooms were accessible although there was no handrail in the toilet.

Staff informed us the service could cater for client's dietary requirements and that they would assess any cultural needs on admission.

Substance misuse/detoxification

However, the service did not embed equality and diversity in to the assessment and care planning processes in relation to the protected characteristics within the Equality Act 2010. Staff were not proactive in addressing equality issues relying on clients to advise them of their specific requirements.

The service did not have access to an interpretation service and information provided within the welcome pack was only available in English.

Listening to and learning from concerns and complaints

We saw complaints posters on the noticeboards and the clients we spoke with said they knew how to complain and felt able to do so.

The management company investigated all formal complaints. We reviewed two complaints and saw a thorough investigation had taken place and that duty of candour had been observed. The management company identified lessons learnt and recommended actions to improve the quality of the service. The provider was given the recommendations to implement but this had not yet been completed.

Are substance misuse/detoxification services well-led?

Vision and values

The staff we spoke to were unclear of the provider's vision and values. Some staff stated they had not received any information on these. Staff were unaware of the management structure within the provider and could not name any senior managers.

The manager informed us the provider had visited the service however this was in the evening, they had not engaged the staff team during the visit.

Good governance

The governance policies we saw related to care homes rather than a substance misuse service and were not appropriate. The registered manager had made the provider aware that policies needed putting in place however; the provider was slow to respond. The manager had implemented a new medication policy due to the risks associated with the previous policy.

Staff we spoke with were aware of the whistleblowing process however all staff were unable to name managers within the provider as people they could raise concerns with.

The provider had not implemented any key performance indicators to rate the service against and there was no clear quality monitoring framework in place. The manager had implemented medication audits and informed us of their plans to introduce further audits.

Leadership, morale and staff engagement

Staff were unable to inform us of the management structure of the provider however all staff spoke highly of the registered manager. Staff informed us of the changes the manager had introduced including ensuring staff received supervision.

Commitment to quality improvement and innovation

Due to the lack of current commissioning arrangements, the service was not required to complete the national drug treatment monitoring system returns.

The provider had not implemented any quality assurance audits and did not require the management company to report against any performance indicators.

The manager had implemented a process of medication audits and had identified other areas where clinical audits were required

The manager was unable to provide any assurance that the provider was taking action on any of the concerns they had raised.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure the process of administering medication is safe including investigating and learning from medication errors.
- The provider must identify where a service user might be deprived of their liberty under the Mental Capacity Act 2005.
- The provider must implement policies and procedures appropriate to the regulated activity including procedures to ensure the safety of staff whilst lone working.
- The provider must implement a process to assess, monitor and improve the quality of the service.
- The provider must ensure there is a process to enable staff to obtain adequate information during admission to complete comprehensive person centred risk assessments
- The provider must ensure that their policies and procedures take account of the nine protected characteristics contained in the Equality Act 2010 – age, disability, gender reassignment, marriage and civil partnership, race, religion or belief, sex, sexual orientation, and pregnancy and maternity.
- The provider must take appropriate action to ensure clients safety when physical health needs are identified and must ensure this is recorded in the clients' records.

Action the provider SHOULD take to improve

- The provider should review their policy regards information sharing in line with the principles of information sharing
- The provider should ensure the risk assessments and care plans are person centred and reflect the needs of each client.
- The provider should ensure staff are confident in reporting safeguarding concerns where these have not been raised directly by the client.
- The provider should ensure the recording of decisions relating to capacity are detailed and reflect the reason for the decision.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider must ensure the proper and safe management of medicines assessing the risks to the health and safety of service users of receiving the care or treatment doing all that is reasonably practicable to mitigate any such risks **How the regulation was not being met** Medication had been administered in error and there was no evidence of any follow up action. We found that staff had recorded concerns in a client's note about high blood sugar levels. They recorded an action plan, which included referring the client to the GP if levels did not fall. A further entry recorded that blood sugar levels were still high despite the client increasing their intake of water. There were no further/subsequent documented notes about the client's blood sugar levels. Regulation 12 (2) (g) Regulation 12 (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment A service user must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority **How the regulation was not being met**

This section is primarily information for the provider

Requirement notices

We found one service user who was on the detoxification unit which had a locked door due to the potential for him to wander at times of confusion. The service had not made an application for a deprivation of liberty.

Regulation 13 (5)

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 17 HSCA (RA) Regulations 2014 Good governance assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity **How the regulation was not being met** The provider did not have a process of quality monitoring in place and the service did not report on any key performance indicators for the purpose of quality assurance. We found evidence of medication errors which were not reported or investigated despite being highlighted in medication audits. The service did not have a process in place to ensure the safety of clients and staff when lone working on the rehabilitation unit. The policies and procedures in place did not relate to the regulated activities. Regulation 17 (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour

This section is primarily information for the provider

Requirement notices

A health service body must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity

notify the relevant person that the incident has occurred in accordance with paragraph (3)

provide reasonable support to the relevant person in relation to the incident, including when giving such notification.

How the regulation was not being met

We saw records of medication errors however these did not contain any reference to a discussion with the person involved regards the error.

Regulation 20 (1) (2) (a) (b)