Phoenix Futures Sheffield Residential Service

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

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

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

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

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

Overall summary

We do not currently rate independent standalone substance misuse services.

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

- Staff did not assess all known risks to people. Where assessments were in place, staff did not review these after incidents. The environment had not been assessed for risks that may be present for people, particularly where people had incidents of self harm and suicidal ideation.
- There was no effective monitoring of detoxification and withdrawal. The tool staff used to monitor alcohol withdrawal was used inconsistently. Staff did not use a tool for monitoring opiate withdrawal. Key policies and procedures such as guidance and practice around detoxifications were still in draft stage.
- Recovery plans were not holistic and it was not clear what objectives people were working towards. There were omissions in care records and some documentation was not signed or dated. People did not have discharge plans and plans for potential unplanned exits.

Summary of findings

- Staff did not report all incidents that met the reporting criteria. Managers did not undertake detailed investigations into the cause of incidents.
- The service advertised separate male and female accommodation on their website. We found there was no separation of male and female accommodation. Males and females slept in rooms on the same floor and had access to the same bathroom facilities.
- People did not always receive their medicines as prescribed. Infection control practices and procedures for drug and alcohol testing were not robust.
- Staff had not completed all necessary mandatory training. Not all staff had received specialist training in order to meet the needs of people they supported. Sessional staff and volunteers did not receive supervisions and appraisals.
- Staff did not fully understand the principles of the Mental Capacity Act 2005 and how this applied to their role.
- The manager did not have access to all necessary information, such as evidence of completed training, for sessional workers employed at the service.
- Monitoring and quality assurance systems were not effective in identifying areas for improvement at the service and risks to people's health and welfare. All operational risks known to the service were not included on the risk register. Risks on the register were not effectively mitigated.

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

- People who used the service, spoke highly of the staff. People felt staff were caring, supportive and listened to them. People had the opportunity to visit the service prior to admission. On admission, people were allocated a keyworker who they said they saw regularly.
- Recruitment processes were designed to help ensure people were safe to work at the service. People using the service told us they felt safe.
- The service had good links with other agencies and organisations. External stakeholders spoke of positive working relationships with staff at the service.People were registered with a local GP during their stay. The GP practice booked out a weekly half day to solely accommodate appointments for people using the service.
- People had opportunities to give feedback about the service and had their own service user forum. They were involved in decisions about the service, for example by being part of recruitment panels for new staff.

Summary of findings

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Summary of this inspection

Background to Phoenix Futures Sheffield Residential Service

Phoenix Futures Sheffield residential service provides a rehabilitation service for people who misuse drugs and alcohol. The service accepts national referrals and privately funded people. It was registered with the Care Quality Commission on 20 January 2011. It is registered for the regulated activity of 'accommodation for persons who require treatment for substance misuse'.

At the time of our inspection the registered manager had ceased employment with the service in December 2015. They had not yet cancelled their registration with the Care Quality Commission. A new manager had commenced employment in April 2016. The new manager was in the process of applying for registration with the Care Quality Commission.

The service could accommodate a maximum of 36 people. At the time of our inspection there were 25 people using the service. The premises consisted of one main house and a smaller separate annexe building on the same site.

The provision of support was based on a therapeutic community model. A therapeutic community is a participative, group-based approach to addiction. External counselling services attended on a regular basis.

The service has been inspected three times since registration. At our inspection in September 2012, there were breaches of two regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These related to the management of medicines and respecting and involving people who use services. At our subsequent inspection in June 2013, we found the service was no longer in breach of these regulations. At the last inspection in April 2014 there were no breaches of regulations.

Our inspection team

The team leader of the inspection was Anita Adams

This inspection team consisted of two CQC inspectors, two CQC inspection managers, a CQC pharmacist inspector and a specialist advisor who was a specialist 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?

Summary of this inspection

- Before the inspection visit, we reviewed information that we held about the location, asked a range of other organisations for information and sought feedback from people using the service at a focus group.

During the inspection visit, the inspection team:

- visited the location, looked at the quality of the physical environment and observed how staff cared for people who used the service
- spoke with eight people using the service
- spoke with the service manager, program manager, head of quality, service user involvement lead, head of operations and the human resources manager
- spoke with six other staff members including therapeutic workers, administration staff and the health and safety officer
- spoke with one peer support volunteer
- spoke with the prescribing detox doctor for the service
- contacted ten stakeholders who had involvement with the service and received feedback from three of these
- attended and observed one staff hand-over and an encounter group meeting for people which was facilitated by two therapeutic workers
- collected feedback using comment cards from twenty one people who had used, or were using, the service
- looked at five peoples' care records
- looked at medicines records for three people
- looked at four staff members personnel records
- observed medicines administration
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

During the inspection, people spoke highly of staff. They said that staff were supportive, listened to them and helped them with their recovery. People said they were treated with dignity and respect. People knew who their keyworkers were and most had regular one to one time with them. People said they were involved in their recovery plans and reviews of their care

We received feedback from 21 people by way of comment cards obtained during the inspection. All of these were positive about how staff treated people which supported what they told us during the inspection. All people felt the service was safe and clean. People knew how to make complaints and would feel comfortable in doing so.

During the inspection, some people told us they did not receive their medicines as needed.

In four comment cards, people expressed concerns about a lack of staff. The impact of this was that people sometimes could not access activities and external appointments. Some people we spoke with felt activities were not varied enough.

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 found the following issues that the provider needs to improve:

- Staff did not always review people's risk management plans in response to incidents and update these where necessary. All known risks to people had not been identified and included in risk management plans.
- There was no assessment of potential environmental risks within the premises, especially where people were known to have a history of self harm and/or suicidal ideation.
- Females and males shared bedrooms with people of the same gender. However, bedrooms were in the same areas and on the same floors with no male and female separation. Bathrooms were also accessible to both males and females. There were no rooms or areas that operated as single sex only. Bedroom doors were kept unlocked. There was no assessment about any risks this arrangement may present.
- Staff did not report all incidents that occurred and met the criteria for reporting.
- Medicines were not managed safely. People did not always have their medicines when needed and in accordance with how they were prescribed. The arrangement for administration of medicines meant staff would often be disrupted which could lead to errors and increased administration time.
- Infection control procedures were not robust in relation to drug and alcohol testing. Staff reused an item that was designed to be disposable. The process staff followed for urine testing did not minimise the prevention, control and spread of infection.

These findings constituted a breach of a regulation. You can read more about this at the end of this report.

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

- All staff were subject to recruitment checks including a disclosure and barring service check prior to starting employment. This helped to ensure they were suitable to work at the service.
- People told us they felt safe and that the service was clean and hygienic. We found the premises were generally clean and there were checks in place for cleaning schedules and maintenance checks.

Summary of this inspection

Are services effective?

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

- Not all staff were up to date with their mandatory training. Not all staff had received specialist training in areas relating to the people they supported. For example, substance misuse and mental health.
- Sessional staff did not receive regular formal supervision and appraisal. Some of these staff often covered shifts as lone workers. It could not be identified what support, training and development needs these staff may have.
- There was no effective monitoring of detoxification and withdrawal. Staff used a nationally recognised tool to assess alcohol withdrawal but this was not used correctly or consistently. They did not receive training in the use of this tool. No formal tool was used to monitor symptoms of opiate withdrawal.
- There was a lack of accurate, complete and contemporaneous records in respect of people. This included a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.
- Recovery plans were not sufficiently detailed and holistic. It was not always clear what objectives people were working towards, how they were to achieve these and what progress they had made.
- Staff did not have a clear understanding of the Mental Capacity Act 2005 and their responsibilities in accordance with this legislation.

Some of these findings constituted a breach of a regulation. You can read more about this at the end of this report.

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

- People's detox regimes was overseen and managed by a GP who had undertaken specialist training in substance misuse.
- People were registered with a local GP during their stay at the service. The GP practice booked out a regular half day to solely accommodate appointments for people using the service if they needed to see a doctor.
- The service worked well with other agencies and professionals involved in people's care and support.

Are services caring?

We found the following areas of good practice:

Summary of this inspection

- People spoke highly of the staff team and said they felt listened to, supported and respected. Some people spoke of staff going the extra mile for them.
- Each person had a named keyworker who staff spent regular one to one time with. People were involved in completion and reviews of care plans and said they had copies of these.
- We observed positive interactions between people and staff. Communication was respectful and appropriate.
- People had opportunity to visit the service prior to admission and speak with people already at the service. Some had their family accompany them on these visits.
- People had opportunities to give feedback about the service and had their own forum . People were involved in decisions about the service, for example by being part of recruitment panels for new staff.

Are services responsive?

We found the following areas of good practice:

- People said they knew how to make complaints and would feel comfortable in doing so.
- There were a variety of ways for people to give feedback about and influence the service. These included meetings, forums, suggestion boxes and feedback forms.
- Staff facilitated a range of in-house groups to aid people's recovery. External organisations also attended the service and held groups for people. People were encouraged to access external support.

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

- There were various activities available at the service. However, some people felt these were lacking and not varied enough to meet their needs.
- There were no discharge and potential unplanned exit plans present in people's records.
- People using the service spent time in the staff room where personal information was kept and staff took phone calls. Some staff had previously raised concerns about maintaining confidentiality due to a lack of rooms for people and staff to use.

Summary of this inspection

Are services well-led?

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

- Managers did not investigate incidents to identify the root cause in order to prevent similar or further incidents. As a result, opportunities for learning from incidents was limited
- Monitoring and quality assurance systems were not effective in identifying areas for improvement and risks to people's health and welfare. The system for monitoring training and supervision had not identified the shortfalls in these areas. Risks to individuals using the service had not been identified.
- The risk register did not reflect all current known risks to the service. Where risks were identified,these were not always effectively mitigated in the safest way.
- The provider had recently introduced a number of new policies and updated some existing ones. These were not yet fully embedded and some were still awaiting ratification.
- Managers did not have and could not easily access information relating to people employed by the service.

Some of these findings constituted a breach of a regulation. You can read more about this at the end of this report.

However, we found the following areas of good practice:

- Staff were aware of and worked in accordance with the visions and values of the service.
- The service had continuity plans to provide information and guidance about what would happen in the event of service disruptions

Detailed findings from this inspection

Mental Health Act responsibilities

Phoenix futures residential service does not admit people who are detained under the provisions of the Mental Health Act.

Mental Capacity Act and Deprivation of Liberty Safeguards

Training in the Mental Capacity Act 2005 and associated Deprivation of liberty safeguards was mandatory for staff. Only seven out of 19 staff had completed this at the time of our inspection.

A Mental Capacity Act standard operating procedure had been introduced in February 2016. The service manager and program manager were not aware of this procedure or the resources available within this for them to use. They said it would not be their role to assess capacity.

Staff said if a situation arose where they felt someone lacked capacity they would refer the person to their GP. Although staff would seek guidance, this demonstrated a lack of understanding and confidence about their own responsibilities in accordance with the Mental Capacity Act.

No one at the service had a Deprivation of liberty authorisation in place.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

The environment was generally clean and tidy. There was some evidence of wear and tear in areas, such as scratched and worn furniture. The premises were in the process of being refurbished and we saw a plan for scheduled maintenance work. The top floor of the main house had recently been completed as part of this work. The service leased the building from a housing association who were responsible for most repairs. Staff kept a maintenance log of repairs that were needed. The service was subject to necessary regulatory checks from external bodies such as the fire service and environmental health office.

Staff completed various environmental checks dependent on their level of health and safety training. A health and safety manager took ownership to ensure these were completed.

Checks of the building included legionella testing, fire alarm and emergency lighting tests. Windows had restrictors in place for safety purposes. Permament staff had completed heath and safety training. It was not possible to establish whether sessional staff had completed this due to a lack of information held at the service.

People using the service helped to clean the premises and we saw completed cleaning schedules. People said the environment was safe, clean and hygienic. Some equipment was broken and not in use. This included a television, a speaker on the music system and one of the two pay phones. People said these had been reported and staff were aware of the faults.

The service's website advertised 'separate male and female accommodation.' There was no separate accommodation at the time of our inspection. Staff said that at times the annex had been used for females only. They said the layout of the main building made it difficult to have separate areas. Most bedrooms were shared by two to four people of the same gender. There were several bathrooms people could use all of which were accessible to both males and females. No rooms at the service catered for female only access. The operations manager said they were looking to use the annex as female only accommodation in the future.

There was a policy dated April 2016 for assessing and managing suicide risk. This said a ligature point risk assessment must be completed quarterly to identify any potential ligature risks. No assessment had been completed at the time of our inspection. In three care records we looked at, people had expressed previous suicidal ideation. Without a ligature risk assessment, there was no guidance for staff about risks present and what actions were required to help maintain safety.

Bedroom doors were kept unlocked at all times and people had no facility to lock these. No-one expressed any concerns about this. However, the results of a feedback survey from September 2015 included several comments from people about improvements in room security and items going missing. People had lockers in their bedrooms where they could store personal items. Senior manager said doors were not lockable to promote therapeutic community living and that people were told about this prior to admission. Access to bedrooms was restricted to specific hours. However, we saw people in bedrooms unaccompanied outside of these times. The 'assessing suicide risk 'policy stated that 'reducing and monitoring access to any potentially harmful objects' should be considered for individuals with suicidal ideation. People kept items such as razors in their rooms. There was no evidence risks had been considered about unlocked bedrooms and possible impact on people's safety and security. This meant that people may be exposed to potential avoidable harm.

Substance misuse services

There was a 'client and property' search policy. Staff searched people and their property upon admission to the service. People were asked and had to consent before staff were able to carry out any search. Staff also searched people where they had suspicion they may have illicit items, such as drugs or alchol and other prohibited items.

We found poor infection control practices in operation. Staff used breathalysers to test for alcohol. A staff member said the mouthpieces were reused and sterilised before next use. There was no reference to this practice in the infection control policy. The manufacturers' guidelines stated, 'A new mouthpiece must be used for each complete breath test'. This meant the breathalysers were not being used in accordance with how they were intended and to promote good infection control practices. Urine testing for drug screening was undertaken in an upstairs toilet in the main building. The nearest handwashing facilities were across the landing in a separate room. The bin for disposal of the tests was on the ground floor in the care team office. This meant that staff were not able to wash their hands immediately before and after conducting the test and they had to transport used materials some distance in order to dispose of these. This process increased the risk of the spread of infection.

Safe staffing

Disclosure and barring service (DBS) checks were mandatory for all roles where staff may come into contact with people using the service. These were in place prior to staff working unsupervised. Checks were renewed every three years as good practice.

There were 13 substantive staff and seven sessional workers employed at the service. Sessional workers were staff who worked as needed such as when there were staff absences. There were no vacancies at the time of our inspection. The program manager told us staffing levels were based on maximum occupancy and remained the same despite the number of people. Staffing for Monday to Friday daytime consisted of four therapeutic workers. Three of these worked from 9 am until 5 pm and one from 1 pm until 9 pm. One care worker worked 9am to 5pm. The program manager, service manager and three administration staff worked Monday to Friday 9am to 5pm.

On weekends there was a reduced complement of staff of one therapeutic and one care worker to cover the day shifts. The program manager told us there were fewer groups at the weekend which meant fewer staff were needed. Data from the service stated a total of 83 shifts had been covered by sessional staff in the three months period ending 2 March 2016. This showed they worked regularly at the service.

One care staff member was rostered as sleeping staff to cover nights. They worked between the hours of 6pm and 9.30am. The hours of 11 pm until 7am were scheduled as sleeping hours. They slept in the main house. There were no emergency alarms or call bells for people to use. People alerted the staff member by calling them from a phone in each building if they needed assistance. There was an on-call rota system whereby a local manager was available throughout the night to attend the service if necessary. There was also a senior a manager available throughout the night to provide advice and guidance. There was a lone working policy and staff carried a mobile phone to use in the event of an emergency.

A staff member said if anyone needed support at night, staff would also ask another person using the service to help provide extra support. This would be a senior person who was in the advanced stages of their treatment. They said that seniors expected this as part of their role. This was not specified as a duty in the 'house roles' which gave a description of tasks that each stage was expected to do. It was not clear what the rationale for people to help staff with such tasks at night was. We were not satisfied that this practice would aid the person's treatment and recovery as opposed to acting as extra support for a lack of staff at key times.

One person told us that often one to one key work sessions were cancelled due to a lack of staff. The procedure for cancelled sessions was that staff would reschedule these to ensure they took place within required time frames. Four comment cards expressed concerns with staffing levels. These said at times people could not access activities and attend appointments due to a lack of staff. Two comments said staff had a high workload which put a greater reliance on the people using the service to help run it. People at the focus group said they had often had to provide support to staff. They hoped this would improve now a new manager was in place. People said staffing was affected if someone absconded or required hospital treatment.

Five volunteers helped at the service who were also subject to disclosure and barring service checks. They did not

undertake any care staff duties. Managers said extra staff could be used if it was felt people's needs warranted this. A staff member could be used as a 'stand by' which meant they were on hand to assist at short notice.

Not all staff had completed all their mandatory training. Mandatory training incorporated a number of subjects. These included fire marshal training, first aid, safeguarding, infection control and medication administration amongst others. The compliance rates provided by the service were not accurate when we checked this against records. For example, 100% compliance was shown for medication administration and fire marshall training but this was incorrect as not all staff had completed or were current with this training. There were shortfalls in key areas. Only 39% of staff had completed first aid training and 28% had yet to complete infection control and safeguarding training. Rotas for the period of January to April 2016 showed four staff, including sessional workers, regularly worked as lone night workers. None of these had completed first aid training with the service. Three had no fire marshall training and infection control training. Two had not completed safeguarding training.

Two lone workers had not completed medication training until several weeks after they showed on the rota. We saw evidence they had administered medication to people during this time, therefore without suitable training. Managers said all staff administering medication had received training. The evidence we were shown for the workers in question was their own signature on a document in a medication file, one staff member had signed in November 2012 and the other in April 2015. There was no record of anybody assessing them as being competent to administer medication until December 2015. Therefore we could be assured that staff members had received suitable medication training before administering medication. The program manager acknowledged there were gaps in training. This demonstrated that staff deployed did not always have the necessary training to help maintain the safety of people.

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

Managers and the prescribing doctor said they would not admit anyone who was high risk and needed a level of support that staff could not provide. The GP and staff told us if it became apparent the service was not suitable for people due to their level of risk they would refer them elsewhere.

Staff completed a risk assessment and management plan for each person at the service which we saw in care records. This was completed at their initial assessment. The current risk assessment tool was designed to capture risk information in a number of areas. These included mental health, forensic history, neglect, physical health and family.

We saw instances where risks were not always captured and reviewed. For example, one person had a risk management plan completed in December 2015 prior to their admission in February 2016. The next risk assessment and management plan evident was completed 25 April 2016 which was almost eight weeks after the person had been admitted. During this period the person had self-harmed several times, expressed suicidal ideation and had absconded. The risk assessment policy said risk assessments should be updated in response to any changes or incidents. The person's risk assessment had not been reviewed in response to the incidents. No changes had been made to the risk plan as a result of any of the incidents.

Two other people's records had information documented from the agency that referred them which highlighted concerns around their physical and mental health. These concerns were not recorded in their risk management or recovery plans. This meant there was no guidance in place as to what support people needed in these areas which could put their health and welfare at risk.

There were no emergency drugs on site and no risk assessment had been completed to establish the need for any. Staff were instructed to seek assistance from the emergency services in the event of a medical emergency. The service had recently acquired an automated external defibrillator. All staff had received training in the use of this.

Regular 'check ins' took place throughout the day to monitor where people were within the service. A senior person using the service manned the reception desk and kept track of where people were. This enabled staff to know where people were at a given time. Managers said they could undertake extra checks and observations of people if they felt this was warranted. This would be discussed and decided at staff handovers.

Substance misuse services

The service had a safeguarding adults and a safeguarding children policy. Both of these were under review at the time of our inspection. Safeguarding adults training was mandatory and provided both face to face and e-learning. Not all staff had completed this. We saw no evidence that staff had completed safeguarding children training. The service manager and program manager had completed safeguarding training with the local authority. Staff said they knew how to make referrals and could recognise abuse. They told us that safeguarding was discussed in team meetings and we it was included as an agenda item in team meeting minutes. The service manager was the safeguarding lead and kept a tracker of all safeguarding incidents. There were no safeguarding matters being investigated at the time of our inspection that related to the service. Information about safeguarding was on display for people around the service and included in the welcome guide.

We reviewed the provider's medicine management arrangements. Prescriptions and administration records we checked for three people were completed accurately. Staff checked people's medicines on admission to the service by contacting their GP. This helped to ensure people received the right treatment. Medicines were stored securely with access restricted to authorised staff. The service held stocks of controlled drugs which are medicines that require extra checks and special storage arrangements because of their potential for misuse. These were managed appropriately.

Fridge temperatures had not been recorded in accordance with national guidance. Only the current temperature had been logged as opposed to the maximum and minimum. The service also had the incorrect temperatures recorded in their policy for refrigerated medicines to be stored at. If medicines are stored at incorrect temperatures, this can affect their efficacy which in turn can impact upon people's treatment and safety.

Staff stored and administered medicines from an office. People queued up outside the office at medicine times. Staff experienced frequent interruptions from knocks on the door and the telephone ringing, both of which increased the risk of administration errors. Medicines were administered at four set times throughout the day. This did not always meet people's needs. For example, two people raised concerns about the inflexibility of medication administration times. One said they did not have a certain medication administered to them with regard to food. We saw that this person was prescribed a medicine which should have been given 30 to 60 minutes before food. This medicine had been given after the person's breakfast on four occasions in May 2016 because the administration time was scheduled after breakfast. This had potential for medicines not to have their desired effect. People said morning and evening administration could take up to two hours at times which could cause delays in routines, such as people wanting to go to bed.

Track record on safety

One serious incident had occurred within the last 12 months. This was an assault by one person on another at night. The service manager and staff had taken action after the incident to maintain the safety of the victim. The incident was reported to the Police and the relevant local authority safeguarding teams.

The incident was discussed in a clinical governance sub-committee meeting five months after it had occurred. It was then discussed again at a later meeting following an investigation report by the head of quality. Learning included the incident policy being amended to allow for more robust investigation of incidents in future . This was due to the finding that not all relevant staff had been interviewed by the manager at the time of the incident. The investigation report said attempts had been made to segregate sleeping accommodation for males and females but that this was not possible due to the number of people and the layout of the building. The investigation did not fully address factors that may have contributed to the incident. For example, there was no evidence of any review of the environment, systems, working practices and protocols to determine if any changes were required. We could not be assured that all necessary consideration had been given to reduce the risk of such incidents recurring. Some staff we spoke with were aware of the incident but not of any feedback or learning from it.

Reporting incidents and learning from when things go wrong

There was a system for reporting incidents though this was not always effective in practice. Staff reported incidents via incident review forms. These were then sent to the quality team and the service manager. The quality team kept a

central incident log. Significant and serious incidents were discussed in clinical governance meetings. The program manager told us debrief sessions took place following incidents and via staff supervisions.

Not all incidents had been reported and added to the central log. For example, one person had three incidents of self harm in March and April 2016 but only two were reported as incidents. There were two incidents documented in the service's 'duty book' in May 2016 that met the reporting criteria. No incident forms had been completed for these.

The service manager was responsible for updating the log with recommendations and learning points. The majority of incidents had been reviewed afterwards and some action points identified. However there was no evidence that efforts had been made to determine the initial cause of incidents, especially where these were recorded as severe. For example, we reviewed the recording and reporting of one recent serious incident involving medicines. Whilst descriptions of the incident and immediate actions taken were comprehensive and appropriate, a full investigation had not been carried out to identify the cause. There was no evidence this had been discussed or shared with staff in order to try to prevent similar incidents. No formal analysis of incidents overall was undertaken to look for themes and trends.

Team meetings were held each week. Serious incidents were an agenda item and we saw evidence of staff discussion around these. However, we could not be confident that learning from incidents was comprehensive and meaningful due to the lack of investigation of these and the omission of some incidents.

Duty of candour

The service did not have a duty of candour policy. Duty of candour was referenced in the provider's updated serious incident policy. Reviews of recent incidents documented whether duty of candour had been followed. Staff said they were open and transparent with people when mistakes had been made.

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

Assessment of needs and planning of care

People had an assessment prior to their admission to the service. This incorporated information from the person's own GP about their physical and mental health. Information from the referrer contributed largely to assessments. Staff would then compile a pre-admission risk assessment and management plan.

For people requiring a detox at the service, the prescribing doctor made determination as to whether the person was suitable for treatment. They said they would not admit anyone who needed a level of support that staff could not provide. For example, people with complex mental health or physical health needs. Draft protocols the doctor was completing with the service had clear exclusion criteria documented which would help improve consistency.

The doctor said if they had concerns about a person's mental health during the assessment process they would communicate this to the person's own GP so they could take appropriate action. The doctor did not complete any physical checks as part of their assessment as they felt these were not required for their input. They would expect the person's own GP to have completed these if needed. Staff did not undertake any physical health checks of people. People registered with a local GP practice for the duration of their stay to meet their healthcare needs outside of substance misuse treatment. Staff told us they had a good relationship with the local practice who booked out a full morning each week to dedicate to people using the service. People could be seen outside of these times if required.

The prescribing doctor's medical assessments were not kept at the service with people's care records. The doctor kept their own assessments and faxed a summary to the service. Therefore staff did not have access to full details of people's assessments. Without this, there was a risk staff would not be aware of necessary information they needed to know about people. Both the doctor and the service manager said they were looking to combine these records in the near future.

Information in some care plans about treatment and support was of poor quality. The admission policy said drug and alcohol dependence levels must be assessed prior to admission. In two of the records we checked, there was no information to show this had been assessed. The majority of recovery plans were generic with a lack of person centred information present. In some cases, objectives that had been identified gave no information

about how staff would support the person to achieve these. For example, where people had goals such as to address their mental and physical health the action was to 'refer to GP' with no other information present. We did see one care plan which was personalised and included clear objectives. Some plans did not include information that had been identified in the initial assessments. This meant it was not clear how people were being supported in these areas. People used the 'outcome star' to assess their progress towards recovery. The outcomes star both measures and supports progress for people towards self-reliance or other goals.

Some care records had omissions which meant we could not see what support people had received. For example, one care record had no entries recorded for a six day period. Another person's had seven instances of gaps between September 2015 and March 2016 which ranged from three days to thirteen days. One person had no key work sessions present for a three month period. A staff member told us entries were missing from daily notes as significant things relating to people were recorded in the handover book. Information recorded in the handover book was not documented in relevant people's care records. The staff member said there had been "slip ups" where daily entries had not been made. This meant accurate records of care and treatment people received were not always present.

Some documents in care records did not contain the name of the person they related to and was not signed or dated. If the document get separated from the file it would be difficult to see who the information related to, who had completed this and when it was from. It also meant in some cases we could not confirm people had agreed to their care plans. Staff signatures were not always legible where there was no printed name. Information was incomplete and incorrect in one risk assessment we looked at. One entry said the person 'takes medication beginning with s.' It also contained entries about a significant life event which related to a different person. The lack of correct information meant the person may not receive support in accordance with their needs.

Best practice in treatment and care

The service operated a therapeutic community model. A therapeutic community is a participative, group-based approach to addiction. The structure of the day and different activities are deliberately designed to help people's health and well-being.

Therapeutic workers facilitated a variety of groups for people to participate in. These included relapse prevention groups, gender groups and encounter groups. The psychological therapies within the groups and key work sessions based on guidance recommended by the National Institute for Health and Care Excellence. This guidance recommends motivational interviewing, cognitive behavioural techniques and solution-focussed therapy which is what the service offered.

The encounter groups were used for people to highlight and discuss their own issues or to challenge other members of the community. We observed an encounter group, with permission from the people in attendance. The purpose, aims and objectives of the group were set out from the start and people contributed to these. People were respectful but challenging in a meaningful way and encouraged one person to view their behaviours. One person told us the structure and groups on offer were very beneficial. They said if people were 'fully signed up' emotionally to the program then they would get a lot out it.

The prescribing doctor was aware of and said they followed guidance from the National Institute of Clinical and Health Excellence so that their work was based on best practice. The doctor was in the process of developing protocols with the service to ensure consistent and evidence-based good practice. These were not yet in place and were in draft form at the time of our inspection.

Staff did not monitor alcohol withdrawal effectively and consistently. The service's medication and detoxification policy said 'alcohol clients will be measured using the clinical institute withdrawal assessment for alcohol (CIWA) on admission and then twice daily until the client scores zero twice in a row'. The clinical institute withdrawal assessment for alcohol is recognised by the National Institute of Health and Social Care Excellence as a tool for monitoring alcohol withdrawal. Staff told us that they used this tool however none had received any formal training in how to use this. Some said they had been shown by another staff member. Staff did not have the means to take physical observations, such as blood pressure, which was required to accurately complete the assessment tool. This

meant the information would be incomplete and possibly inaccurate. A staff member told us assessments of withdrawal were recorded in the duty book. We saw no evidence of these in the duty book and they were not present in people's care records we looked at.

The prescribing doctor said that whilst the clinical institute withdrawal assessment for alcohol may be useful for staff to monitor people's withdrawal, they would not use findings from these to influence their treatment of people. The doctor said they were satisfied with how staff supported people and said there was a strong buddy system which provided necessary therapeutic support. Although the buddy system was valued, other people in using the service acting in this role would not necessarily be aware of, or responsible for, assessing people's wellbeing during detox.

Staff did not use an assessment tool to monitor people's symptoms during an opiate detox. They told us they would observe people, take into account self reported symptoms and seek medical assistance for people where required. Staff said they were aware of symptoms associated with detox to look out for and this information was available in the medication and detoxification policy.

There was no clear rationale about why the service expected the use of clinical assessment tools for alcohol withdrawal which were not taken into clinical consideration. Similarly, there was no rationale in place to warrant why the service did not use recognised tools and follow best practice for opiate withdrawal. The lack of formal and consistent monitoring during detox withdrawals meant there was a risk that people may not receive suitable and safe support.

Staff did not complete nutritional assessments to assess for risk of malnutrition. This meant it was not apparent whether people needed any support in this area.

Staff participated in regular audits. The majority of these had been completed by the program manager and another member of staff who had been acting up into a more senior position during the absence of a service manager. They completed regular audits of medicines. Care records had recently started to be audited. The program manager said the results of audits were shared for staff to action where shortfalls had been identified. We saw evidence in file audits where the actions identified had been addressed.

There were arrangements for people to access medical care. No clinical staff worked at the service but people had access to the prescribing doctor in relation to their substance misuse. The doctor had completed the Royal College of General Practitioners certificate in substance misuse, parts one and two. They had regular annual appraisals to assess their competency in relation to substance misuse. The service was unable to provide information about their assurance of the GP's revalidation at the time of our inspection. Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practise. They subsequently advised the GP had been revalidated in June 2015.

The prescribing doctor attended at least twice a week and said they would review all patients detoxing twice a week. They lived nearby and could be responsive outside of these times, for example if staff wanted them to see someone as a priority.

New staff were subject to a six month probation period and an induction into the service. A staff member told us they had completed a period of shadowing another staff member when they commenced employment. New starters had an induction workbook that had recently been introduced which they completed to help monitor their progress. We saw one of these workbooks but there was little information within this. It was not clear the workbook was effective in identifying and monitoring training needs.

Staff told us they had regular supervisions and we saw evidence of these recorded in substantive staff member's files. Ten out of 13 staff had received an appraisal within the 12 months prior to our inspection. The remaining three had joined the service within the last 12 months and were due to have theirs in the upcoming months. Staff new in post were managed in accordance with the probation policy. However, regular sessional workers and volunteers did not have formal supervisions or appraisals. The program manager confirmed this and said support was provided on an informal basis but not recorded. As such, there was no means to identify and record how these workers and volunteers were progressing and areas for further development. A volunteer told us they would find supervision useful as it would help both them and the service to establish that they were meeting each other's expectations.

Skilled staff to deliver care

There were various training courses, besides mandatory subjects, that staff could access. These were identified on an individual needs basis via supervisions and appraisals. Training topics set out in the provider's 'job roles and training requirements' program included subjects such as motivational interviewing, managing challenging behaviour, professional boundaries and harm reduction some of which staff had completed. Substance misuse training was listed as 'organisational training' for therapeutic and care workers, therefore what the provider expected staff to have. None of the staff had completed substance misuse training at the service although several had completed training in this area external to the service. Many staff had relevant skills, qualifications and experience which they had obtained prior to working for the service. However, there was no assessment of what specialist training each staff member needed in accordance with the service's own requirements. As such, we could not determine that all staff had relevant specialist training designed to meet the needs of people using the service. Mental health awareness training was not a requirement, despite many people using the service having mental health issues, but was included in the subjects staff could access.

Depending on their nature, staff performance issues were addressed by way of supervisions. There were processes in place for where matters needed to be escalated or addressed directly by the human resources team.

Multidisciplinary and inter-agency team work

There was evidence of multidisciplinary involvement and joint working. Most people had care co-ordinators and we saw information from these in assessments and referral information. Information was present from people's doctors, family and other relevant professionals. The program manager said it was not always possible to have regular meetings with other professionals. This was in part due to the fact that people were admitted from all areas of the country which made it geographically difficult. However, staff told us and information showed, that relevant professionals were involved in people's care where necessary.

The service had good working relationships with other organisations. We received feedback from three stakeholders who had involvement with the service. One felt the service was good but that staff were sometimes slow at passing messages on. However another said staff were quick to respond. They spoke highly of the service and said staff liaised effectively and kept key people up to date with any concerns or risks. Another stakeholder gave a positive example of successful joint working with the service.

Narcotics Anonymous and Self Management and Recovery Training (SMART) groups attended the service to facilitate groups twice a month. People were encouraged to attend support groups whilst in the senior stage of their program. The service also had good links with the local 'improving access to psychological therapies'' team and voluntary support services. Females using the service had opportunities to attend events at a local service which ran a variety of women only groups.

An independent charity called Phoenix Association worked closely with, and provided support, to people using the service. The charity consisted of people in the local area who fundraised in order to provide grants for people. These could be used for pursuits such as sports and education as well as helping to contribute to events at the service.

Staff handover took place three times a day at each shift change. An administration worker attended morning handover to keep up to date with on-going issues. We attended a handover at 1pm. The service manager was present at the handover with support staff. Staff had an in-depth discussion about one person who had a condition that had not been evident on their referral information. Staff agreed an action that further information was required from the person's GP. Staff discussed new admissions and people's support needs around these as well as one person who had left the service. Although we observed detailed discussions around specific individuals, not everyone was mentioned in the handover. The service provided us with handover notes for several days prior to the inspection. These did not include information about all people but did highlight where actions were needed with regard to individuals as we had observed. As such, it was not possible to get an oversight about all people at the service, even if this was to highlight there were no concerns.

Good practice in applying the MCA

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves.

Substance misuse services

The service had recently introduced mandatory training in the Mental Capacity Act and associated Deprivation of liberty safeguards. Thirty nine percent of required staff had completed this training at the time of our inspection. A Mental Capacity Act standard operating procedure had been introduced in February 2016. This provided information about how capacity should be assessed and provided documentation staff could use to assess capacity. Senior staff we spoke with were not aware of this procedure or the resources available for them to use. Staff felt it would not be their role to assess capacity. They said if a situation arose where they felt someone did not have capacity they would refer the person to the GP. Although staff would seek guidance, this demonstrated a lack of understanding and confidence about their own responsibilities in accordance with the Mental Capacity Act.

We saw signed agreements in care records where people had consented to receive treatment at the service. Agreements covered a number of areas such as the rules of the service, visitor's arrangements, media usage and consent to share information. People confirmed that they signed contracts at the beginning of their care. However, most felt this was too soon as they could not process information or remember what the contracts said. They did not receive a copy of the contract. This meant they may not be fully aware of what they had consented to.

No one at the service had a Deprivation of liberty authorisation in place. People knew they could leave the service if they wished to end their treatment. Staff knew they were not able to prevent people from leaving should they choose to do so. They said they would encourage people to stay in their treatment and explain the risks so the person could make an informed choice.

Equality and human rights

The service had an equality and diversity policy. The majority of staff had completed equality and diversity training. We saw information available for people's protected rights. For example, there was information on display for lesbian, bisexual, gay and transgender support. There were people from ethnic minorities both employed and using the service. Staff received information about people at the time of referral to ascertain whether adaptations were needed to ensure they had equal rights to access the service and not discriminated against. For example, people who had been homeless, had a forensic history and learning difficulties had used the service. A staff member acted as a lead for equality and diversity.

There were a number of restrictions in operation. Staff said these were designed so that people had structure and routine in order to aid their recovery. Restrictions included access to communal areas, access to watch TV and access to own rooms during certain hours. Mobile phones were not allowed. The service had two pay phones and people had could use these between 8.30pm and 10.30pm. People made requests for calls which were documented on a notice board. Authorisation was granted by staff who reviewed requests and determined if the call was allowed.

Staff said people were aware of the restrictions. They agreed to these when they consented to admission and accepted these as part of the treatment program. They said exceptions could be made to restrictions, for example to allow calls on an individual basis such as if someone had a family emergency or children. Only one person we spoke with during the inspection expressed dissatisfaction with the restrictions. They felt there was little time to 'chill out' alone due to not being allowed in their room until 8.30pm. In the results of a feedback survey the service undertook in September 2015, several people commented they would like to be able to access their rooms outside of the restricted times.

Management of transition arrangements

People transitioned through the service as they progressed with their recovery. There were set measures and markers of achievement for each stage of recovery and information about what was expected of people. The level of integration and responsibility for people increased as they moved through the stages. New people on admission were initially assigned to the Welcome House and spent between four to eight weeks there. They then moved onto primary stage one and two where they spent between 12 and 22 weeks. The final stage was the senior stage where people spent a minimum of 10 weeks.

People were transferred and referred to more appropriate organisations if it was established the service could not meet their needs. There were occasions of females being transferred to female only services where it was felt such an environment would be more beneficial. The provider was a registered landlord and had their own supported living

accommodation. Some people who had completed the program moved onto this supported housing once they were discharged. The provider was looking to increase their provision in supported accommodation.

Are substance misuse services caring?

Kindness, dignity, respect and support

Staff displayed positive attitudes and behaviours during their interactions with people. Feedback from the latest service user satisfaction surveys undertaken in September 2015 included positive comments from people about how staff supported them. All of the 21 comments cards we received during our inspection contained positive feedback about staff and the service. People described the staff as 'friendly', 'great', 'fantastic', 'brilliant', 'caring' and 'supportive.' An external stakeholder said staff were caring, respectful and honest. The majority of recorded compliments were thanks to staff from people using the service. The compliments weremainly for their support, advice and encouragement.

All of the people we spoke with told us staff were respectful and treated them with dignity. They felt staff helped them with their needs, listened, and supported them in their recovery. People said many staff had been through the program themselves in the past which meant it was easier for them to understand what they were going through. They felt staff helped them get the best out of the program. One person told us about their personal situation and said staff had gone above and beyond in providing support to them and helping them with a number of challenges they were facing. New people were allocated a 'buddy' on arrival at the service. The buddy was a senior person using the service. The buddy acted as someone they could turn to and receive support from.

Although no one raised it as an issue during our inspection, the fact that people were not able to lock their own doors had potential to impact on people's privacy. There was no separation of sleeping accommodation and bathrooms for males and females. This could also compromise people's safety and dignity.

The involvement of people in the care they receive

People told us they had received information about the service prior to their admission. Some received information from their care manager or via the telephone and the internet. Several people said they had participated in a tour and talk before they were admitted to the service to see if it was the right provision for them. People had found this useful as it provided insight about what to expect. Some had taken family members along to support them. Former service users sometimes attended other locations to tell people about the service when they were not able to visit themselves.

People received a welcome guide and there was a manual explaining the structure of the service and how a therapeutic community worked. These helped people be aware of what they could expect. People signed a contract at the start of their admission agreeing to their admission. Although people told us they received information and explanations about how the therapeutic community worked, some said they felt this did not always prepare them for the experience.

Each person was allocated a keyworker who they had regular one to one time with. The keyworker helped the person to compile their care plan. All people, except one, we spoke with told us they had copies of their care plans and that their keyworkers reviewed these with them. One person told us they had reviewed theirs two weeks prior to our visit.

No-one at the service had an advocate at the time of our inspection. Staff said they could signpost people to advocacy services if people required support in this area.

People had opportunity to give feedback about the service and were involved in decisions to influence how it ran, for example by being part of recruitment panels for new staff. There was a service user council which was made up of people who had lived experiences of using the service. They met with the service user involvement lead on a regular basis. Their key responsibilities were to support service user representatives in each service and host forums. Service user council members had recently been involved in road shows with senior managers. Three senior people using the service were service user representatives. They met every two weeks without staff to discuss any issues people wanted to raise. They then met with staff on monthly basis with an agenda so that problems or concerns could be addressed where appropriate. Satisfaction surveys were sent out twice a year. The latest ones we saw had been completed in September 2015.

Substance misuse services

There was evidence of improvements being made from these. For example, some people felt that pre-admission information was too lengthy. As a result, the service user council had reviewed this and produced a new document.

There was an initiative called 'Families and loved ones accessing support' (FLAMES). These were groups to help support families and friends of people using the service. These were created to help them understand the service and to help support the person. The groups met every two months. A therapeutic worker at the service facilitated these.

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

Access and discharge

There were 25 people using the service at the time of our inspection out of a capacity of 36 the service could accommodate. Most referrals were made by care co-ordinators in the community. The service also accepted self referrals and people who were privately funded. Referrals were accepted on a national basis. The program manager told us that the provider was looking at initiatives to increase the amount of referrals as these had slowed down recently.

In the six months prior to our inspection there had been 27 new admissions. In the same period, 3% of admissions were recorded as incomplete, 51% had transferred and 46% completed their treatment. The average length of stay in the 12 month period prior to the inspection for people was 124 days.

The service accepted people who required detoxification at the start of their treatment as well as people who had been through that process and needed rehabilitation and support. There was no set number of people the service would accommodate for people completing a detoxification. Managers said this would be balanced against the mix of people already present so as not to disrupt the dynamics by admitting too many people who needed extra support. They felt this could impact upon other people and their recovery so would avoid this. People were admitted any day of week but not weekends.

People requiring a detox were seen in person by the prescribing doctor as soon as they were able. People who had completed a detox at the service told us they had seen the doctor within one day of arriving.

Eighty six people who used the service had been discharged in the 12 months prior to February 2016. The service did not routinely follow up people once they had been discharged as their care manager took responsibility for this in most cases. People we spoke with told us discharge plans changed often. A stakeholder told us that although staff could provide details verbally about discharge, there was sometimes a delay in getting written discharge plans. The program manager told us discharge planning was discussed with people straightaway. Where appropriate staff would encourage people to look for properties and accommodation for when they had completed their treatment. There was no evidence of discharge information in people's care records.

The program manager told us about the protocols staff would follow where people absconded or left the service unplanned. However, there was no information about what individual support people would need with regard to unplanned exits. This meant that where people chose to exit the program early there was no guidance for staff about what support they would need.

The facilities promote recovery, comfort, dignity and confidentiality

There were several rooms available around the service that people could use and spend time in. In the main building there was one main lounge with a TV. People were restricted to how and when they could access this room and watch TV. There was also a 'snug' area which was a smaller room for people to use outside of restricted times. This contained a music system and a pool table. Staff said the restrictions were in place to encourage people to be involved in groups and to participate in the community. The rooms were used to host various therapy groups which also restricted their use. There was a large dining room where people dined together. We saw people spent time in the reception area where one senior person worked at the reception desk to keep track of where people were. There was a separate building called 'squirrel's lodge' which housed several computers. People could book time to use the internet. People were able to personalise their areas in their bed room, for example we saw some people had photos on display. People had access to storage for

personal possessions. There was access to outside space, gardens and areas where people could go to smoke. There were no dedicated rooms for people to have private visits but they told us they always had areas to speak with staff and visit family in private.

People's care records were kept in a locked cupboard in the main staff office. We did not hear staff talking about confidential information in front of people using the service. We saw some people using the service spent time in the main staff office. Care records were in a locked cupboard in this office however there was potential that people may hear or see personal information. Staff had also raised this as a concern in a team meeting in March 2016. Some staff had said the logistics of rooms available to people and staff were an issue. Staff highlighted difficulties experienced in maintaining confidentiality and privacy during busy times and times of crisis. They had expressed concerns about the appropriateness of this. The program manager was unaware that this had been raised as an issue.

The two pay phones were each located at the top of a flight of stairs. They were not in a private area as the stairs were used by people and staff to access bedrooms. The program manager told us people could also make calls from the staff office on occasions. The service did not have a clinic room. Staff did not undertake any examination of patients. The prescribing doctor would see people in private areas.

People had mixed comments about the frequency and suitability of activities on offer. One person said activities tended to be quite 'last minute' and did not always meet people's needs due to a lack of forethought. They said there was a lack of variety in the types of activities staff provided. Two people felt Welcome House was 'boring' as they said there were fewer activities on offer. Activities on offer included yoga and reading groups. People could attend a local university to take part in swimming and circuit exercises. Some people had commented in the latest service user meeting that swimming had not been happening regularly. The service was looking to increase the number of volunteers it used so they could help facilitate more activities.

People in the more advances stages of their treatment were able to have visits to town at weekends. Staff facilitated a group called 'recovery through nature'. This was an initiative to help aid recovery. It involved people working as a team on practical conservation projects and undertaking tasks such as dry stone walling. Several people went off site to take part in this group during our inspection.

People were involved in food preparation including menu planning, cooking and service of meals. The program manager told us people had food hygiene training and advice. We saw that meals looked appetising with plenty of choice available. No one had any complaints with the meals provided.

Meeting the needs of all people who use the service

Due to the current structure and layout of the building, there was limited access for people with physical disabilities. The rooms in the main house were on three levels. There were several flights of stairs which meant people with mobility issues would find it challenging to get around. Wheelchair users would not have been able to access the premises. As the building was not owned by the provider, there were limitations to any modifications they could make. The service did not accommodate anyone with significant mobility limitations due to the access restrictions.

The separate annexe had an accessible room for people with mobility needs. There was a lounge, kitchen area and wet room on the ground floor. Staff said people with mobility or health issues that would make sleeping in the main building a challenge, would be accommodated in the annexe.

There were leaflets and notices on display to provide advice to people as well as information about services they could access. This included information about psychological therapies, bereavement, self help guides, alcohol and drug support services and physical health information. Staff said they could access interpreters if needed. The service could accommodate people's cultural needs. One person at the service required food to be provided in a certain way in accordance with their religion. The program manager told us they had worked with kitchen staff to ensure the person's needs were accommodated. One person we spoke with told us they attended Church. There were prayer mats and religious texts people could access. Staff said people would be allowed time for religious observances such as prayers if required.

Substance misuse services

Listening to and learning from concerns and complaints

People were aware of how to make complaints. They said they would firstly go to a staff member or could use a confidential complaints box. There were also avenues to complain via service user involvement representatives and community meetings. People said they would escalate complaints higher up if they felt this was warranted. One person had recently made a complaint directly to the manager. They felt this had been dealt with appropriately and quickly resolved.

The complaints and compliments process was included in the welcome guide. This included timescales for dealing with complaints, stages of the complaints process and how to appeal the outcome to head office. It included contact details of the Care Quality Commission as an avenue whereby people could take their complaint. Although the Care Quality Commission receives information about services, it does not have the power to investigate individual complaints for people. As this was not clear in the text, it could lead to unrealistic expectations for people about how their complaint may be managed. No information was included about people's rights to complain to the ombudsman service and this was not included in the complaints policy.

No complaints were being investigated at the time of our inspection. The service made distinctions between formal and informal complaints. Informal complaints were resolved at a local level and people had the option to escalate these if they wished. One formal complaint and nine informal complaints had been made in the 12 months prior to our inspection. None of these had been escalated to the ombudsman. A complaints tracker for the service was used by the manager. This showed complaints had been addressed with learning identified. Apologies had been made by staff to complainants and actions taken to address the nature of the complaints where needed.

In the same period, four official compliments and 113 unofficial compliments had been recorded. Details of these were read out in meetings, the majority of which were people thanking staff. This showed that both positive and negative feedback was shared between people using the service and staff and was used to make improvements where necessary.

Are substance misuse services well-led?

Vision and values

The service had visions and values that they expected staff to share and promote. These were; '**We believe in being the best', 'We are passionate about recovery' and 'We value our history and use it to inform our future'.** Staff we spoke with were positive about working at the service and aware of the visions and values. One senior staff member said it was a special place to work and described the people as being 'Phoenix people'. Staff took pride in working at the service and wanting to improve. The visions and values of the service were on display for people to see.

Staff knew who all of the managers were and senior managers at organisational level spent time at the service. Managers at the service told us that senior managers were 'hands on', knew people individually and were supportive.

The chief executive held annual roadshows each year throughout the country. All staff had to attend one of these and people using the service were facilitated to attend also. The purpose of these was to give the executive team a chance to meet staff and people and discuss the strategy and priorities for the organisation. The roadshows gave people and staff an opportunity to contribute and be involved in the future of the service.

Good governance

Managers had systems to document staff training, supervisions and assess staffing levels. However, not all shortfalls and gaps had been identified and addressed. There was no effective monitoring of what mandatory training staff had completed to ensure staff had the necessary skills to meet the needs of the service. Substantive staff received supervision and appraisal but this was lacking for sessional and voluntary staff. We were told staffing levels had been considered for maximum occupancy but there was no rationale to determine how these levels had been decided to ensure they were safe.

Managers did not have access to necessary information about staff employed at the service. We asked for training details of two sessional staff members. The program manager told us this was not kept on site and they would have to request this from the staff members themselves. There was very little, if any, information present for people

who were not substantive staff. We were not able to confirm at the time of our inspection that these staff had disclosure and barring checks. We did subsequently receive this information.

The service had introduced a number of new standard operating procedures that staff were expected to implement and follow. Not all staff were familiar with the information within these. A number of policies were still awaiting sign off at clinical governance level. Several protocols were still in draft stage. These included updated protocols for support of people detoxing from alcohol and opiates.

There was an environmental/operational risk register for organisational risks but this did not reflect all current risks to the service. It was not apparent of when the risks had been identified. This meant we could not be sure how long the risk had been present and therefore what progress had been made. It had last been reviewed in May 2016. Some known risks were not included on the register. There was no information about doctors' assessments not being present in people's care records despite this being acknowledged by senior staff as a risk. Some risks did not have effective mitigation. For example, one risk was an inadequate amount of first aid trained staff. The plan was for all staff to have training by the end of July 2016. Several staff often regularly worked alone without this training but this had not been identified and there was no plan for training for some of these staff. This demonstrated action to mitigate risks to the service had not been appropriately addressed and prioritised.

There were systems to measure performance of the service. The service had recently undertaken a mock Care Quality Commission inspection. The head of quality produced an action plan from the findings of this. Some actions had been completed but we found some ongoing issues at our inspection. The quality team also undertook unannounced visits. There were seven various visits undertaken in the 12 months prior to our inspection.

Staff completed audits regularly but these had not always identified shortfalls. For example, we found omitted signatures, dates and information in care plans. These had not been highlighted on the corresponding care plan audits. Information from audits was not always acted upon. For example, an external audit had been completed on 15 March 2016 by a pharmacist. The pharmacist had highlighted areas for improvement. The actions related to producing care plans for 'as required' medicines and including the reason for the return of medicines back to the pharmacy. An action plan completed at the service said these had been passed on to be discussed and included in the new medication policy that was awaiting sign off. We saw the draft medication policy and neither of these suggestions had been incorporated. There was no information to show they had been considered.

Clinical oversight for the service was provided by a clinical governance sub-committee. This was chaired by a Consultant Psychiatrist. The committee met three times a year and were responsible for approving policies. There was no other clinical input from the provider outside of this. The head of quality said that they had consulted clinicians in the past where required, for example to provide input into the medicines policy. However, the lack of more frequent clinical input meant there could be delays in addressing clinical matters and ensuring clinical practices at service level were effective. For example, that staff were monitoring withdrawal in accordance with current health and clinical guidelines.

The service had a business continuity plan in place. This provided guidance of actions staff should take in the event of emergencies such as loss of premises and adverse incidents.

The service used a case management and reporting system for substance misuse services. Managers could use this to produce reports about the service and monitor performance. They also provided monthly figures to The National Drug Treatment Monitoring Data. The National Drug Treatment Monitoring System (NDTMS) collects, collates and analyses information about services involved in the drug treatment sector. Information is used in order to monitor and assist the management of progress towards government's targets for participation in drug treatment programmes. This allowed the service to see how effectively they were performing and to identify areas for further development.

Leadership, morale and staff engagement

The registered manager for the service had ceased working with Phoenix Futures in December 2015. They had not worked at the service since September 2015. Since this time, the program manager had been acting up into the manager's role. A new manager commenced employment on 4 April 2016. They were in the process of applying to

become registered with the Care Quality Commission. At the time of our inspection, the new service manager was being supported by the program manager. Some staff and people felt management changes had been difficult but that these should be resolved now there was a manager in post.

The program manager and service manager felt morale was good and it was a close team. The service manager said although they had only started employment recently, they had been supported and felt involved with the team. They had not yet had a formal supervision. They said they had regular contact with senior management and could contact them for guidance.

Staff had weekly team meetings to keep updated about information relevant to the service. Employee engagement surveys were completed annually to measure staff satisfaction and engagement. However, one had not been completed for the last year. This meant the provider would not be able to fully gauge staff satisfaction levels.

Commitment to quality improvement and innovation

The service had identified areas where they could improve and were clear about what improvements they wanted to make. These included greater community links, more volunteers to facilitate activity and further opportunities for people to give feedback. The service was looking at ways to increase referrals and maximise use of the service.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that staff assess all risks to the health and safety of people using the service. There must be plans in place for how these are to be managed which must be reviewed and updated as necessary.
- The provider must assess the requirements for physical health checks and observations to be undertaken during detoxification. The use of recognised withdrawal scales should be assessed. Clear protocols setting out any such requirements need to be implemented. Staff must be competent to identify and monitor symptoms of withdrawal.
- The provider must ensure environmental risks are assessed to establish what support people may require to keep them safe in relation to these. Particularly where people have a history of self harm and/or suicidal ideation.
- The provider must ensure that staffing levels are appropriate to meet people's needs at all times, including at nights. Safe staffing should not be reliant on support from people using the service to the extent it has a detrimental impact on people's recovery.
- The provider must ensure that care records accurately reflect people's needs, are personalised and have clear objectives. These should include how people are to be supported in the event of unplanned exits. Records of care and treatment should be complete, contemporaneous, and include details of any decisions made in relation to people's care and treatment.
- The provider must ensure all incidents are reported where these meet the criteria. These should be investigated as proportionate to identify areas for learning and improvement. Findings and learning opportunities should be shared with staff as necessary.
- The provider must ensure medicines are managed safely. People must receive medicines as required, in a timely manner, and in accordance with how they are prescribed.
- The provider must ensure infection control procedures and practices, especially in relation to drug and alcohol screening, are undertaken in a way to minimise the risk of the spread of infection.
- The provider must ensure that staff have completed necessary mandatory training to carry out their roles safely and effectively. Staff must have the necessary skills and training to meet the needs of people using the service. Training information should be accessible to relevant staff and people.
- The provider must ensure all staff employed by, and working within, the service have regular supervision and appraisal as necessary. These should be used to identify any training needs and areas for further development. Volunteers should receive necessary support as required.
- The provider must ensure that doctors providing treatment at the service have received necessary revalidation as required by the General Medical Council.
- The provider must ensure that there are policies and procedures in place for staff to follow which are based on recognised good practice and national guidelines where applicable. Systems and processes in operation to improve the service, such as audits and quality monitoring, must be robust and effective to identify risks and make improvements.

Action the provider SHOULD take to improve

- The provider should continue to embed and enhance staff understanding and responsibilities in relation to the Mental Capacity Act 2005 and how this applies in practice.
- The provider should review the risk register to ensure it appropriately captures all current risks applicable to the service.
- The provider should review the need and implementation of separate male and female accommodation. Risks around shared accommodation should be considered as part of this.
- The provider should review their complaints process to consider including information about how complaints can be escalated to the relevant ombudsman service and details of how to do this.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** Care and treatment was not provided in a safe way for service users. The provider did not ensure that all risks relating to the health and safety of people using the service had been assessed and reviewed as required. The provider did not ensure they had done all that was reasonably practicable to mitigate any such risks; The provider did not ensure that all risks in relation to the environment were assessed to ensure that the premises were safe for people with a history of self harm and suicidal ideation to use. The provider did not ensure that medicines were managed in a safe way. Medicines were not always administered as prescribed. The provider did not have robust measures in place to minimise the risk of preventing, detecting and controlling the spread of infections. Regulation 12 (1)(a)(b)(g)(h)

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The registered provider did not ensure systems and processes were established to assess, monitor and

This section is primarily information for the provider

Requirement notices

improve the quality and safety of the services; and to mitigate the risks relating to the health, safety and welfare of service users in the carrying on of the regulated activity.

Incidents were not always reported where they met the criteria. Incidents were not analysed for themes and trends and were not fully investigated to identify learning points.

The provider failed to maintain an accurate, complete and contemporaneous record in respect of each person using the service. There were gaps in records, inaccuracies and omissions in documented information about people's care and treatment.

The provider failed to maintain securely such other records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity.

Regulation 17 (1)(a)(b)(c)(d)(I)

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** The provider did not ensure and demonstrate that there were sufficient numbers of staff deployed at all times. The provider did not ensure that staff were suitably qualified, competent, skilled and experienced to meet the needs of the people they supported. Staff working alone to carry on the regulated activity had not completed necessary mandatory training. All staff employed by the service did not receive appropriate supervision and appraisals. The provider had not ensured that the doctor prescribing to people had undergone necessary revalidation with their regulatory body. Regulation 18(1)(2)(a)