FOCUS12 - Treatment Centre

Quality Report

82-87 Risbygate Street,
Bury St Edmunds,
Suffolk,
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Date of inspection visit: 05 March 2018
Date of publication: 02/05/2018

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

Overall summary

We do not currently rate independent standalone substance misuse services.

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

- There was a failure to ensure that governance systems and processes were established and operated effectively within the service. Management arrangements for frontline staff were not robust. The provider did not ensure there were adequate reporting, audit and learning from incidents.
- Managers did not supervise and appraise staff's work performance consistently. There was no agreed mandatory training for staff, which meant we could not be assured that they had the basic skills required to fulfil their role.
- The provider did not ensure the proper and safe management of medication and the safe disposal of clinical waste.
- The provider did not ensure that all people working in the service had an up to date DBS (disclosure and barring system) check. There were no references available or employment checks made with one person who was involved at a senior level with all aspects of the organisation, including the development of policies, the assessment of patients and responding as an on –call clinician.
- Parts of the environment were not clean. There was not an effective system in place to maintain cleanliness.

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

- Staff had completed initial brief risk assessments by telephone as part of the admissions process. There was an initial measurement of the severity of dependence for alcohol or substances. The service had an admissions criteria. Staff considered mental health and self-harm risk as part of this process, and this would be discussed with the consultant psychiatrist.
- Clients spoke highly of staff, they felt passionate about the support and treatment they received, and they were complimentary about the manager.

Summary of findings

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Background to FOCUS12 - Treatment Centre

Focus 12 is an independent charity established in 1997 in Bury St Edmunds.

82- 87 Risbygate Street is a community based treatment centre, which offered detoxification from both drugs and/or alcohol under staff supervision.

The primary treatment was offered over a 12 week period. The provider delivered ongoing abstinence based treatment, which included group therapy and individual counselling.

In addition to the treatment centre, Focus 12 also had Three different residential accommodations, whereby clients receiving treatment could reside. These were all located in Bury St Edmunds.

Clients using this service were either privately funded, charity funded or had funding approved by statutory organisations.

There were seven clients in treatment at the time of our visit. One client was charity funded and three privately funded in residential treatment. Two clients were company funded and one client was charity funded for day programme attendance.

The provider is registered with the Care Quality Commission to provide the following regulated activities.

Our inspection team

The team that inspected the service comprised a lead CQC inspector, Teresa Radcliffe, and one other CQC inspector.

Why we carried out this inspection

This was an unannounced focussed inspection carried out in response to concerns raised with the Care Quality Commission.

How we carried out this inspection

We specifically looked at three questions at this unannounced focussed inspection.

- Is it safe?
- Is it caring?
- Is it well led?

During the inspection visit, the inspection team:

- reviewed the quality of the physical environment, and observed how staff cared for clients
- spoke with three clients
- spoke with the manager and the lead counsellor
- met with five other staff members
- reviewed three care and treatment records, including medicines records
- observed medicines being administered to clients
- reviewed the systems in place for the management storage and administration of medicines
- examined the incident reports log
- looked at HR files of six staff

Summary of this inspection

- Reviewed the policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with three clients who used the service.

They told us that were very glad to be receiving treatment at this service. They said staff were friendly and that they felt trusted. They said that they were involved in decisions about their treatment programme and received appropriate support. One client was due to graduate from their treatment programme and felt optimistic about the future. Another client said that staff had established clear treatment guidelines but responded appropriately to client feedback.

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 needed to improve:

- Managers had not implemented a protocol or procedure that ensured safe recording of medication from the initial prescription to the medicine administration recording sheets.
- Staff dispensed medication in the treatment centre and transported it to the client's accommodation based in the local area. This medication was not labelled in accordance with the Medicines and Healthcare products Regulatory Agency (MHRA) 2012 Schedule 24. The transporting of this medication was not in a tamper proof container.
- There was no system for the safe disposal of medicines. We found a bag of medicine in a shopping carrier bag at the bottom of the medication cupboard. This was separate to the returns box and had no instruction of why they were there or what was to be done with them.
- We saw tablets disposed of in the sharps bin. The medication fridge key was lost and was unlocked with prescribed items stored in it.
- While there were no Controlled Drugs (CDs) present; staff confirmed that clients were regularly prescribed these. The CD storage cabinet seen was made of plastic and stored in a filing cabinet and was not fixed to an anchor point.
- The provider did not have a system to record or monitor the prescriptions issued.
- There was no cleaning schedule in place to ensure that the cleaning of the centre was carried out effectively and cleaning products were not stored correctly.
- There was no system to dispose of clinical waste. There was no clinical waste bin.
- There was no environmental risk assessment in place.

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

- Staff completed initial brief risk assessments by telephone as part of the admissions process. There was an initial measurement of severity of dependence for alcohol or substances. The service had an admissions criteria. Mental health and self-harm risk were considered as part of this process, and this would be discussed with the consultant psychiatrist. Admissions staff sought additional information

Summary of this inspection

from the clients GP, mental health teams, social workers, and criminal justice teams as appropriate. This would form part of the risk assessment on clients' admission to the service as part of the comprehensive assessment.

- Managers adjusted staffing shifts daily. There was a duty rota in place. We reviewed five weeks of staff rotas and this showed that staffing figures were sufficient for the number clients currently at the service. The service was fully staffed when we inspected.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Staff interactions with clients were respectful and kind. Front line staff were positive and supportive. Staff knew their clients well and understood their individual needs.
- Clients spoke highly of staff, they felt passionate about the support and treatment received, and they were complimentary about the manager.
- The clients spoken with were happy with their treatment programme and felt optimistic about the future. The clients reported that senior managers were engaged, friendly and involved with all aspects of the service.
- There was good collaborative working with clients. Clients were involved in their risk assessment and their recovery plans and goals, clients were fully aware of the content of their care plan. They were able to have a copy of their care plan and assignments if they wished to do so.

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:

- The provider did not ensure that all DBS (disclosure and barring system) checks were in place and reviewed. Three new staff did not have a DBS check prior to starting work in the service. Managers did not have a risk assessment in place for those members of staff working with clients. This would reduce the risk to clients until the checks were completed.
- There were no references available or employment checks made with one person who was involved at a senior level with all aspects of the organisation, including the development of policies, the assessment of patients and responding as an on–call clinician.

Summary of this inspection

- There was no check to ensure that their professional qualification was valid, without restrictions for one person.
- Staff had not received regular supervision and annual appraisals.
- We saw no evidence of staff adherence to the Mental Capacity Act, specifically that staff had not considered clients' capacity to consent to treatment at the point of admission There was no guidance within the provider's policy to inform staff of the need to consider consent and staff told us they did not routinely assess capacity when clients were admitted for treatment.
- There was no robust system in place for incident reporting, reviewing and learning from these. This included sharing any lessons learned with frontline staff.
- The service had not identified mandatory training requirements for staff. There was no central record of staff training provided. For example records were not available to demonstrate staff training in safeguarding, basic life support skills and medication management.

Substance misuse services

Safe	
Caring	
Well-led	

Are substance misuse services safe?

Safe and clean environment

- The clinic room was clean, tidy and adequate in size. All stock was in date. There was a defibrillation machine available and accessible this was charged and the pads for this in date. There was no record that staff checked the equipment on a regular basis. There was no evidence of calibration of medical equipment.
- The clients' common room area and own kitchen was not clean. Clients had complained in community meetings about the lack of cleanliness at times. The cleaner attended the service once a week. Staff and clients were responsible for cleanliness of the centre for the remainder of the week. There was no system in place to ensure this happened and no audit carried out of cleanliness.
- Cleaning equipment was stored in the area leading to the disabled toilet, which was not well maintained, not colour coded and was dirty.
- There was no system to dispose of clinical waste. There was no clinical waste bin.
- The cleaner who worked for the service attended on a weekly basis. There were no cleaning schedules available, managers could not evidence when areas were cleaned.
- Furnishings were clean and well maintained throughout the premises. Staff maintained the garden areas, which were clean and tidy for clients to use.
- We observed Staff adhere to infection control principles relating to handwashing. There were handwashing facilities available throughout the centre and these were used.
- There were no environmental risk assessments in place. This meant we were not assured that staff knew of any risks and consequently there were no plans to mitigate risks.
- Staff at the treatment centre did not have access to personal alarms. The centre had a static alarm in place, which, if activated, went straight through to the local police station.

Safe staffing

- The service had a minimum staffing level of two staff during the day and evening at the centre. The evening shift finished at 11pm. The manager completed staff rotas and determined staffing levels required for the treatment centre. There were 18 members of staff consisting of a consultant psychiatrist and addiction nurse, both contracted to the service, counsellors, keyworkers, administration and night staff.
- There was a specialist substance misuse nurse available to the service and attended throughout the week. The nurse was available on call and attended when required. The service had systems in place to manage the withdrawal of substances and alcohol. There were no night staff, however the manager assured us that if there was an identified risk, staff could be made available.
- There were no staff vacancies and no sickness absence. The service was fully staffed and had recently recruited a new member of staff. Managers adjusted staffing shifts daily. We reviewed five weeks of staff rotas and this showed that staffing figures were sufficient for the number clients currently at the service.
- There was enough staff for clients to receive their one to one sessions with their named keyworker.
- Managers had the option to use agency staff if required, there had been one agency staff used over the Christmas period. This was a regular member of staff familiar with the service.
- The Consultant Psychiatrist attended the practise regularly to review clients; the contracted nurse in post had recently qualified as a nonmedical prescriber. There was an out of hours on call system for clinical support from the contracted qualified nurse. There was no out of hours on- call doctor and staff would call 111 or 999 in an emergency.

- Staff had received basic medication administration training. This included the administration of emergency medication for opioid overdose. However, staff did not routinely carry emergency medication when visiting the accommodation houses in the evenings and weekends.
- Managers and staff told us they had completed on line training provided from an outside provider. There were plans for the nurse to deliver face to face training regarding withdrawal and detoxification. However, this had not yet happened.
- There was no mandatory training programme for staff available.

Assessing and managing risk to clients and staff

- Staff completed initial brief risk assessments by telephone as part of the admissions process. Clients as part of the admission process had a severity of alcohol dependence questionnaire completed. Staff assessed mental health and self-harm risk concerns, and this would be discussed with the consultant psychiatrist. The admissions staff sought additional information from the clients' GP, mental health teams, social workers, and criminal justice team as appropriate.
- Staff searched clients' property on admission to the service. The client was present during the search.
- The service used recognised screening tools such as; objective and subjective opioid withdrawal scale, and the clinical institute withdrawal scale. Staff had not recorded any physical observations. This was because there were no clients having active treatment at the time of inspection.
- There were no details of any staff trained in safeguarding of vulnerable adults and there were no training records available. We saw evidence of some historical safeguarding training in staff HR files. There was a clear flow chart available for staff to follow regarding the procedure for abuse or suspected abuse of children and adults.
- Managers had not implemented a protocol or procedure to ensure the safe recording of medication from the prescription to the medication administration record sheets. There was no space for staff to sign the chart and there was no second person check to ensure that the information had been transcribed correctly. There was no audit available of this process.
- There were errors in transcribing on the medication administration sheet. This included the incorrect recording of allergies, gaps in signatures and dates were missing. Staff did not report all of these errors via the internal incident forms.
- Staff dispensed medication at the treatment centre. Two staff checked the medication. They checked the client's name when they arrived for it. However, the staff signed to say the client had received the routine medication prior to it being given.
- Staff dispensed medication in the treatment centre and transported this to the client accommodation based in the local area. This medication was not labelled in accordance with the Medicines and Healthcare products Regulatory Agency (MHRA) 2012 Schedule 24. The transporting of this medication was not in a tamper proof container.
- There was no system for the safe disposal of medicines. We found a bag of medicine in a shopping carrier bag at the bottom of the medication cupboard. This was separate to the returns box and had no instruction of why they were there or what was to be done with them. We saw tablets disposed of in the sharps bin.
- There was not a system to record or monitor the prescription issued prescriptions were secured in a safe.
- There had been a review of the medicines management policy and a new policy was in place. The service has changed their pharmacy provider recently. There was no oversight or audit agreement in place with this provider.
- The medicine management systems relating to transport, storage and dispensing and medicine reconciliation were not robust. On inspection, the fridge lock was broken. The temperatures were out of range on some days. Staff were unaware of what action to take regarding this.
- The control drugs safe was broken and the new one ordered was not fit for purpose. The service was aware of this and they planned to order an alternative. At the time of inspection, there were no controlled drugs required for current clients.
- While there were no Controlled Drugs (CDs) present; staff confirmed that clients were regularly prescribed these. The CD storage cabinet seen was made of plastic and stored in a filing cabinet and was not fixed to an anchor point.

- There was a child visitors' policy in place. This stated that children were not allowed to visit the treatment centre or clients' accommodation. Visits with family members were community based.

Track record on safety

- There has been one serious incident in the last 12 months. This incident was reviewed internally and actions had been taken to address the identified concerns.

Reporting incidents and learning from when things go wrong

- There was a system in place to report incidents. There was an incident file which recorded reported incidents. We reviewed nine incidents and found that the information recorded lacked detail. Two incidents had not been reported on an incident form. We saw evidence of two incidents in the report log but no corresponding information in the clinical notes. It was not clear what immediate action was taken with three incidents.
- An incident report was reviewed where two clients were drinking and allowed to remain in the property unsupervised. Staff had not intervened appropriately at the time. This was subsequently reported and measures were put in place to prevent this from reoccurring.
- There was no evidence of lessons learnt within the service, or being discussed and cascaded to front line staff. The management of incidents and wider learning from these were discussed with senior managers.
- Incidents had not been reported to the Care Quality Commission despite clearly meeting the criteria for this.

Duty of candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify clients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. The manager was not able to outline the responsibilities of duty of candour. Staff may not have understood the terminology but we saw evidence on inspection of staff being open and honest with clients.

Are substance misuse services caring?

Kindness, dignity, respect and support

- Staff interactions with clients were respectful and kind. Front line staff were positive and supportive. Staff knew their clients well and understood their individual needs.
- Clients spoke highly of staff, they felt passionate about the support and treatment received, and they were complimentary about the manager.
- The clients spoken with were happy with their treatment programme and felt optimistic about the future. The clients reported that senior managers were engaged, friendly and involved with all aspects of the service.

The involvement of clients in the care they receive

- Clients were given information about the service prior to admission, and were sent a welcome pack with a range of information. On admission clients were shown around the service and introduced to everyone.
- There was good collaborative working with clients. Clients were involved in their risk assessment and their recovery plans and goals, clients were fully aware of the content of their care plan. They were able to have a copy of their care plan and assignments if they wished to do so.
- There was one notice board in the common room which had information regarding alcohol and drug group timetable. There was no further information regarding advocacy, mental health services, other agencies or community help.
- Family members were involved in client's treatment when consent was given and were invited to therapy sessions.
- Clients had an opportunity to give feedback on the service. Forms were available in common room areas for them to do this at any time. Community and accommodation meetings were held and they were able to approach senior managers with any concerns. There was no guidance for clients on how to complain externally about the service.

Substance misuse services

Are substance misuse services well-led?

Vision and values

- The service had recovery based visions and values. Those staff spoken with knew these and reflected the values of the organisation in their work.
- Staff knew who the senior members of the organisation. The chief executive officer was based at the service and was available to staff and clients.

Good governance

- Managers did not keep a record of mandatory training for staff employed by the service. There were no training records or training timetable in place. Those staff records reviewed supported these findings. There was one reference to a previous training session seen in the clinical governance minutes dated December 2017.
- Managers reported that clinical supervision took place and was a contracted service on a three weekly basis. There was no evidence in staff files after August 2017 of this taking place. Recording of management supervision also had gaps in record keeping, one record viewed showed the last entry as January 2017.
- Managers did not carry out staff appraisals in 2017. We spoke to the manager who told us appraisals had not taken place. Those staff records seen supported this.
- The provider did not ensure that all DBS (disclosure and barring system) checks were in place and reviewed. Three new staff did not have a DBS check prior to starting work in the service. Managers did not have an organisational risk assessment in place for those members of staff working with clients. This would reduce the risk to clients until the checks were completed.
- There were no references available or employment checks made with one person who was involved at a senior level with all aspects of the organisation, including the development of policies, the assessment of patients and responding as an on–call clinician. We were informed this person was not employed by the service.
- Managers informed us that the nurse conducted clinical audits on medication. However, these audits were not available for inspection. There was no evidence that other staff participated in any audits in the service and this was confirmed by those staff spoken with.
- There was no complaints log in place. The manager stated there had been no formal complaints received whilst they have been in post. There was no evidence of the procedure including how to complain externally if the client was unhappy with the outcome of an internal review of any complaint. There was no complaints policy in place at the service.
- There were a number of policies and procedures that were not in place. Others did not reflect best practice or were current.This included policies such as discharge procedures, lone working, staff training and collaboration with third party organisations.
- Three months of clinical governance meeting minutes were reviewed. Evidence to the lessons learnt from incidents was limited. There was no evidence of this being cascaded to staff, or feedback given to clients.
- We saw no evidence of staff adherence to the Mental Capacity Act, specifically that staff had not considered clients' capacity to consent to treatment at the point of admission There was no guidance within the provider's policy to inform staff of the need to consider consent and staff told us they did not routinely assess capacity when clients were admitted for treatment.
- There was a safeguarding policy in place and in date giving guidelines on action that should be taken There was no safeguarding log available at the service. There was clear evidence through client records, medical notes and the incident folder that staff were not reporting safeguarding concerns There was no evidence of statutory reporting to the local authority or the CQC. There was no evidence of safeguarding listed as mandatory training.
- The service did not use key performance indicators to monitor and measure individual performance.
- The manager of the service had administrative support in place. They received support from the charity's trustees.

- There was no risk register in place at the service. This meant that there was no system in place for managers and staff to monitor overall risks to the organisation, staff, and clients.

Leadership, morale and staff engagement

- There were no reported cases of bullying or harassment.
- Some staff had left the service, and overall staff turnover figures were not available.
- Staff spoken with reported a good level of job satisfaction and enjoyed their jobs.
- We reviewed team meeting minutes and six staff files. We saw evidence that some staff had raised concerns to managers after identifying areas for improvement. Staff were able to describe the whistleblowing process, and did report concerns to the appropriate manager.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure the safe management of medication.
- The provider must ensure that the policies and procedures for medicines management are fit for purpose, in date and reflect best practice.
- The provider must ensure the safe and secure storage of medications including controlled drugs.
- The provider must ensure the safe administration of medication.
- The provider must ensure that there is a protocol and policy to ensure the safe and accurate written record of the medicine administered and the use of the medication administration chart by staff.
- The provider must ensure that they have a policy setting out the safe management and of spillage of blood or body fluids and the management of waste.
- The provider must ensure that infection prevention and control audits are carried out and recorded to enable staff to make improvements to the service.
- The provider must ensure there is a programme of audit to ensure that improvements are made to the service when concerns are identified.
- The provider must ensure that staff mandatory training needs are identified and training provided to support staff to carry out their roles safely and effectively.
- The provider must ensure that all people working for the service have an up to date DBS (disclosure and barring system) check.
- The provider must ensure that DBS applications are reviewed and there are risk assessments in place where appropriate.
- The provider must ensure that pre-employment checks are carried out to ensure that all staff employed by the service are safe, fit and appropriate to work with clients.
- The provider must ensure that there is an environmental risk assessment in place to mitigate risks to clients.
- The provider must ensure that their policies and procedures are fit for purpose, in date and reflect best practice.
- The provider must ensure that all staff receive regular supervision and their performance is appraised.
- The provider must implement a system to ensure that clients' mental capacity is assessed and documented as required.
- The provider must ensure that there is a robust system for incident reporting, reviewing, learning and feeding this back to staff.
- The provider must have a risk register that identifies and addresses the risks to the organisation.

Action the provider SHOULD take to improve

- The provider should review their complaints process to include explaining how a client can make a complaint external to the organisation.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The provider did not ensure that infection prevention and control audits were carried out and recorded to enable staff to make improvements to the service. • The provider did not ensure that an environmental risk assessment was in place to mitigate risks to clients. This was a breach of regulation 12

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The provider did not ensure that there was a programme of audit to ensure that improvements were made to the service when concerns were identified. • The provider did not ensure that there was a robust system for incident reporting, reviewing, learning and feeding this back to staff. • The provider did not have a risk register that identified and addressed the risks to the organisation. • The provider had not ensured that their policies and procedures were fit for purpose, in date and reflected best practice. This was a breach of regulation 17

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

- The provider did not have a system in place to ensure that clients' mental capacity was assessed and documented where relevant.

This was a breach of regulation 11

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The provider did not ensure the proper and safe management of medicines. • The provider did not ensure that there was a policy setting out the safe management and of spillage of blood or body fluids. • The provider did not have a clear system for the disposal of clinical waste. This was a breach of regulation 12.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The provider did not ensure that systems and processes were in place to assess, monitor and improve the quality of the service and mitigate risks to the health, safety and welfare of clients. This was a breach of regulation 17

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed • The provider did not ensure that the required information was available in relation to fit and proper persons.

This section is primarily information for the provider

Enforcement actions

This was a breach of regulation 19