Turning Point - Smithfield Detoxification Unit

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

Ratings

Overall rating for this location	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Outstanding
Are services well-led?	Good

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.

Summary of findings

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 rated Smithfield as good because:

- The service provided safe care. The clinical premises where clients were seen were safe and clean. The service had enough staff. Staff assessed and managed risk well and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the clients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The teams included or had access to the full range of specialists required to meet the needs of clients under their care. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multidisciplinary team and relevant services outside the organisation.
- Staff treated clients with compassion and kindness and understood the individual needs of clients. They actively involved clients in decisions and care planning.
- The service was tailored to meet the needs of individual people and were delivered in a way to ensure flexibility, choice and continuity of care.
- The service was flexible, provided informed choice and ensured continuity of care post discharge with the group that ran on a Sunday for past clients
- The service had created strong links with the local community. This offered clients choice not only around which abstinence meetings they wanted to attend but also hobbies and interests they could take up to aid their own sobriety in the future.
- The service was easy to access and clients never waited for a bed. Staff planned and managed discharge well. The service had alternative care pathways and referral systems for people whose needs it could not meet.
- The service was well led, and the governance processes ensured that its procedures ran smoothly.

However,

- We found that the monitoring and recording of withdrawal symptoms and when required medication was given were not always complete. Although nurses were keeping patients safe by assessing their symptoms and dispensing when required medication accordingly, this was not always being documented. This meant there was a risk to patients that physical health was not monitored effectively throughout withdrawal.
- Controlled drugs that were delivered from the pharmacy prior to the patient being admitted were checked on arrival but then they were not checked again until the day the patient was admitted. This meant that staff may not be aware if medication had gone missing.
- We found one example of a patient who had brought their own inhaler to the service but the self-medication chart was not completed.

Summary of findings

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Good

Turning Point – Smithfield Detoxification Unit

Services we looked at:
Residential substance misuse services

Summary of this inspection

Background to Turning Point - Smithfield Detoxification Unit

Turning Point is a national health and social care provider with over 250 specialist and integrated services across England and Wales, focusing on improving lives and communities across substance misuse, learning disability, mental health and employment. Turning Point Smithfield is a 22-bed inpatient unit that provides treatment to men and women over 18 years of age who have a drug or alcohol dependency. The service provides a detoxification service. The majority of clients are referred to Smithfield by the community drug and alcohol teams, with their places being funded through their Local Authority. However, clients can also refer themselves to the service and self-fund. The service takes referrals from all over the country however, the majority of clients on the day of our inspection were from the local area. The service is situated close to the city centre of Manchester and it is easily reached on foot, by car and public transport. There was a registered manager at the time of our inspection.

The service is registered to provide the following regulated activities:

• Accommodation for persons who require treatment for substance misuse

Turning Point Smithfield has been registered with CQC since 8 February 2011. There have been three previous inspections carried out at Smithfield; the most recent was conducted on 23 August 2016. We did not rate inspections at that time. The service was found to be meeting all the required standards inspected.

Our inspection team

The team that inspected the service comprised two CQC Inspectors one CQC pharmacy inspectors and one expert by experience.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

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

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

During the inspection visit, the inspection team:

- visited the hospital and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with six patients who were using the service
- spoke with the registered manager
- spoke with 14 other staff members; including doctors, nurses, support workers, the chef, peer mentors, student nurses and psychology students
- observed an admission, a relapse prevention group and a guest speaker who had completed their own detox at Smithfield

Summary of this inspection

- collected feedback from 28 patients using comment cards
- looked at seven care and treatment records of patients
- carried out a specific check of the medication management and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We collected feedback from clients by meeting them on the day of the inspection and through comment cards. We received universally positive feedback about the service. All the clients we spoke to told us how things had improved for them since they were admitted to the hospital. They told us how staff were friendly and approachable and always had time to talk to them no matter how busy they were.

We were given universally positive comments about the food. The clients reported there was lots of choice, the food was tasty and that they were able to make hot drinks and snacks whenever they wanted them. They were also encouraged to build a basis knowledge of cooking if they needed it to support their recovery through a health balanced diet.

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?

Requires improvement 

We rated safe as requires improvement because:

- We found that the monitoring and recording of withdrawal symptoms and when required medication was given were not always complete. Although nurses were keeping patients safe by assessing their symptoms and dispensing when required medication accordingly, this was not always being documented. This was not in line with the providers policy. This meant there was a risk to patients that physical health was not monitored effectively throughout withdrawal.
- Controlled drugs were delivered from the pharmacy prior to the patient being admitted were checked when the service received them but then not checked again until the patient was admitted.
- We found one example of a patient who had brought their own inhaler to the service, but the self-medication chart was not completed.

However,

- The clinical premises where clients received care were safe, clean, well equipped, well furnished, and fit for purpose. The service had enough nursing and medical staff, who knew the clients and received basic training to keep them safe from avoidable harm.
- Staff screened clients before admission and only offered admitted them if it was safe to do so. They assessed and managed risks to clients and themselves well. They responded promptly to sudden deterioration in clients' physical and mental health.
- Staff understood how to protect clients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records.
- The service had a good track record on safety. The service managed client safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave clients honest information and suitable support.

Summary of this inspection

Are services effective?

Good

We rated effective as good because:

- Staff completed comprehensive assessments with clients on admission to the service. They worked with clients to develop individual care plans and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of care and treatment interventions suitable for the client group and consistent with national guidance on best practice. They ensured that clients had good access to physical healthcare and supported clients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The teams included or had access to the full range of specialists required to meet the needs of clients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit clients. They supported each other to make sure clients had no gaps in their care. The team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff supported clients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2015 and knew what to do if a client's capacity to make decisions about their care might be impaired.

Are services caring?

Good

We rated caring as good because:

- Feedback from the people that used the service was universally positive about the way staff treated them.
- Clients felt that staff went the extra mile and their care and support exceeded their expectations. One client commented "Smithfield never shuts the door on you".
- Staff were highly motivated and many have lived experience of substance misuse. Staff treated clients with compassion and kindness. They respected patients' privacy and dignity. They fully understood the individual needs of clients and empowered clients to understand and manage their care and treatment.

Summary of this inspection

- Staff involved clients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that clients had easy access to additional support.
- Clients emotional and social needs were seen as being just as important as their physical needs. Clients felt genuinely cared for and that they truly mattered. Relationships between people who use the service, those close to them and staff are strong, caring, respectful and supportive.

Are services responsive?

Outstanding 

We rated responsive as outstanding because:

- The service was tailored to meet the needs of individual people and were delivered in a way to ensure flexibility, choice and continuity of care.
- The service was flexible, provided informed choice and ensured continuity of care post discharge with the group that ran on a Sunday for past clients.
- The service had created strong links with the local community. This offered clients choice not only around which abstinence meetings they wanted to attend but also hobbies and interests they could take up to aid their own sobriety in the future.
- The service was easy to access and clients never waited for a bed. Staff planned and managed discharge well. The service had alternative care pathways and referral systems for people whose needs it could not meet.
- The design, layout, and furnishings of the ward supported clients' treatment, privacy and dignity. Each client had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy.
- The service met the needs of all clients, including those with a protected characteristic or with communication support needs.
- The service used innovative ways to ensure communication needs were met. For example, a programme on the computer system to translate care plans into different languages.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

Are services well-led?

Good

We rated well-led as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for clients and staff.

Summary of this inspection

- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff collected and analysed data about outcomes and performance.

Detailed findings from this inspection

Mental Health Act responsibilities

The service did not accept patients who were detained under the Mental Health Act

Mental Capacity Act and Deprivation of Liberty Safeguards

The service had a policy on the Mental Capacity Act. Staff that we interviewed had a good understanding on the Act and its guiding principles. Staff always assumed capacity and supported clients to make decisions for themselves. The admission criteria meant that clients who lacked capacity would not be suitable to be admitted to the service. However; the staff had good awareness that capacity could sometimes change once a detoxification had started and monitored this closely. The records we reviewed showed capacity assessments being done where appropriate. Clients signed a form to allow information sharing during their stay and all had consented to their admission.

Good

Residential substance misuse services

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Outstanding
Well-led	Good

Are residential substance misuse services safe?

Requires improvement

Safe and clean environment

The clinical premises where clients received care were clean and well equipped. The décor needed some attention as paint was peeling in some areas and there were marks on the walls. The operations manager had already discussed this with the landlord with a view to getting this done sooner as the current contract was three yearly.

There was 24 hour access to an outdoor area that was well maintained. There was artwork on display that had been created by clients past and present.

Smithfield was a large building over two floors. The bedrooms were all on the upstairs corridors. At the time of our inspection only one corridor was being used. The clients at Smithfield were both male and female. Bedrooms were all on corridor and were mixed meaning that a male could be next to a female. Bedrooms were not en suite although they did all contain a sink. This meant that females would need to pass by male bedrooms in order to get to a bathroom and vice versa. Bedrooms were allocated based on risk of physical health issues, primarily risk of seizures but also mobility, risk of falls etc. Patients who needed higher observation levels would be nearer to the nurses' station. Bathrooms were gender specific with male and female signage clearly displayed. During our inspection we saw how the mixed sex environment was safely managed and monitored. There was a female only lounge area. The pre admission assessment process identified any risks, for example detailing any history of sexual abuse or offenses. If the staff felt that these risks were too high to be managed, then admission would be refused, and the client would be identified as needed a different detoxification unit. There was a clear rationale for how the bedrooms were allocated, as mentioned above those at higher risk of seizures being near to the nurses' station. There was CCTV on the bedroom corridor, so staff could observe client's movements in relation to bedrooms. The shower and bath areas provided space for clients to undress, dry and dress in private before travelling across communal areas. Clients all had keys to their own bedrooms and could lock their door.

Although there were not clear lines of sight in the building this was mitigated by the use of thorough risk assessments, observations and CCTV on upstairs corridors. There was signage in place to inform clients this was being used. Where there were ligature points (a place where someone intent on harming themselves could tie something around too strangle themselves) there was a ligature risk assessment carried out annually which identified these and ways in which these would be managed. Clients at Smithfield were assessed prior to admission, anyone who was actively suicidal or had thoughts of self-harm at this point would not be admitted. However, if these thoughts occurred during admission then staff would manage this via a care plan, observation levels and thorough risk assessments. Staff had access to ligature cutters and had been trained on how to use this.

Appropriate maintenance checks were in place. Fire detection, prevention and fighting equipment had been checked regularly. Certificates confirmed that checks of electrical wiring, gas safety and the boiler had been

completed by an approved individual. There were fire extinguishers and evac chairs for use if a fire occurred. Staff had received infection control training. They were aware of infection control principles such as hand washing and disposal of clinical waste.

There was a fully equipped clinic room that was clean and tidy during our inspection. There was equipment to take physical observations including weighing scales, blood pressure machine and temperature recording device. Medicines were stored securely with access restricted to authorised staff. A controlled drug is a medicine that is controlled under the Misuse of Drugs regulations (and subsequent amendments) and these were managed appropriately on the most part. However, when a client was due to come into the unit who was on a controlled drug, these would be delivered prior to the patient arriving. They were in a bag and securely stored but these were not checked until the client arrived, and this meant that there was a risk that these drugs could go missing without staff realising and little ability to trace when this happened. We checked medicines requiring cold storage and found fridge temperatures had been recorded in accordance with national guidance.

There were nurse call buttons in all the bedrooms for clients to alert staff if they needed them.

The box to tell staff where the alarm was activated was at the nurses' station, which was always manned by staff.

Safe staffing

The service was staffed 24 hours a day 7 days a week. The staffing establishment for each shift was one qualified staff member and two support staff. In addition to this there were peer mentors who were voluntary and there were usually students (nurses or psychology students) on duty. At the time of our inspection there were two vacancies for qualified nurses. These had been filled and staff were due to start in the coming months. However, this meant that to fill these shifts the Clinical Lead and Registered Manager needed to work shifts on the unit, they would normally be supernumerary. The unit did not tend to use agency staff as it was difficult to take someone on for one or two shifts when the detoxification regime was quite complex in terms or staff knowledge of withdrawal symptoms and medication regimes. However, it was recognised by the service managers that the use of agency staff could alleviate some of the pressures until new staff members started. When agency staff were used they were given a thorough induction documented in an induction folder. The service manager had the authority to increase staffing numbers if needed to suit the needs of the unit.

Smithfield employed 33 staff in total. This included 7 qualified nurses and eleven support workers as well as a registered manager, clinical lead, peer mentors, a chef, administration staff and domestics. There were two vacancies for qualified nurses, but these had been filled and staff were awaiting start dates. There were no vacancies for support workers. There were three shifts in the last twelve months covered by agency staff and this was due to late notice sickness. The staff sickness rate in the last twelve months was 9% and there had been six staff leave during this time. Reasons for this included higher rates of pay being offered, natural progression of career and personal circumstances changing. Staff and clients told us that the staffing levels were sufficient to provide one to one time for clients. Planned groups and activities off the unit were not cancelled due to staffing shortages and clients told us they could seek support from staff at any time.

There was medical cover provided by a consultant psychiatrist who was a specialist in detoxification. They were contracted to five sessions per week and were on call the other two days. In an emergency the ambulance service would be used to transfer clients to the local accident and emergency.

Mandatory training.

Overall, staff in this service had undertaken 91% of the various elements of training that the provider had set as mandatory. This included basic life support, fire training and mental capacity act amongst others.

Assessment of patient risk

We reviewed six care records. Each client had a pre admission risk assessment that captured sufficient information to inform the decision to admit the client to the unit. This included information from the GP. On admission a comprehensive risk assessment was completed, this captured risks around substance and alcohol misuse; mental health; forensic history; mental health and suicidal intent; neglect; social factors (including

family); safe sexual practice. These were updated at key working sessions which occurred around once per week, they were also updated if an incident occurred. Identified risks were managed via a care plan.

Management of patient risk

Staff followed the provider policy for the use of observations. On admission all clients were placed on fifteen minute observations. This was to monitor the patient's withdrawal safely and ensure that the risk of seizures was managed safely. As the admission progressed observations would usually become less frequent with the minimum check being hourly.

There were some banned items from the unit which included alcohol and illegal substances and energy drinks. Other items were managed on a client risk basis. Patients were not detained but signed an agreement to the unit rules which did include going out escorted by staff during the detoxification.

Safeguarding

Staff knew how to protect clients from abuse and had good working relationships with the local safeguarding teams as well as informing the clients home team if this was not local. There was a safeguarding policy to support staff and offer guidance. Staff were able to tell us how they would recognise and report abuse.

Staff access to essential information

All information needed to deliver patient care was available to all relevant staff (including agency staff) when they needed it and was in an accessible form. Records were in electronic and paper format, this did not cause any problems in accessing records.

Medicines management

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

Clients were reviewed by the doctor before being commenced onto a detoxification regime. A full medical and drug history were recorded and a copy of the client's medical history and blood results from the client's GP was obtained. We found that the service had printed prescription charts for nurses to use, which reduced the detoxification medication down each day with additional boxes for when further medication was administered if needed. Client's starting their detox in the afternoon were not given the initial four (higher) doses on day one as on the second day nurses gave the reduced second day dosage.

When a client brought medicines in such as inhalers or creams, staff completed an assessment on whether the client could self-medicate. We found one record where this was not completed and there was no record of self-medicating medicines on the prescription chart making the records incomplete.

Staff reviewed client's medicines regularly and provided specific advice to clients and carers about their medicines. Clients were reviewed by the doctor each week or more frequently if needed. Staff provided advice to clients on medicines.

Staff stored and managed all medicines and prescribing documents in line with the provider's policy. All medicines and prescribing documents were stored securely in the medicines room. Access to the room was restricted to nursing staff. The service had two Controlled Drugs cabinets, one for clients who had been admitted into the service and one for those who were due to be admitted. Staff only checked controlled drugs for clients who had been admitted into the service when they were delivered from the pharmacy and then they were not checked again until the client was admitted. This meant there was a risk it would not be recognised in a timely manner if any of these went missing.

Staff followed current national practice to check clients had the correct medicines. The doctor ensured that he had a full GP summary before commencing detoxification regimes. Staff did not record Clinical Institute Withdrawal Assessment for Alcohol (CIWA) scores regularly and it was therefore unclear whether clients were receiving the correct detox medications based on their withdrawal scores.

The service had systems to ensure staff knew about safety alerts and incidents, so clients received their medicines safely.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Clients were reviewed each week by the doctor and medication was reviewed daily if needed by the request of the client or nursing staff.

Good

Residential substance misuse services

Staff reviewed the effects of each client's medication on their physical health according to NICE guidance.

The documentation of physical observations was not always completed in full in relation to dispensing when required medication. CIWA scores were not always documented when a when required detox medication was administered. Blood pressure and pulses recorded out of range were not always recorded that they had been repeated.

Track record on safety

The service had not reported any serious incidents since our last inspection.

Reporting incidents and learning from when things go wrong

Staff used an online incident reporting system to report incidents. Reports were reviewed by the senior staff at the unit and the risk and assurance team. Staff we spoke to knew how to report incidents and what would constitute an incident. Learning from incidents was shared via team meetings and if needed individual supervision.

Staff followed duty of candour requirements when incidents met this threshold. This meant that a letter was issued, and an apology given. Duty of candour is a legal duty on hospital, community and mental health services to inform and apologise to clients if there have been mistakes made in their care that have or could have potentially led to significant harm.

There was evidence that changes were made following on from incidents. For example, there was an incident when a client had a fall and was unable to get up off the floor. Although admission criteria for Smithfield did indicate that clients should be independently mobile, it was recognised because of this incident that mobility may decline post admission. The need for moving and handling training for staff was identified along with some equipment to assist people up off the floor. The service was able to access the training via the providers learning disability services purchase an Emergency Lifting Cushion that could be used to help people off the floor.

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

Good

Assessment of needs and planning of care

Each record we reviewed had a comprehensive assessment of the client that was completed on admission. A full GP transfer of care including Information relating blood Bourne viruses were received from the GP before the client was admitted. All clients had a full physical examination on admission carried out by the doctor this included blood pressure, pulse, a check of the abdomen and a check of the central and peripheral nervous system. The doctor also completed a document which included information such as medical history, previous substance misuses and alcohol use and treatment; physical health, mental health, medication, observations, and treatment plan.

Care plans were derived from the admission assessment in collaboration with the client. Staff wrote the care plans and the clients had signed them all to show their agreement with the content. Care plans were personalised, holistic and recovery orientated.

The service had plans in place for a clients' unexpected exit from treatment. Staff understood the procedures to follow. Where clients were exiting treatment unexpectedly staff provided information on local support and crisis services as well as harm reduction advice. Staff could also provide naloxone packs to clients. Naloxone is a medication that can reverse the effects of an overdose.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence. Detoxification regimes were able to be tailored to suit the client need. For example, adding supplementary medications and the number of days the detoxification lasted. The service provided detoxification for a number of substances including alcohol and opiates as well as synthetic cannabinoids, prescription medication and methadone.

Clients also had access to a weekly timetable of group work and therapeutic activities. These included SMART recovery sessions, recovery skills group work programme, access to mutual aid both in house and in the community and yoga.

Staff supported clients with access to physical health services. As clients were only admitted for short periods they remained under their home GP. However, they were able to use the local walk in centre if there was anything the doctor could not resolve. There was a local clinic for dressing of any wounds in relation to injecting substances. The local accident and emergency would be used in an emergency.

Clients were supported to live healthier lives and smoking cessation advice and support was available to them. Healthy eating was encouraged, and the menus were designed to ensure clients were receiving the nutrients they required during a detoxification.

Staff engaged in local clinical audits, these included medications, infection control and records. This was then monitored by senior managers through the quality improvement programme and through regular reviews and audits by the risk and assurance team.

Skilled staff to deliver care

The team either included or had access to a full range of specialist. The staff team were experienced in substance misuse and there was 24 hour access to a doctor and nurses. The team included a registered manager, support workers, peer mentors.

We reviewed five staff files and found these to be in good order. There was an induction checklist, disclosure and barring service documents, evidence of sickness monitoring and support and details of supervision and appraisal. All staff had an up to date appraisal and supervision was in line with the provider policy which identified a minimum of eight sessions per year. All staff we spoke to told us they felt well supported. There were regular team meetings and we reviewed the minutes from the last three. We were able to see where actions were carried out and fed back at the next meeting. All staff on duty (and off duty if they wanted to attend) were invited to join the meetings. We were able to see how managers identified learning needs of staff through the appraisal system and implemented goals over the year to help staff to achieve them. For example, due to the fact that the provider was finding it difficult to attract new staff to the service they had implemented a number of initiatives one being "grow our own" nursing strategy. This meant they were working with a local college for all peer mentors to complete a Level 2, Diploma in Care, funded by the Adult Training fund. Then, all support workers would work towards a Level 3, Diploma in Care, funded by Adult Training fund, plus support to achieve Level 2 in Maths and English (if required) as preparation for the Nursing Associate Course. Staff had also completed training around the provision and use of Naloxone. Naloxone is an emergency medication that can reverse the effects of overdose.

The peer mentor programme was an eight week training course which clients could embark on once they had maintained three months of abstinence following a detoxification. Following completion of the course peer mentors worked voluntarily for as many or as little hours as they wished at the unit. The peer mentors were given support including appraisal and supervision by a senior support worker. Newly qualified staff were given a six month preceptorship supported by a senior qualified nurse. There were qualified mentors and associate mentors to support student nurses.

Poor staff performance was managed effectively. At the time of our inspection there was nobody being performance managed but senior staff were able to give us examples of when this had been done and how it was managed. There was also support from human resources available if needed.

Multi-disciplinary and inter-agency team work

Staff from different disciplines worked together to enhance the client experience. There was input pre admission from the community drug and alcohol team, the doctor, nurses and the clients GP. This allowed the team to ensure the detoxification plan was individually tailored to meet the needs of the client. The discharge plan was also done at the same time so there was a clear plan in place prior to the client entering the unit. The service had good links with the local recovery community and services. These included local peer support groups and support services. Staff maintained contact with care co-ordinators from the client's local substance misuse service where this was applicable. Care co-ordinators were invited to attend relevant meetings.

Adherence to the MHA and the MHA Code of Practice

The service did not admit patients detained under the Mental Health Act.

Good practice in applying the MCA

Good

Residential substance misuse services

The service had a policy on the Mental Capacity Act. Staff that we interviewed had a good understanding on the act and its guiding principles. Staff always assumed capacity and supported clients to make decisions for themselves. The admission criteria meant that clients who lacked capacity would not be suitable to be admitted to the service. However, the staff had good awareness that capacity could sometimes change once a detoxification started and monitored this closely. The records we reviewed showed capacity assessments being done where appropriate. Clients signed a form to allow information sharing during their stay and all had consented to their admission.

Are residential substance misuse services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

During our inspection we spoke to six of the fourteen clients who were at Smithfield and had feedback from a further twenty eight on comment cards. We received universally positive feedback about the service. Clients told us "staff are amazing" "Smithfield never closes the door on you" and "Everyone is so friendly". During our inspection we observed interactions between clients and staff. Staff were respectful and polite in their manner and clients told us this was the case. They told us staff respected their cultural, social and individual needs. Clients told us that staff were always available when they wanted to talk, and medication was always explained at each medication round. Nurses took time to answer questions about medications and explain what they were for. It was clear from our interviews with staff that they knew clients well and took the time to understand their needs even though they were only admitted for relatively short periods of time. All clients we spoke to told us they would feel confident to raise any issues with staff and that these would be taken seriously and addressed quickly. All clients told us the manager and senior team were approachable.

Clients spoke very highly of the peer mentors. They felt that they gave them hope that they could get through the detoxification and have a fulfilled life afterwards. They were described as visible recovery.

On the day of our inspection we observed two groups. One was a relapse prevention group, and another was a guest speaker who completed their own detoxification at Smithfield. Fourteen clients attended these groups. We observed how the staff facilitating the groups involved everyone who was present and gave them time in a safe place to share information about their own lives. Clients who were less vocal were encouraged to be involved with support to ensure that all voices were heard. Staff also gave emotional support when this was needed.

Involvement in care

There was an in depth admission process at Smithfield. This meant that it was discussed in detail prior to the client being accepted if Smithfield was the right place for the client to undertake their detoxification. There was a pre detox group that clients could attend where information about Smithfield and how it worked once they were admitted was given. If the client wanted to visit Smithfield before they were admitted, then this was possible and would be accommodated.

We observed an admission during our inspection. We found that this was dealt with sensitively and the client given lots of time to ask questions. The doctor and a qualified nurse were both present. The client was told about the service and how the detoxification would work including medication regimes and times, group work, mealtimes and food availability, side effects and management of withdrawal. Once the client had completed this part of the admission one of the peer mentors showed them around the service and helped them unpack their belongings. They also introduced them to other clients, so they were able to start talking to other people in a similar situation straight away.

All clients were actively involved in their care plans. As clients could be quite physically unwell at the beginning of their detoxification we found that sometimes care plans for physical health concerns and for example, management of seizures were done without the client present. However, care plans that could wait were done at key working sessions with the client involvement. The care plans that were done in their absence were also revisited and signed at these sessions. For those who were physically well enough they were involved from the beginning. All clients we spoke to told us they felt involved in decisions about their care and treatment.

Good

Residential substance misuse services

Clients were asked to give feedback on the service in a number of ways. There was an annual service user survey that was sent out to all clients who had been in the service in that year. The 2019 service found that 100% of patients felt communicated with, 100% felt they were treated with dignity and respect and 100% of clients would recommend Smithfield to family and friends. There was also a monthly feedback from done at Smithfield and some of the comments received over the three months leading up to our inspection included “a brilliant place” “magic” and “thank you for getting me on the road to recovery”.

Involvement of families and carers

Staff encouraged maintaining contact with family when the client wanted this. There was a family visiting room on the ground floor where children could visit safely. Although it was stipulated that they needed to inform staff before the visit, so they could risk assess the current client group. There was an information poster displayed in the unit that explained to family and friends about the support Smithfield would offer them whilst their loved one was in Smithfield. This included face to face or over the phone support.

Are residential substance misuse services responsive to people’s needs?

(for example, to feedback?)

Outstanding ☆

Access and discharge

Referrals to Smithfield were from both private and statutory sources. Prior to any admissions the Clinical Lead or Registered Manager would go and meet the client to do a pre admission assessment to assess the client’s suitability for the service. There was a single point of access for referrals to come in via and this was managed by the referral pathway coordinator. There were systems in place to gather relevant information about the client prior to admission. This included full history from the GP, blood test results and information about blood-borne viruses. The service also worked closely with the referrer (usually from a community drug and alcohol team) to gather all relevant information including risk history and discharge plans. Smithfield guarantees admission within 21 days of the referral request being received.

On admission the client was reviewed by the doctor and a registered nurse. Physical health observations were carried out to give baseline readings, this included blood pressure, pulse and temperature. Drug and alcohol screenings were also done. The length of admission was tailored to suit the individual, but this typically lasted for between three and 28 days. There were clear discharge plans in place prior to the client being admitted. However, if a client expressed a wish to leave early then emergency exit plans detailed who would need to be contacted and what action would need to be taken depending on the level of risk. This would include a review by the doctor and providing ongoing medication including advice around low tolerance levels if the person decided to leave. The activity plan in place at Smithfield encouraged clients to make links with support groups prior to their discharge so they had the tools they needed to maintain sobriety once discharged. This included mutual aid groups and other support networks. There was also a group on a Sunday where past clients could attend, and this was well attended.

The facilities promote recovery, comfort, dignity and confidentiality

Each client had their own bedroom which contained a sink. There were shared facilities that were gender specific for toilets, showering and bathing. Clients were able to personalise their own bedrooms for example with photographs or trinkets from home. All clients had a key to their bedroom and there was a secure space to store valuables. Staff and patients had access to the full range of rooms and equipment to support treatment and care. This included lounges, dining room, clinic room and activity rooms. There were also small rooms where one to one could take place a family room and an outdoor area. Clients had access to their own mobile phones if they wanted to make a call in private. However, they could also use the phone at the unit if they needed to.

Clients gave us universally positive feedback about the food. There was an onsite chef who was able to provide food that the clients wanted to eat. The service was able to meet cultural and dietary requirements such as vegan meals and halal and kosher meat. Dietary requirements were identified as part of the admissions process. We observed the food to be healthy, of a good portion size and there was plenty of choice. The chef helped clients learn to cook some basic recipes whilst they were at Smithfield and put these into a recipe folder they could take home with

them. There were also regular smoothie making groups to encourage a range of nutrients which were a valuable part of rebuilding client dietary intake post detoxification. Clients had their own kitchen where they could make hot drinks and snacks whenever they wished.

Patients' engagement with the wider community

The service put a lot of emphasis on links with the wider community. Staff told us it was important to give clients the tools they would need to maintain their sobriety once they left Smithfield. With that in mind the team encouraged clients to try a number of activities both based around addiction and for personal enjoyment. There were groups daily which were around abstinence including alcoholics anonymous, narcotics anonymous and cocaine anonymous. They were also introduced SMART recovery groups, so they could decide which (or both) worked best for them. As well as these organised groups, there were groups led by the peer mentors that focused on recovery, this included crisis survival, dealing with cravings and success stories. There were also groups that encouraged clients to take an interest in a social activity. These included drop in from back on track which is a charity that works with adults in recovery to make positive changes in their lives. There is also a basic first aid course provided by the Red Cross, art groups, Pilates and guided meditation. The service attended a local church group and did walking groups around the local area. Lunchtime concerts were provided by the local school of music which allowed clients exposure to different types of music they may not have listened to before. There were also groups just to allow clients to relax and have fun such as film nights, bingo and quizzes. There was a new group starting which encouraged exercise to promote a healthy mind. This was to engage with local gyms to allow the clients to use them for free to take part in cross fit sessions which ended with a session of mindfulness. This was to both encourage clients to take up a new hobby once they completed their detoxification and to ensure that wellbeing of the mind was maintained by using both exercise and mindfulness.

Maintaining links with family and carers was actively encouraged. Children were able to visit if this was risk assessed to be appropriate.

Meeting the needs of all people who use the service

The hospital was designed over two floors. There was a lift that people with poorer mobility could access and there were evacuation chairs around the building to use in the event of a fire. There was access to leaflets in different languages if required and this were obtained from the providers intranet. Similarly, they were able to translate care plans into different languages by clicking a button on the system. Communication needs were identified during the referral process and discussed with the client. Clients were able to access translation services, which included face to face and telephone. Where English was not the clients first language, staff assessed their ability to communicate in English. This was due to the need to participate in group work and activities as part of the treatment programme.

The chef was able to tailor menus and order food in specially to meet special dietary requirements. This included for religious reasons and for other reasons such as coeliac disease or if someone was a vegetarian or vegan.

There was a quiet room or bedroom space for clients o pray if they wished to. The service also had good links with local religious groups and attended a church once a week.

Listening to and learning from concerns and complaints

In the twelve months leading up to our inspection there were 366 compliments for Smithfield. In that time there were three complaints. Two of these were informal and one was a formal complaint. None were referred to the ombudsmen.

Clients we spoke to all knew how to complain if they wanted to. There was information displayed around the unit and there was a complaints policy for staff to follow. Clients we spoke to told us they would feel comfortable raising concerns and felt they would be managed appropriately.

Staff we spoke to were able to tell us how complaints were managed. Feedback from complaints was shared in team meetings and individual supervision.

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Good

Residential substance misuse services

Are residential substance misuse services well-led?

Good

Leadership

The registered manager and Clinical Lead had the correct skills and experience for their roles. The registered manager has been in post for many years and showed a genuine commitment to their role and the service. Many of the senior team had been with the service for a long time and provided consistent, supportive leadership. Staff and clients spoke positively about the managers and the support they offered them.

All senior staff demonstrated a good understanding of the client group. Managers were supported in their own development. There were plans for one of the senior team to complete a non-medical prescribing course. There were also opportunities for degree level qualifications and leadership courses.

Vision and strategy

The provider had a vision that was:

“To constantly find ways to support more people to discover new possibilities in their lives”

They also had a set of values:

We all communicate in an authentic and confident way that blends support and challenge

We commit to building a strong and financially viable Turning Point together

We deliver better outcomes by encouraging ideas and new thinking

We treat each other and those we support as individuals however difficult and challenging

We believe that everyone has the potential to grow, learn and make choices

We are here to embrace change even when it is complex and uncomfortable

Staff were aware of the vision and values, they informed the teams work. The values were embedded into the annual appraisals and interview process of the service.

Staff had the opportunity to contribute to discussions about the service and service development. They were involved in making decisions around changes to the service and in developing actions to deliver improvements. Staff we spoke with told us that managers were open to ideas and suggestions from both themselves and clients.

Culture

All staff we spoke to told us they felt respected and valued. They told us the management were supportive and were clear about their roles and responsibilities. They felt the service promoted equality and diversity and provided opportunities for career development. Staff felt positive and proud about the work they were doing. Staff spoke positively about their colleagues and were motivated and enthusiastic about the work they did. Many of the staff had worked at the service for some time and this showed the levels of commitment shown by staff to the service user group.

Staff felt they could raise concerns without fear of retribution. They told us the manager would take any issues they raised seriously, and they would be dealt with accordingly. Staff were aware of the whistleblowing procedure.

Managers addressed poor performance promptly and were clear about the correct process to follow. If more informal support and guidance did not improve performance, then the managers felt supported by human resources to deal with the issues more formally.

Staff told us they felt supported in their career progression. Staff were able to take on additional training to further their career within the service. Supervision and appraisals were in line with the providers policy and we saw evidence that career progression was discussed as part of these.

Governance

There were systems and processes established to ensure that the quality and safety of the unit was assessed, monitored and improved. Overall these worked well and learning from these was clear. However, during our inspection we found that the documentation of observations was not always completed in full. CIWA scores were not documented when a when required detox medication was administered as per the provider policy. Blood pressure and pulses recorded out of range were not recorded that they had been repeated. Although we felt

that staff managed withdrawal symptoms safely by observing the service user and giving extra medication where required, we found that staff were not always documenting this at the time it was done and the adding the reasons why, backed up by the withdrawal symptom tools available to them. As staff worked 12 hour shifts they would make one entry in the notes at the end of the shift, this did not always detail the reasons for giving when required medication or the scores from the withdrawal symptom tool. In the days following the inspection the service provided us with an action plan of how they were going to improve this going forward. This included, ensuring all medication administration records had a physical observation recording chart with them, so these could be documented at the time of administering medication. To develop competency based assessment tool to support the nurses in improving practice and ensuring CIWA were recorded as per procedure. Medication sheets to be audited during clinic time to ensure observations and withdrawal scores are recorded when as required medication I given. Learning from all the above to be fed back to the team through team meetings and one to ones where appropriate. The standard operating procedure was also updated to include clear guidance on the recording of scores whether medication was given or not as this gives the evidence as to the decision to administer or not administer medication.

Staff at all levels were clear about their roles and accountabilities and had regular

opportunities to meet, discuss and learn from the performance of the service. There was a clear framework of what must be discussed in team meetings to ensure that essential information, such as learning from incidents and complaints was shared and discussed.

Management of risk, issues and performance

Staff maintained and had access to a risk register at location and provider level. Concerns could be highlighted at the hospital and escalated as necessary to the provider level risk register. The service had plans for emergency situations such as bad weather conditions. There was clear information for staff on how this could be managed. The service submitted performance information to public health England. The provider monitored its own performance via activity reports.

Information management

Staff had access to the information and equipment required to carry out their roles and deliver treatment. Information needed to deliver care was in an accessible format and stored securely.

Managers had access to information to support them with their management role, such as information on staffing and training.

All staff had completed information governance training which included confidentiality of patient records. Patient records were kept in a locked office and within a lockable cabinet. Detention papers were kept in a separate cabinet securely. Staff made notifications to external bodies as needed such as commissioners, the local authority safeguarding team and care quality commission.

Engagement

The provider provided staff with up to date information through the intranet and bulletins.

Patients and carers were given the opportunity to give feedback on the service at regular intervals. This was done via feedback surveys, community meetings, complaints and suggestion boxes.

Managers and staff had access to feedback from patients and carers. They were able to use these to make changes at the service. The hospital manager engaged with external stakeholders such as referring agencies to ensure that the needs of the patients admitted to the hospital were being met.

Learning, continuous improvement and innovation

The provider welcomed students from lots of professional disciplines including student nurses, and psychologists. This enhanced the work the team already carry out with the patient group and provided ongoing professional development for the registered nurses who were qualified mentors.

The service was committed to improving care and treatment from learning when things went well or went wrong. The service reviewed adverse incidents and completed audits. Actions were identified and completed. Staff we spoke with reported that managers were receptive to new ideas and encouraged improvement.

Good

Residential substance misuse services

Staff were encouraged to be creative and they had introduced Pilates and mindfulness as part of the group programme to enable clients to try new methods of relaxation and exercise techniques.

Outstanding practice and areas for improvement

Outstanding practice

- The hospital had very positive links with the local recovery community as well as the wider community. They were involved in local church groups, attended concerts by the local music school and attended local recovery groups on a regular basis.
- The chef at the hospital had developed groups to promote a healthy balanced diet to improve the health of the client group. They would develop healthy recipes and cook them alongside the chef, these would then be laminated for the client to continue to use once discharged. The group also included smoothie making in order for the client group to begin to replace vitamins and minerals that may be lacking in their diet due to substance misuse.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that that withdrawal scales relating to the decision to administer when required medication is completed in full at the time the medication is given.
- The provider must ensure that physical observations are documented in relation to the decision to give when required medication, and action taken following out of range observations is documented clearly.

Action the provider SHOULD take to improve

- The provider should ensure that the environment is well maintained for the client group
- The provider should review the management of controlled drugs in relation to medication that arrives prior to the patient being admitted.
- The provider should ensure that documentation is complete for patients bringing their own medication to self-administer into the service.

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 Regulation 12 HSCA 2008(Regulated Activities) Regulations 2010 Safe care and treatment. Withdrawal symptom scales were not being completed prior to patients being given when required medication. When patients physical observations taken for dispensing when required medication were out of range there was no documentation of this being repeated or what action was taken. This was a breach of regulation 12 (2) (a)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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