Long Yard

Quality Report

8-9 Long Yard
London WC1 3LU
Tel:020 7404 1117
Website:www.phoenix-futures.org.uk

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

Overall summary

We carried out a focused inspection of Long Yard on 25 and 27 January 2016. The inspection checked the safety and effectiveness of the service.

Some aspects of the service were not safe. Risk management plans and care plans were not always comprehensive and clients were at risk of not having all their needs met. Staff did not consistently administer medicines safely. Staff had not always kept accurate records in relation to clients' medicines. Staff had not ensured that medicines were always stored at the correct temperature. The provider did not have robust arrangements to ensure prescriptions pads were kept securely and there was a risk they could be misused. Staff made observations on clients' health during alcohol withdrawal. However, staff had not always recorded how decisions about the type and frequency of observations had been made. Clients were at risk of not being observed at the appropriate level to identify risks to their health at the earliest possible stage. Since the inspection, the provider has ensured any discussion staff hold with the contracted doctor about observations are always recorded.

A suitably qualified contracted doctor assessed the medical needs of clients referred to the service and provided appropriate treatment and medical monitoring of clients which complied with NICE guidance. The provider had begun to take action to improve the accuracy and thoroughness of record-keeping but some further improvements were required. Staff were appropriately trained and supervised in relation to working with people undergoing alcohol withdrawal treatment.

Summary of findings

Contents

Long Yard

Services we looked at:
Substance misuse/detoxification

Summary of this inspection

Background to Long Yard

Long Yard is registered with the CQC to provide accommodation for up to 16 clients over 18 years who require treatment for substance misuse. The service provides a medically monitored residential alcohol withdrawal treatment programme over a period of up to three weeks. The provider has a contract with doctors at a local GP practice who assess the suitability of new referrals to the service and plan and monitor their medical treatment. At the time of the inspection the service was providing rehabilitation for up to 12 weeks for clients who had already completed an alcohol withdrawal programme either at Long Yard or another service. Staff at the service provided individual support to clients and arrange therapeutic groups and rehabilitation activities.

In most instances, clients are referred to Long Yard by local authority substance misuse teams. At the time of this inspection in January 2016, five clients were using the service for supervised alcohol withdrawal and five clients were using it for rehabilitation.

Long Yard has a registered manager who has been in post for over two years. The service was last inspected in March 2014 and was found to meet all the regulations checked at that time.

Our inspection team

The team that inspected the service comprised two CQC inspectors, a CQC pharmacist specialist and a doctor who is a specialist in substance misuse services.

Why we carried out this inspection

We carried out this focused inspection in response to information we had received from about the safety of Long Yard.

How we carried out this inspection

This inspection was focused on the safety and effectiveness of the service. Before the inspection visit, we reviewed the information that we held about Long Yard.

A CQC pharmacist specialist visited Long Yard on 25 January 2016 to review medicines management at the service. Two CQC inspectors and a doctor who is a specialist in substance misuse services visited the service on 27 January 2016.

During the inspection visit, the inspection team:

- Visited Long Yard.
- Read six care and treatment records and six medical files.
- Spoke with three clients who were using the service.
- Spoke with a GP who was contracted to assess referrals and provide treatment to clients.
- Checked how staff managed medicines in the service.
- Spoke with the registered manager and the Head of Quality and Performance.
- Spoke with three other staff members.

After the inspection, we received further information about the operation of the service from the provider.

Summary of this inspection

What people who use the service say

We spoke with three clients of the service. They told us all members of the staff team treated them kindly and with respect. They said they enjoyed the meals at the service.

Clients told us staff explained the alcohol withdrawal programme to them. They said staff provided groups and individual sessions which were supportive and helpful.

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?

- Not all clients had a comprehensive risk management plan and care plan which included the healthcare needs identified by the contracted doctor at the initial medical assessment of the client. Clients were at risk of not having all their healthcare needs met.
- Medicines were not administered safely. Staff did not always record whether clients had received their prescribed medicines or not. The storage of medicines was not effectively monitored each day to ensure medicines were kept at the correct temperature. The provider did not monitor the security of prescription pads and this placed people at risk.
- Staff observed clients for adverse symptoms. However, staff had not always recorded how they made decisions on the type and frequency of observations for each client.In the absence of such records, we could not be certain that the assessment and management of risk to clients was safely managed.
- The medicines prescribed to clients and their individual treatment regime complied with NICE guidance.
- Staff reported incidents and improvement plans were in place to develop the standard of record-keeping in the service.

Are services effective?

- The contracted doctor had appropriately assessed clients to ensure their needs could be met by the service during alcohol withdrawal treatment and provided medical monitoring of clients whilst they were at the service.
- The provider had ensured staff were trained on the health complications which could arise in clients undergoing alcohol withdrawal and knew what action to take.
- The provider had accepted written referrals from external agencies which were poorly completed and lacking information on the health and background of clients.
- Staff told us they did not feel they were adequately trained and to support frail clients in relation to their mobility needs.

Substance misuse/detoxification

Safe	
Effective	

Summary of findings

Are substance misuse/detoxification services safe?

Safe staffing

At the time of the inspection, there were two staff vacancies; the provider was in the process of recruiting to these. Relief workers from the provider's 'bank' of staff had covered vacancies and no shifts were short-staffed. After 5pm and at weekends there were two members of staff on duty. During the week there were additional managerial staff and staff providing rehabilitation support to clients on site. After the inspection, we received further information on the occupancy of the service over the previous year. Clients and staff told us they thought there were always enough staff on duty. We were satisfied staffing levels at the service were safe.

Assessing and managing risk to clients and staff

Nine of the ten clients who were using Long Yard at the time of the inspection had been referred to it by their local authority substance misuse team. We checked six clients' care and medical records. Local authority case workers had used the provider's referral form to give information about the client and their background. In most instances, the information on these forms was sparse and lacked detail. For example, one client's referral form had the information 'has had mental health problems in the past' with no more details. In another case, the referring worker had omitted key information about a client's physical health condition. However, this information was in a report supplied by the client's GP.

The registered manager and contracted doctor told us that decisions about a client's suitability for admission to the service were made by a contracted doctor. The contracted doctors were GP partners and had attained the Royal College of General Practitioners Part 1 qualification in alcohol dependency management in the community.

We spoke with a contracted doctor about how he decided whether a client was safe to be receiving alcohol withdrawal treatment at Long Yard. We were satisfied that he took steps to ensure he received all the appropriate medical information and blood test results. The six records

we reviewed showed that the doctor had accepted referrals appropriately in accordance with NICE guidance for a residential alcohol withdrawal service. Care records included a pro forma for the doctor to sign confirming medical acceptance of the client but these had not been completed.

We read the provider's policies and procedures in relation to the admission criteria and pre-assessment process for Long Yard. These were generic for all the provider's substance misuse services. Consequently, the specific admission criteria and assessment procedures for the alcohol withdrawal service at Long Yard were not set out in detail. The provider's procedures stated a client would not be admitted to their substance misuse services if they have, "Significant physical or psychiatric illness likely to be exacerbated by the withdrawal process to the extent that hospital treatment is required." NICE guidelines (CG100, Alcohol-use disorders: diagnosis and management of physical complications, published: June 2010) state the circumstances in which alcohol withdrawal should take place in hospital. This includes people at high risk of developing alcohol withdrawal seizure or delirium tremens, for example vulnerable people who may frail, have cognitive impairment or multiple comorbidities, lack social support or have learning difficulties.

The six records we reviewed showed the contracted doctor had carried out an initial face to face medical examination and assessment of each client. Records showed this had taken place on the day of admission. The contracted doctor did not use a formal method such as the Severity of Alcohol Dependence Questionnaire (SADQ) or other similar tool to assess the client's pattern of alcohol use and severity of dependence as suggested by NICE (CG115, Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence, NICE guidelines, February 2011). However, the contracted doctor had undertaken an assessment of the client's mental health, alcohol dependency level and healthcare needs.

The doctor had developed a clear management plan in relation to each client's healthcare needs. However, in the case of one client, we identified that care staff had not referred to the client's long-term health condition at all in their care plan. Consequently, there was no information for staff to ensure the delivery of the management plan drawn up by the doctor in relation to monitoring their long-term health condition. Care staff had not noted the relevant information in the client's risk management plan. We were concerned that managers of the service had not identified this issue which may have had serious adverse consequences for the client's health.

During the inspection,we spoke with the registered manager and two members of staff about this. It was clear to us that there was no procedure to ensure that staff always read and reviewed the doctor's management plan before drawing up the risk management plan that staff used to plan and deliver support to the client. Staff told us they did not routinely record the outcome of any of the discussions staff held with the contracted doctor about how they should support clients with their healthcare needs. The lack of recording in relation to clients' health needs meant there was a risk that staff would not put into operation decisions agreed by their colleagues. Consequently, the health of clients was at risk because staff could be unaware of the actions they needed to take to ensure their needs were met.

During the inspection, the registered manager checked that any recommendations made by the doctor had been included in care plans. He told us he would ensure staff would make appropriate care plans in future through team briefings, individual supervision and spot checks.

Since the inspection, the provider has told us that they have rectified this through staff making handover notes of decisions made with the contracted doctor.

A staff member measured each client's blood pressure once, on admission to the service.

When patients were undergoing treatment, the contracted doctor decided how often the staff team should initially make observations. However, subsequent decisions about the frequency of observations and how they should be reduced were not recorded. This has been rectified since the inspection.

Case records showed staff had carried out observations of clients' health hourly during the first 24 hours of their alcohol withdrawal programme, which included a visual check on whether the client was showing signs of delirium tremens (DT) or seizure. Thereafter, staff in discussion with the doctor, decided how often they should make observations of clients, however this decision was not recorded. There was no detailed policy in place which linked the frequency and type of observations to identified risks for each client. Staff were not using a formal system to

undertake observations such as 'Clinical Institute Withdrawal Assessment of Alcohol Scale, revised (CIWA-Ar)' for severity of withdrawal symptoms as suggested by NICE. (CG115), Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence, NICE guidelines, February 2011). This meant that clients were at risk of not receiving observations of the appropriate type and frequency to ensure they were safe. This has been rectified since the inspection.

The doctor had recorded his rationale for the prescribing regime for each client's alcohol withdrawal which took place over 10-14 days. Each client's prescription was safe and appropriately met their needs in accordance with NICE guidance in terms of the individual drugs prescribed and the amount prescribed. The doctor had recorded that he had discussed with each client the risks associated with alcohol withdrawal, such as delirium tremens (DTs) and seizures.

We reviewed six clients' medicines administration record (MAR) charts. Staff had written out a separate MAR chart for each medicine to record the date and time the medicine was administered. This meant staff could not easily see the overall situation in relation to all the medicines each client was prescribed. Two staff and the client had signed the record to show they had received their medicines which were prescribed for alcohol detoxification.

The doctor routinely assessed clients' nutritional status and prescribed 'Pabrinex', a vitamin injection, to address health risks associated with alcohol withdrawal. We noted that each client's medicines administration record in relation to 'Pabrinex' were blank. Clients and staff told us this was because clients declined to have this injection. Staff had not complied with the provider's medicines management procedures and recorded the client's refusal of 'Pabrinex'. We noted that clients had received oral vitamins which mitigated the risk of them not taking this medicine. Staff told us they had discussed the fact that clients had declined their 'Pabrinex' injections with the contracted doctor but this was not recorded. We were also told that members of the staff team discussed the benefits of 'Pabrinex' with clients but this was not recorded. Since the inspection, the provider has told us they have rectified this and ensured any refusals of 'Pabrinex' injections are recorded.

Only one member of staff at the service was qualified to administer 'Pabrinex' injections. When this staff member was unavailable we were told that qualified healthcare staff from the contracted doctor's GP surgery could administer it. However, in practice this did not happen because the clients tended to refuse 'Pabrinex' injections.

The contracted doctor visited the service daily Monday to Friday and staff told us they could contact him directly out of these hours for advice. Clients told us they could see the doctor if they felt unwell.

Care records showed that when a client's health had deteriorated noted staff had taken prompt and effective action to ensure the client's well-being and safety. For example, when a client had fallen, staff had taken appropriate initial action and then accompanied the client to hospital for further investigations and arranged appropriate follow up.

The service had suitable procedures in place to support clients during alcohol withdrawal. For example, on admission to the service clients were asked to sign their acceptance of the house rules of the service. No alcohol was allowed on the premises. The rules included a 'Seven days rule' clients were asked not to leave the service during the first seven days of their stay without escort. Thereafter, staff assessed the individual risks to clients and arranged for them to be escorted when this was appropriate.

Spot urine tests were conducted. If a client persistently did not comply with the rules they were asked to leave the service. Staff followed a protocol if a client left the service before their treatment was complete. This included information on how the service should liaise with other services to promote the client's safety.

Staff had followed the provider's procedures to account for medicines. Staff logged any medicines received from the pharmacy or brought in by clients using the service.

The service held a quantity of prescription pads, which were logged on receipt with their serial number and the date received, but the quantity received was not documented. The provider did not have sufficiently robust arrangements in relation to these pads. There was a risk prescription forms could be stolen or misused, this placed clients at risk. The provider has since rectified this.

We did not see any records or evidence of daily fridge and room temperature monitoring at the service. Staff told us that they monitored the fridge temperature only once a week. This did not meet regulatory requirements in relation

to the management of medicines and meant that medicines may have been stored at the incorrect temperature which might make them unsafe or ineffective. The provider has told us that this has been rectified.

Reporting incidents and learning from when things go wrong

We reviewed how incidents were reported at the service. We read details of a range of incidents which had occurred in the 12 months prior to the inspection. This included information on minor accidents such as falls. Appropriate medical follow up had occurred. Staff we spoke with told us they knew which incidents to report and said that incidents were discussed in team meetings to learn lessons.

The manager of another of the provider's services had written a detailed and robust investigation report dated 17 November 2015 on a serious incident which had occurred at the service in October 2015. The report had identified areas for improvement, primarily in relation to record-keeping. For example, it was noted that staff had not ensured that the risks they had identified for a client were followed through to management plans. The report recommended further training for staff on care planning and record-keeping and the auditing of records to ensure improvements were made. The target date for the improvements to be put in place was six weeks from the date of the report i.e. by the end of January 2016. Most of these actions had been completed. Two staff were due to have further training on care planning in February 2016.

During the inspection we saw evidence that a programme of case file audits had commenced which had identified further shortfalls in recording procedures. For example, although new risk checklists had been introduced staff were not consistently using them. The registered manager told us this would be followed up in team meetings and individual staff supervision meetings.

Are substance misuse/detoxification services effective?

(for example, treatment is effective)

Assessment of needs and planning of care

The six medical records we reviewed showed that the contracted doctor saw each client on the day of their admission to the service. He had carried out a face to face medical examination and an assessment of each client's level of alcohol dependency and healthcare needs. The contracted doctor did not use a validated method, such as the Severity of Alcohol Dependence Questionnaire (SADQ) or other similar tool to assess the client's pattern of alcohol use and severity of dependence. However, the contracted doctor had undertaken a thorough assessment of the client's mental health, alcohol dependency level and healthcare needs which enabled him to appropriately plan their alcohol withdrawal programme.

Staff in the service had not always ensured that the management plans developed by the doctor were incorporated into plans of care. In one instance, staff had failed to act on the doctor's recommendations in relation to oversight of the client's long-term medical condition. This may have had adverse consequences for the client. During the inspection we informed the registered manager about this and he confirmed before we left the service that all medical recommendations had been followed up. He told us staff would be immediately reminded that they must ensure medical issues are addressed in care planning and he would make spot checks on this.

Best practice in treatment and care

The doctor had recorded his rationale for the prescribing regime for each client's alcohol withdrawal which took place over 10-14 days. Each client's prescription was safe and appropriately met their needs in accordance with NICE guidance in terms of the drugs prescribed and the amount prescribed. The doctor had recorded that he had discussed the risks associated with alcohol withdrawal, such as delirium tremens (DTs) and seizures with each client.

There was no system in place for decision-making in relation to the type and frequency of observations throughout their treatment for alcohol withdrawal. This may have placed clients' health at risk.

Case records showed staff had carried out observations of clients' health hourly during the first 24 hours of their alcohol withdrawal programme, which included a visual check on whether the client was showing signs of delirium tremens (DT) or seizure. Thereafter, staff in discussion with the doctor, decided how often they should make observations of clients, however this decision was not recorded. The provider told us that this has been rectified.

Skilled staff to deliver care

Substance misuse/detoxification

The doctors who prescribed medicines to clients had the appropriate qualifications. They had attained the Royal College of General Practitioners Part 1 qualification in alcohol dependency management in the community.

None of the staff at the service had nursing qualifications. One member of staff at the service was trained to administer intramuscular injection and take blood pressure readings. We saw evidence of her training to effectively carry out intramuscular injections.

We checked the training records and supervision records of staff. There was evidence that they had received training appropriate to support people during alcohol withdrawal. For example, the provider had ensured that staff had received 'refresher training' in administering medicines and first aid. Staff we spoke with were able to describe the signs and symptoms of seizures and delirium tremens and the action they would take if a client's health deteriorated. However, staff said they were unsure how to best support frail clients with impaired mobility. For example, they were unsure how to support them safely when they were escorting them to appointments. Staff told us they would like more training on this.

Staff had received appropriate training in supporting client's with their rehabilitation. Staff had developed detailed rehabilitation plans with clients and ran groups and individual programmes to support people with their recovery. Clients were positive about the support they received from staff. A commissioner told us the service was effective and had outcome measures which confirmed its performance was in line with similar services in terms of the outcomes for clients.

The registered manager told us that if a client required personal care they were only admitted to the service on condition personal care was provided for the client by another agency. All of the clients in the service at the time of the inspection were self-caring.

Multi-disciplinary and inter-agency team work

Staff reported positive morale and constructive working relationships at the service. They told us there was good communication within the staff team and at the handover between shifts. The staff team at Long Yard met weekly and staff said they found these meetings supportive and helpful.

At the time of the inspection,the registered manager met with the contracted doctor each week. However, there were no formal meetings between the staff team and the contracted doctor to review and develop multidisciplinary practice.

The six care records we reviewed showed the service accepted referral forms from local authority service misuse teams which were often poorly completed. However, we saw evidence that the service worked effectively in partnership referring local authorities in relation to reviewing client progress and planning their discharge.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- The provider must ensure all clients have a risk management plan and care plan which addresses all their needs including those needs identified by the contracted doctor at his initial medical assessment of the client.
- The provider must ensure that staff record the details and outcome of discussions between staff and the contracted doctor in relation to monitoring the health of patients.
- The provider must ensure that medicines are administered safely. The recording of medicines administered and refused must be comprehensive and the storage of medicines effective. Prescription pads must be logged appropriately and stored securely. Fridge temperatures and room temperatures must be regularly checked and recorded.

Action the provider SHOULD take to improve

- The provider should ensure that file audits include checks that medical assessment information is appropriately reflected in risk management plans and care plans.
- The provider should take action to improve the quality of referral information from external agencies.
- The provider should ensure staff are trained to support frail clients in relation to their mobility and healthcare needs.
- The provider should ensure that the policies and procedures for Long Yard are reviewed to ensure they are appropriately detailed to ensure the safety of patients undergoing treatment for alcohol withdrawal.

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(1), and (2) (a) (b) and (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.** How the regulation was not being met: The provider had not ensured that risks to patients' health were always comprehensively assessed. Effective plans had not been developed and implemented in relation to mitigating risks. This was a breach of Regulation 12(1), and (2) (a) (b). Medicines were not appropriately managed and administered to ensure people were safe. Room and fridge temperatures were not monitored at the appropriate frequency. The provider did not have adequate arrangements to ensure prescription pads were kept securely. This was a breach of Regulation 12(1), and (2) (g).