Rebbeck, Knole, Percy, Windham, Connaught, Gordon, 6 & 16

Quality Report

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

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

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

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

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

Overall summary

We do not currently rate independent standalone substance misuse services.

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

- The provider had a formal agreement with a local doctor and GP surgery to provide prescriptions for opiate detoxification and medical treatment for clients. The practitioner regularly prescribed medication for opiate detoxification that guidance states is not a first line treatment and should not be used routinely. The service did not use formal rating

Summary of findings

scales to measure client's withdrawals in line with best practice during opiate detoxification. This meant staff were unable to accurately and impartially assess the efficacy of the treatment given.

- The service placed clients at potential risk of harm. It did not provide safe supervision overnight for clients in the early stages of alcohol detoxification to ensure their safety.
- The service used structured formulaic care plans that did not capture client's views although clients did tell us they had discussed them during one to ones with their counsellors. Staff did not provide clients with nutritional advice and support even though clients' care plans specified this as a need.
- Governance structures were not robust and had not identified and managed areas of concern raised during the inspection. The management team was not aware of the potential risks posed to clients by the service's practices, or that the service did not adhere to best practice guidelines. There was no formal structure for managers to provide one to one supervision of staff or for staff to feedback on the service to help it develop.

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

- The service completed a thorough admission process including a risk assessment prior to prescribing treatment.
- There was good communication between the provider and services that referred clients to them. Referrers we spoke to were positive about the care given.
- Clients felt supported and cared for by staff. They stated that the programme provided by the service kept them safe and supported their recovery. The service actively engaged with families, providing support and information to enable them to support their relative who was in recovery.

Summary of findings

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Rebbeck, Knole, Percy, Windham, Connaught, Gordon, 6 & 16

Services we looked at:
Substance misuse services

Summary of this inspection

Background to Rebbeck, Knole, Percy, Windham, Connaught, Gordon, 6 & 16

Providence Projects Rehab Group provides residential rehabilitation and substance misuse and alcohol detoxification services.

The service provides all therapy and detoxification treatment in two community-based treatment centres. Clients use the primary treatment centre when they are at the beginning of their treatment or need to receive medicine. The secondary centre was for clients who had progressed further through their treatment.

Accommodation for clients is within eight houses in walking distance of the treatment centres.

The service provides accommodation at the following locations:

- Rebbeck provides accommodation for four clients
- Windham, Percy, Knole and Connaught each provide accommodation for five clients
- Gordon, 6 and 16 each provide accommodation for six clients.

All of the accommodation caters for males and females. Apart from Rebbeck and Windham, each of the properties has one twin bedroom in addition to single rooms. Staff use these to provide peer support to clients who would benefit from sharing a room with a client further through their treatment programme.

Staff visit the accommodation on a daily basis to carry out regular checks and in response to concerns that arose. Staff assess clients prior to admission and develop an individual care package tailored to their needs. These can vary in length dependent on the client's circumstances. Treatment can include medical detoxification under supervision from a local GP surgery and psychological therapies from trained counsellors.

Charities and statutory organisations such as local authorities fund treatment for clients. Other clients are able to self-fund.

CQC has registered the service to provide accommodation for persons who require treatment for substance misuse.

CQC previously inspected Providence Projects Rehab Group on 6 – 7 August 2013. On this occasion, the service was compliant with the Health and Social Care Act 2008 (regulated activities) regulations 2010.

Our inspection team

The inspection team comprised of a lead inspector, Colin Jarratt, an inspection manager, two other inspectors and a specialist professional adviser who was experienced in working in substance misuse services.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme to make sure health and care services in England meet the Health and Social Care Act 2008 (regulated activities) regulations 2014.

Summary of this inspection

How we carried out this inspection

To understand the experience of people who use services, we ask the following five questions about every service:

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

Before the inspection visit, we reviewed information that we held about the location and asked other organisations for information.

During the inspection visit, the inspection team:

- visited this location and looked at the quality of the physical environment
- visited the two community treatment centres where therapy and detoxification treatment was provided and observed how staff were caring for clients
- spoke with eight clients
- spoke with the registered manager
- spoke with eight other members of staff including the admissions manager, counsellors and support workers
- spoke with two general practitioners who worked at the local GP surgery, one of which was the prescriber, that provided monitoring of patients' detoxifications and physical and mental health needs
- received feedback about the service from four services that refer clients to the provider
- looked at 12 care records for clients and 10 medicine charts
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with two groups of four clients during our inspection. The clients we spoke with were extremely positive about the care they received from the staff. They described the staff as being positive, kind and supportive. The clients felt that the staff treated people with dignity and respected their differences as individuals. They stated that the staff had given them a sense of belonging and that the skills staff taught them would enable them to lead independent lives after discharge from the service.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We do not currently rate standalone substance misuse services.

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

- The service did not have an automated external defibrillator (AED) available for staff to use in a medical emergency.
- The service did not provide clients that received detoxification treatment from alcohol dependency with safe supervision overnight which placed clients at risk.
- The service gave clients their medication to self-administer shortly after admission which had the potential to increase risks to the clients.

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

- Staff completed a comprehensive risk screening prior to admission and risk assessments if clients required it and reviewed clients' risks regularly after admission.
- Staff received safeguarding training and confidently discussed the process to make a referral.

Are services effective?

We do not currently rate standalone substance misuse services.

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

- The doctor the service had a formal agreement with prescribed medication that should not be used routinely for opiate detoxification in the majority of cases. This was not in line with National institute of Health and Care Excellence (NICE) guidelines and Drug Misuse and dependence: UK guidelines on clinical management for the treatment of substance abuse.
- The provider did not complete formal opiate withdrawal scales to enable them to monitor the safety and efficacy of the treatment as accurately as possible.
- The provider did not ensure that clients detoxifying from alcohol received pabrinex (high dose vitamin B and C) injections as recommended in good practice guidelines.
- The service used formulaic, structured care plans with little space for personalisation and recording of client's views or wishes.
- There was no formal process for managers to provide line management supervision for staff.

Summary of this inspection

- Support team staff did not receive equality and diversity training.

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

- The provider completed a robust admission assessment process prior to prescribing treatment
- There was good communication between the provider and clients' care managers from services who referred clients to ensure plans were in place to manage a crisis.
- All staff had completed a role specific induction and mandatory training.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice.

- We witnessed warm and positive interactions between clients and staff.
- Clients we spoke with were extremely positive about the care and support they received from the staff.
- Clients felt that they had been involved in the planning of their care and that the support they received was individualised.
- Clients had access to independent advocacy through a service dedicated to service users in the local area.
- The service had actively engaged with clients' families and arranged information days to support the families of clients in recovery.

However, we found the following issues that the provider needs to improve.

- Care plans we reviewed did not clearly evidence the goals clients had identified during one to one sessions with their counsellors.

Are services responsive?

We do not currently rate standalone substance misuse services.

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

- The provider had not monitored clients' nutrition and hydration needs or provided clients with nutritional advice and information. This is important due to the impact poor nutrition has on clients who have been excessive users of alcohol or other substances.

However we found the following areas of good practice.

Summary of this inspection

- The service encouraged and supported clients to maintain their independence and begin to develop support networks in the community.

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 had not recognised the need to use formal withdrawal scales for opiate detoxification to monitor the safety and efficacy of treatment given.
- The provider had not recognised the need to monitor medication prescribing by the doctor with whom it had a formal agreement to ensure that it complied with National Institute of Health and Care Excellence (NICE) guidelines and Drug Misuse and dependence: UK guidelines on clinical management for the treatment of substance abuse. The service had not ensured treatments such as pabrinex were prescribed in line with best practice guidelines.
- There was no system in place for the provider to monitor whether they adhered to best practice guidelines at all times.
- The management team had not identified the need to keep clients in the early stages of detoxifying from alcohol safe from harm by providing safe supervision overnight in their accommodation.
- The training and development policy had not identified the need for staff to regularly update their medication administration practice. No set timeframe was indicated and there had been a gap of four years and a gap of two years between training sessions
- There was no formal process for one to one line management supervision or for staff to feedback on the service to help it develop and improve.

However, we found the following areas of good practice.

- Staff strongly identified with the vision and values of the service and worked to achieve these with the clients in their care.
- Staff morale was high and they felt that the management team at the provider was supportive.
- There were systems in place to monitor the quality of the service including regular audits and the use of feedback from clients.

Detailed findings from this inspection

Mental Health Act responsibilities

The service was not registered to accept clients detained under the Mental Health Act. If a client's mental health were to deteriorate, staff were aware of who to contact. The GP surgery that worked closely with the provider contacted a psychiatrist in these circumstances.

Mental Capacity Act and Deprivation of Liberty Safeguards

- All counselling, support and admission staff had completed training in the Mental Capacity Act (MCA).
- The service had a policy regarding the MCA that gave clear guidance to staff regarding the Act and steps they had to take if concerns arose about clients' ability to consent.
- Staff assessed the client's capacity to consent to treatment prior to admission or giving medication.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

- Six of the eight houses had a twin bedroom. Staff offered clients the option of sharing a bedroom before treatment started. Clients gave consent to share a room at the assessment stage. Staff offered clients who were unwilling to share the option to delay treatment until a single room became available.
- The primary treatment centre, where clients initially attended for their treatment at the start of their programme, contained the room used for administering medicine. The room was clean, well maintained and contained a locked medicines cupboard. The room remained locked when not in use. Controlled drugs were stored in a locked section of the medicines cupboard.
- However, there were no controlled drugs in stock at the time of inspection. Staff had not received training to use specialist resuscitation equipment, automated electronic defibrillators (AEDs) or emergency medicines so none were available in the treatment centre. Staff had received training in basic life support and first aid. They understood what to do in the event of a medical concern involving a client. They escorted the client to the local GP surgery or called an ambulance.
- The accommodation was clean, comfortable and appropriately furnished throughout. However, at Rebbeck there was a need for some cosmetic decoration and upgrading. Staff told us that this was in the process of being resolved. Staff showed us the daily maintenance logs that they completed to highlight issues. An example was a broken fence at Knole that was awaiting a contractor to repair it. The clients had responsibility for cleaning the houses and treatment centres as part of their rehabilitation programme. They also cooked their meals and helped maintain the garden at each property. Clients had use of a shared washing machine at each residential property.
- Staff followed infection prevention and control measures. Infection control was part of mandatory training and all staff had completed this. The provider had hand-washing signs displayed in the building.
- The provider had clear fire alarm and evacuation procedures in the houses and the treatment centres. Support staff tested carbon monoxide and fire alarms on a weekly basis and kept logs centrally to provide evidence. Emergency exits were clearly marked.
- Support workers carried out environmental risk assessments of the buildings each day and on a monthly basis. They completed daily maintenance logs to highlight concerns with the environment. A
- There were ligature points (environmental features that could support a noose or other method of strangulation), across all accommodation. Clients were risk assessed prior to admission to ensure they were safe within these environments. If clients presented as a risk of self-harm by this method the provider did not accept them.

Safe staffing

- Providence projects had a permanent staff team of 17 based at the primary and secondary treatment centres. This included qualified addiction therapists who also administered medication and support staff who maintained the properties and completed administrative tasks. The support staff also facilitated clients to attend appointments and community groups. There was also a registered manager, an admissions manager and administrative staff on site.

- Staffing numbers were set dependent on the activities staff had to complete that day. Staff facilitated therapy groups at the second treatment centre for clients more advanced in their treatment. There were no staff vacancies at the time of our inspection.
- The provider had not used bank or agency staff to cover sickness or vacancies in the previous three months before the inspection. The sickness rate reported by the provider in the previous 12 months was 1.9%. One member of staff had left the organisation in the previous 12 months but the provider had employed a replacement.
- Staff did not work at the accommodation where clients stayed after treatment during the day. Clients had two emergency numbers to ring if they needed to contact one of the staff members on the on-call rota. These staff gave advice over the telephone or if necessary visited the home to provide support to the clients. Staff did not provide overnight supervision for clients that received detoxification treatment for alcohol dependency. This placed these clients at risk of seizures or other complications and placed an unreasonable degree of responsibility on other potentially vulnerable clients.
- All relevant staff had completed mandatory training in each subject including first aid, Mental Capacity Act and safeguarding. The provider's policy on training did not specify how often mandatory training should be repeated.

Assessing and managing risk to clients and staff

- During the inspection, we reviewed the care records of 12 current clients and one ex-client. Staff had completed a risk screening form for each client prior to admission. The registered manager and the chief executive officer then decided if the client was suitable for admission. The form covered subjects such as mental health risk, risk of violence and whether clients were physically active. Where staff had identified risks, they completed a risk assessment at admission that included standardised statements of how staff would manage the risk. Staff reviewed these risk assessments every 14 days.
- All staff had received training in safeguarding. The provider had a safeguarding policy available to all staff. This contained clear procedures for staff to follow to report safeguarding issues. Staff described the process of how to make a safeguarding referral and whom they would talk to. There had been one safeguarding concern raised prior to the inspection. Staff had reported this to the local safeguarding team and the police had begun to make enquiries. Staff had not reported it to CQC as it had been a case of historical abuse. The inspection team asked the manager to report it to CQC as soon as possible for our records.
- Counselling staff had not received regular training to administer medicine to the clients using the service. The service provided training in 2010, 2014 and 2016. This meant that clients had been at risk of staff not following current best practice. There were procedures in place for the storage, handling and disposal of medication. When clients presented for treatment the local doctor interviewed them and reconciled their medication with the client's doctor. The local pharmacy provided medicine following completion of a prescription by the doctor. The pharmacy dispensed detoxification programmes ready made up in dosette boxes for seven days. Non- detoxification medications came in boxes labelled with the client's details. Staff kept a copy of the client's prescription with the medication administration record (MAR) chart to ensure that staff had correctly recorded the medication.
- Medicines for the management of substance misuse were stored securely. Only one member of was allocated to administer medication to clients during a shift. One member of staff administered the medication and another checked the MAR sheets at the end of the day. This ensured that there were no recording gaps on the MAR chart and that the staff member had administered the correct amount of medicine through the day. When clients left the treatment centre at the end of each day, staff gave them medication that was due during that evening or at night to take with them.
- Staff assessed the client first to ascertain if they were safe to administer their own medication. Staff completed a brief risk assessment to do this. We saw evidence that this happened as early as the first day after a client had commenced treatment. If staff had assessed the client as safe, the client received the medication in the box from the pharmacist. This showed the label with details of the client, drug type, dose and details on when to take it. Staff gave detoxification medicine in a dosette box that showed

the client which times to take it. There were risks to clients due this practice. These included the possibility of the client overdosing or visitors having access to their medicine. In addition, clients may sell or distribute their tablets to others or they may be intimidated by others to share their tablets. The service provided each client with a lockable safe in their bedroom at the accommodation to store their medication safely and securely. For medication that needed to remain in a fridge, the service supplied lockable fridges for clients to use. If staff had not assessed clients as safe to self-administer their medication, on-call staff delivered medication to clients at the accommodation at the appropriate times.

- Staff at the service used the clinical institute withdrawal assessment for alcohol (CIWA) to assess the withdrawals of clients receiving treatment to detox from alcohol. Staff had placed completed forms in the files of clients who had received this treatment. However, the service did not use any formal rating scales for clients that received treatment for opiate detoxification. For example, the clinical opiate withdrawal scale (COWS) and the subjective opiate withdrawal scales (SOWS). They also did not undertake daily clinical monitoring of withdrawals within the treatment centre and did not have the equipment to do so. National Institute for Health and Clinical Excellence (NICE) guideline 52: Drug misuse in over 16s: Opioid detoxification states that staff undertake monitoring of clients' withdrawals. Staff stated they felt as experienced practitioners that they could recognise if a client was experiencing withdrawals. By not using formal rating scales or clinical monitoring staff were unable to accurately assess the effectiveness of the treatment provided to manage a client's withdrawals.

- Thorough assessment before admission ensured that the service did not admit clients at risk of seizure during detoxification treatment. We saw evidence in one file of a client at high risk receiving detoxification at a more appropriate placement before commencing treatment at Providence. Protocols were in place for staff to call an ambulance if a client unexpectedly suffered a seizure or another form of medical emergency.

Track record on safety

- There had been no serious incidents reported during the twelve months prior to the inspection.

Reporting incidents and learning from when things go wrong

- The organisation had a policy for the reporting of incidents and accidents. Although this did not give specific examples of what would constitute an incident or accident it did give a definition of each. It also highlighted the need to report near misses (where an incident or accident could have occurred in different circumstances). The policy gave staff details of the forms to complete to report the incident. Once competed, staff sent the form to the manager. The manager had responsibility for investigating the incident. Forms we saw confirmed that the manager had done this and documented actions for learning. For example, when two clients had an altercation, the manager arranged for one of the clients to move to different accommodation provided by the service.

- Staff explained to us the system for reporting incidents. Staff confirmed the manager discussed incidents within the twice-daily team meetings. The manager shared learning from incidents during this time and sent out emails to staff that confirmed the findings.

Duty of candour

- The provider had a policy regarding duty of candour. The registered manager had responsibility to inform the service user or their representative within 10 days of an incident if the client had suffered a notifiable level of harm.

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

Assessment of needs and planning of care

- There were 33 clients at Providence Projects Rehab Group at the time of our inspection. We reviewed 13 care records. All contained a comprehensive person centred assessment of the client's needs.

- The assessment covered a wide range of subjects including physical and mental health needs. It included social factors such as housing, family and legal issues, including whether there were any pending court dates or convictions. Staff completed a risk screen and additional risk assessments if required. Staff also recorded the client's substance misuse history.

- The local GP surgery that worked with the provider ensured that a doctor saw the client promptly on the day of admission. The doctor completed physical health checks, an interview regarding the client's substance misuse and referred the client for further medical tests if required. The doctor did not prescribe medicine for detoxification before assessing the client. The provider did not have any equipment to check the clients' physical health. If there were any concerns, they used a daily time slot at the GP surgery for the client to see a doctor. The doctor obtained consent from all new clients in the service to register them at the surgery so they could gain full access to the client's medical records.
- Staff completed care plans with clients. These had a standard wording and structure. They were not personalised although they were holistic and addressed a large number of issues. There was limited space for clients to provide their views, opinions and wishes. Only five of the 13 care plans we reviewed contained personal goals the client had identified. Clients received copies of the care plans for their records.
- The service used paper client records at the time of inspection, with some information duplicated on computer files for staff at the secondary treatment centre to access if necessary. They were stored safely and securely in locked cabinets.

Best practice in treatment and care

- The provider had a formal agreement with a local doctor to be responsible for the prescribing and overall clinical management of detoxification treatment. The doctor did not follow the guidelines from the National Institute of Health and Care Excellence (NICE) or the Department of Health for the prescribing of detoxification treatment. They predominantly prescribed a detox programme that used dihydrocodeine and chlordiazepoxide rather than either methadone or buprenorpheine. In the 12 months prior to the inspection, 56 clients received opiate detoxification treatment. Of those, the doctors prescribed 49 clients dihydrocodeine and chlordiazepoxide and seven clients buprenorpheine.
- This followed discussions between the doctor and the client about both treatment options and the advantages and disadvantages of both. The client then chose their preferred option. Within the guidance mentioned, doctors should not use dihydrocodeine routinely for opiate detoxification and the guidance does not mention chlordiazepoxide at all as a detoxification treatment for opiates. The evidence provided by the doctor for using this method of treatment was out of date and superseded by the aforementioned clinical guidance. However, the doctor did follow guidance when they prescribed treatment for clients to detox from alcohol.
- Doctors had not prescribed pabrinex (high dose vitamin B and C) injections in line with good practice guidelines. Guidelines recommend these to reduce the potential physical impact of prolonged excessive alcohol abuse.
- Staff followed management plans and liaised closely with the GP surgery throughout the detoxification process.
- The provider offered a wide range of treatments. These included one-to-one counselling, relapse prevention workshops, group therapy and alternative therapies such as reiki and acupuncture. The provider also arranged social activities and days out.
- The service did provide psychological therapies in line with guidance on the treatment for substance misuse published by the National Institute for Health and Care Excellence (NICE) and The counsellor's within the service provided these treatments one to one or they used a group approach. Clients attended groups based on a recognised model of treatment. The provider expected clients to attend 12 step fellowship meetings, for example Alcoholics Anonymous, every evening and on Saturday. This expectation was included in the client's contract of treatment. These meetings occurred in the community and at the treatment centre.
- The clients we spoke with were very positive about the treatment programme. They described it as intense but felt this kept them focussed on their recovery. They described the structured nature of the programme as a "safety net" for them.

Skilled staff to deliver care

- The provider employed counsellors and support staff. The management team provided support and oversight of the service. Clerical staff provided administrative support. However, the provider did not employ any

registered nurses within its staff team. They contracted input for prescribing from an independent doctor and a local GP surgery to provide physical and mental health care.

- Staff we spoke with demonstrated a high level of knowledge and dedication to working with clients who had issues associated substance misuse. Staff had received a role specific induction and mandatory training dependent on their role.
- Staff had contact with clients during the day but were not present in the accommodation overnight or at weekends. If clients displayed signs of physical deterioration when staff were present, staff escorted them to the local GP surgery or telephoned for an ambulance. Staff had told clients that if a problem occurred at the accommodation, they should contact the on-call emergency number for advice and follow the guidance provided by the on-call staff.
- All staff employed by the provider had received an annual appraisal. Managers and staff used this process to identify areas for development and training needs.
- All counselling staff received weekly group supervision facilitated by an impartial supervisor from outside of the provider. Managers did not attend this to ensure it was independent. However, there was no line management supervision in place. Staff within the support team did not receive supervision as they had identified their role as being purely practical. They confirmed that the manager had an open door policy so they could approach them with any concerns.

Multidisciplinary and inter-agency team work

- The team worked closely with a number of agencies to ensure that a robust plan was in place if a crisis occurred. Staff made regular contact with clients' care managers. Care managers we spoke with were positive about the work that Providence did and the level of contact the service had with them.
- The service had a strong working relationship with the local GP surgery. They had access to allocated time every day for clients to attend the surgery if required. The doctors were responsible for all prescribing. This included detoxification programmes and other medication. The doctors reconciled client's medication by contacting the client's previous doctor. If a client presented with mental health difficulties, the surgery arranged for a psychiatrist to see them. The surgery monitored all aspects of the clients' physical health care and completed all physical health checks, including taking bloods. They provided a blood borne virus checking service if the client requested testing for this.
- The service held two meetings a day that all staff attended. These enabled staff to be aware of any on-going concerns or issues that had arisen throughout the day. The staff used the morning meeting to identify any tasks that needed to be completed or appointments that clients needed to attend.

Adherence to the MHA

- The service did not admit anyone detained under the Mental Health Act 1983.

Good practice in applying the MCA

- The service assumed that all clients had capacity to make decisions and therefore were able to consent to treatment.
- Staff received awareness training in the MCA. Counsellors demonstrated awareness and understanding of the principles of the Act.
- The service had a staff handbook that included information about the MCA to enable staff to act within the terms of the act.
- Staff confirmed that they sought guidance if they thought that a client's level of capacity had changed. If there were concerns, they asked the doctor to assess the client's level of understanding. The service's policy regardingthe MCA also highlighted the need to contact an independent mental capacity advocate if required (IMCA)
- Staff documented in the client's notes when they had given consent to treatment. Staff also documented when clients had given permission to share information. This included what information could be shared and with whom.

Equality and human rights

- The service had a comprehensive equality and diversity policy that covered employees and clients.
- The service provided training in equality and diversity for the counselling team as part of their induction

programme. However, they did not provide this training for the support workers. The manager confirmed that this was due to the limited interactions that the support workers had with the clients.

- Not all accommodation sites were accessible for clients with mobility issues. Only Gordon Road and Portman Road had ground floor bedrooms with access to adjacent shower and toilet. If a client needed this level of access, they waited until this bedroom became available in those sites. If necessary the service referred clients to other providers who may be more suitable for the client's needs.
- The service used blanket restrictions (rules that apply to everyone irrespective of individual risks) to maintain client safety and support their recovery. This is standard practice for substance misuse services and part of the treatment programme. Staff advised clients of the rules before admission and clients had to agree to stick to them and signed a contract to that effect. Staff made clients aware that breaking these rules could affect their admission to the service.

Management of transition arrangements, referral and discharge

- The service worked with care managers for clients at risk due to difficult social circumstances. These included clients who were homeless or were in an abusive relationship. The provider and the care manager formulated an exit plan for these clients. This meant that if the admission to the service broke down there was information for staff about what they needed to do and whom they should contact in these circumstances.

Are substance misuse services caring?

Kindness, dignity, respect and support

- Interactions we witnessed between the staff team and clients were warm, respectful, kind and supportive.
- Clients we spoke with told us they felt safe with the staff, that the staff respected their differences as individuals and treated them with dignity and respect. They felt that the staff displayed empathy with their situation. They stated the staff supported them well throughout the programme and were caring without being patronising.
- Staff demonstrated a good understanding of the needs of clients receiving treatment within this kind of service and used this to inform the care provided.

The involvement of clients in the care they receive

- Clients we spoke with told us that they had been involved in the planning of their care and treatment. They said that they had devised their goals for treatment in conjunction with their counsellors during one to one sessions. However, we saw that staff had not always transferred these goals to the care plans we reviewed. Inspectors raised this with staff at the time of the inspection. Staff updated a care plan that had no client goals when reviewed on the first day of inspection. When inspectors reviewed it on day two staff had added the client's goals. Clients stated that they were able to track their progress and address new goals for their treatment. Staff gave clients copies of their care plans.
- Clients had information to access an independent advocate through Bournemouth alcohol and drug service user forum (BADSUF).
- The service attempted to involved families and carers as much as possible within the treatment programme if the client gave consent. The service had developed a family programme in which staff facilitated family conferences every 6-8 weeks when a "family day" occurs. The service used family days to provide information to families, signpost local support and enable families to voice concerns. The staff supported the families to set boundaries for family members returning from treatment so that they are better able to support their recovery.
- Clients commented on the service and gave feedback during the morning meeting held every day and other community meetings. Clients also completed a service evaluation questionnaire at the end of their admission.

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

Access and discharge

- The provider had robust admissions policies to ensure that they did not accept inappropriate admissions. The admissions manager reviewed client's details and

referred them to the panel of directors for approval. Exclusion criteria for admission included a history of seizures or if staff decided the client's current level of use of prescribed or illicit drugs was too high. If staff decided the service was not suitable for the client, they referred them to another provider. Staff gave clients clear information about the service and restrictions in place before they accepted the client for admission. Examples of these restrictions included always going out in groups of three if they left the accommodation and not to visit other sober living homes run by the service.

- Clients signed a contract before admission. This explained the rules and expectations of the service and the consequences of their behaviour. For example, if clients were unable to stick to the terms of the contract or used mood- altering substances they could have their admission reviewed. This could result in staff discharging them from the service.
- The provider confirmed that 24 organisations commissioned services at Providence Project Rehab Group.
- The provider offered a number of treatment options dependent on the needs of the client. These varied from 28 days to three months as standard. However, there was the option to extend these stays if funding allowed. Staff felt that the service's model of treatment encouraged clients to develop or maintain their independence and to develop community support networks ready for discharge. The provider offered an aftercare service for clients who lived in the Bournemouth area.
- In the twelve months prior to September 2016, the provider discharged 287 clients. Of these, 206 had successfully completed their treatment and had received follow-up within seven days. Forty-six clients had chosen to discharge themselves from treatment and the service had discharged 35 clients early from treatment.

The facilities promote recovery, comfort, dignity and confidentiality

- The two treatment centres had environments that were comfortable and welcoming. There were a range of interview and group rooms available and there was good soundproofing. Both had kitchen and communal dining areas.
- At Providence Projects – 16 there was a ground floor bedroom adjacent to the kitchen, with an incomplete blind covering the window. We bought this to the attention of the support worker, who told us they would get this addressed as a matter of urgency.
- Clients could have visitors in the living accommodation on Sundays; however, the service did not allow children to visit. Each house and the treatment centres had outside spaces, including a smoking area.
- Clients had access to their own mobile phones and each treatment centre had a separate client phone. The contract clients signed a contract to confirm they would hand in their mobile phone on each occasion they attended the treatment centre. Clients could have some personal belongings in their rooms, for example personal photo frames or their own bedding.
- Each client was self-catering, but each house could choose to cook communally. Support staff would help clients choose and buy food. In each home, we found a widely differing range of foodstuffs, from salads to ready meals. We found no evidence of any monitoring of nutritional value or education programmes around the benefits of a balanced diet.ot and cold drinks were available at all times in the houses or treatment centres.
- The service provided all clients with a weekly timetable that specified all of the planned activities. The programme included structured therapy groups, individual therapy, access to alternative therapies and lectures about the therapy model clients followed. Clients attended a 12-step fellowship meeting every evening with their housemates. Clients only left the house in groups of three to support their recovery. Activities were also available on Saturday. The service also provided planned social activities. These included days out to local places of interest or groups walks. The clients we spoke with felt positive about the highly structured programme, stating that it was a safety net and supported them in their recovery.

Meeting the needs of all clients

Substance misuse services

- All the clients entering treatment at Providence Projects had vulnerabilities and varying levels of complex needs. Policies and procedures were compliant with the Equality Act 2010. This ensured there was no discrimination because of a protected characteristic for example race, gender or sexual orientation.
- There were facilities for clients with mobility issues at Providence Projects – 16 and Gordon. These properties had downstairs bedrooms with adjacent bathrooms and toilets. Clients had to walk each day to the treatment centre from their accommodation. Due to this staff assessed clients' level of mobility. Staff arranged the use of a motorised scooter if clients requested it. The client or funder had to pay for this equipment.
- Staff obtained information regarding many subjects from the internet. This included information in other languages for non-English speaking service users. They also obtained 12 step reference books from other countries to assist their clients.
- Staff provided support for clients to access places of worship. For example, the service used a volunteer from the local recovery community to escort a client to church.

Listening to and learning from concerns and complaints

- The service had a complaints policy in place. There had been one complaint in the previous 12 months that the service had managed as per their policy.
- Clients we spoke with told us that they had received details of the complaints procedure in their welcome pack. The service also displayed these details in the kitchen area of the treatment centre. All the service users stated that they were aware they could go straight to the manager to raise a complaint. On Fridays, a "meet-the-manager" session was available to raise concerns. Support workers held a community meeting each week at all the houses to resolve any concerns before they escalated. Staff used these meetings to collect feedback on the service from the clients.

Are substance misuse services well-led?

Vision and values

- The vision of the service was to provide effective treatment to help men, women and families to begin the process of recovery. The service identified that each clients' version of recovery was different.
- Staff supported clients by promoting personal choice and independence of the clients whilst they made changes to support their recovery. Staff felt that they worked to achieve the best possible outcomes for clients within the values of the service.
- Staff we spoke with knew whom the senior managers of the service were and felt that they were accessible when needed.

Good governance

- The management of the provider had made a formal agreement with a local doctor who routinely prescribed outside of guidance from the National Institute for Health and Care Excellence (NICE) and Drug misuse and dependence: UK guidelines on clinical management for opiate detoxification.The provider had chosen to do this without having recognised opiate withdrawal assessment frameworks in place to monitor the efficacy or safety of the treatment the service provided. The service had a protocol for both alcohol and opiate detoxification prescribing. The alcohol detoxification protocol clearly stated that the medication the doctor offered was the first line treatment for this condition. This was in line with the above-mentioned guidance. The opiate protocol did not mention any form of medication that the doctor prescribed. This meant that there was no way for the service to monitor if the medicine prescribed for opiate detoxification was in line with national guidance.
- The registered manager completed a number of audits to ensure that the staff worked to maintain the quality and safety of care. These included audits of medication charts, medication stock and clients records. If the manager identified concerns, they raised them with the staff member concerned to resolve. The manager discussed lessons learnt through this process during team meetings and sent out emails.
- The provider did not have a structure in place to monitor whether the service followed and adhered to

best practice guidelines at all times. This meant that the provider was not acting as effectively as possible or addressing potential risks to clients that occurred by not following these guidelines.

- The provider had policies in place. However, aspects of its practice, especially the lack of recognised assessment tools for opiate withdrawals and use of off guidance medication meant that the service was not effective in all areas. Policies ensured that inappropriate admission did not occur. Clear guidance indicated that staff should not admit clients at risk of complications during detox nor had high levels of substance use. The managers had additional input in the admission process to ensure that staff followed this protocol. Policies informed staff how to report incidents, make safeguarding referrals and work within the Mental Capacity Act (MCA).
- Investigations after incidents were prompt and thorough. The manager identified issues arising from incidents and took steps to ensure that there was not a reoccurrence. They communicated lessons learnt through team meetings and via email. Incidents records were up to date.
- The registered manager received appropriate administrative support. They felt that they had sufficient authority to ensure effective management and support their staff. However the manager did not provide regular line supervision to staff, the service had chosen to provide supervision as a group once a week. This was only provided to counsellors as the support staff had identified that this was unnecessary for them due to theirs being a practical role.
- There was a policy in place to manage training and development. This had not identified the topics that comprised mandatory training or the frequency training occurred. This meant that staff who administered medication had not received regular updates or assessment of their practice. The service had provided training in 2010, 2014 and 2016 according to training records. This placed clients at potential risk from staff not following current best practice.

Leadership, morale and staff engagement

- The leadership from the chief executive and the registered manager demonstrated passion and commitment to working with their clients and staff followed this lead. Staff we spoke with were positive about the management of the service. However, the leadership did not recognise the potential risk to clients from some of their practices and therefore the services posed potential risks to client which neither the leaders nor staff were aware of.
- Managers reported an annual sickness rate of 2% at 10 June 2016. This was low in comparison with other services, as was the turnover rate for staff. This reflected well on the morale of the team and the leadership of the organisation.
- Staff we spoke with told us that they were aware of the whistleblowing process. Staff said that they felt confident in raising any concerns they had with the senior managers. No whistleblowing concerns were on going at the time of the inspection.
- Staff morale was high. Staff said that the teams were supportive and that they enjoyed working at Providence Projects.
- The service had a staff development policy and encouraged staff to apply for appropriate training. A counsellor had travelled to United States of America for a conference on relapse prevention with funding from the service.
- Staff understood the duty of candour and the service had a policy that confirmed their commitment to work within this legislation.
- There was no formal method for staff to give feedback to contribute to the improvement or development of the service for example, staff experience questionnaires. The manager confirmed that staff could give feedback but this was on an informal basis.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that opiate detoxification treatment prescribed for clients in their service is in line with published guidance form National Institute for Health and Care Excellence (NICE) and
- The provider must ensure that they formally monitor for clinical withdrawals on a daily basis for clients undergoing opiate detoxification to measure the effectiveness of the treatment provided.
- The Provider must provide safe supervision at night for clients who are receiving detoxification treatment from alcohol to ensure their safety during this time.
- The provider must ensure that governance structures in place are robust and able to assess and monitor the quality, safety and effectiveness within the practice and treatment provided by the service.
- The provider must provide monitoring of clients' nutrition and hydration and nutrition and ensure that clients receive advice regarding diet and nutrition.

Action the provider SHOULD take to improve

- The provider should ensure that support staff receive equality and diversity training.
- The provider should ensure that staff regularly repeat mandatory training for medicine administration to ensure staff safely follow current best practice
- The provider should ensure that there is an automated electronic defibrillator (AED) available for staff to use in a medical emergency.
- The provider should ensure that they review processes for supervision to ensure that all staff have appropriate levels of individual supervision for their role.
- The service should ensure that all staff have the opportunity to influence the way the service operates and develops.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The provider had a formal agreement with a local doctor to prescribe detoxification treatment who routinely prescribed outside of guidance provided by NICE and Drug misuse and dependence: UK guidelines on clinical management for opiate detoxification. Regulation 12 (1) (2) (c)

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The provider did not use recognised rating scales or daily clinical monitoring to assess the withdrawals of clients to measure the effectiveness of the opiate detoxification treatment given to them. Staff members did not safely supervise overnight clients receiving detoxification treatment from alcohol dependency. Regulation 12 (1) (2) (a)

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

How the regulation was not being met:

The service had not recognised issues that affected the quality, safety and effectiveness of the service provided.

Regulation 17 (1) (2) (a)

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs How the regulation was not being met: The service did not monitor clients dietary and hydration needs or provide information and advice on diet and nutrition to clients. Drug misuse and dependence: UK guidelines on clinical management for opiate detoxification states that services should be provide this for clients with a history of substance misuse. Regulation 14 (2) (a) 14(4) (a)