SASS-Residential - Steade Road

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

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

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.

Summary of findings

Overall summary

We do not currently rate substance misuse services.

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

• Staff did not identify or manage risk effectively. Staff did not record the risks in sufficient detail or review clients' risk assessments regularly. Clients did not have a risk management plan. This meant staff relied on verbal information from discussions with clients and information recorded in the handover diary.

• Clients' care plans varied in content. Three of the four care plans we looked at were incomplete. The care plans did not have clear goals or outline the recovery process. This meant there was no clear indication that the client was involved in constructing their care plan or agreed with it. Clients could have a copy of their care plan if they requested it.

• Staff did not have a clear understanding of the Mental Capacity Act and its application to clients using the service.

• The clients' induction pack provided clear information on confidentiality and sharing of information. However, staff did not ask clients for consent to share information with the National Drug Treatment Monitoring System (NDTMS).

• While there was clear learning from serious incidents, staff did not appear to follow the governance structure for reporting all incidents. Staff dealt with some incidents informally and did not record them according to policy. This meant they could not identify trends.

• Staff dealt with informal complaints during the morning 'feelings' meeting. However, they did not document what the complaint was about or how it was resolved.

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

• The environment was homely and welcoming, with empathic and respectful staff.

• Clients were involved in decisions about their care and the service. They regulated their own code of conduct and agreed house rules with other clients.

• Staff tried to meet the diverse needs of clients and made arrangements or adapted rooms to meet individual needs.

• Staff had regular supervision and ongoing appraisals of their work performance from their manager, giving them the support and professional development needed to carry out their duties.

• Clients received care and treatment underpinned by best practice, and had access to psychosocial therapies, group work sessions and individual one to one sessions with a counsellor.

• Discharge planning included an aftercare package to support clients for up to five years following rehabilitation.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Substance misuse services		This report describes our judgement of the quality of care provided within this core service by Sheffield Alcohol Support Service. Where relevant we provide detail of each location or area of service visited. Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations. Where applicable, we have reported on each core service provided by Sheffield Alcohol Support Service and these are brought together to inform our overall judgement of SASS-Residential - Steade Road.

Summary of findings

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Location name here

Services we looked at
Substance misuse services

Summary of this inspection

Our inspection team

Our inspection team was led by: Jacqui Holmes, Care Quality Commission.

The team that inspected SASS-Residential – Steade Road included two CQC inspectors, a mental health nurse and an expert by experience (someone with experience of similar services – for example, as a client or carer).

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive substance misuse 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 service.

During the inspection visit, the inspection team:

• visited the premises and observed how staff were caring for clients

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• 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 service.

During the inspection visit, the inspection team:

• visited the premises and observed how staff were caring for clients

• spoke with four clients who were using the service

• spoke with the registered manager

• spoke with three other staff members, including counsellors and sessional workers

• attended and observed a feelings meeting and a therapy meeting

• looked at four clients' care and treatment records

• looked at policies, procedures and other documents relating to the running of the service.

Information about SASS-Residential - Steade Road

SASS-Residential – Steade Road is an alcohol rehabilitation service. It is one of two residential

Summary of this inspection

rehabilitation houses provided by the Sheffield Alcohol Support Service (SASS). The regulated activity for this service is accommodation for persons who require treatment for substance misuse. The service has a registered manager.

The service offers residential rehabilitation to people who have a problem with alcohol as well as training, peer recovery support, counselling and an aftercare package.

The rehabilitation service comprises a large house consisting of five bedrooms, lounge/dining room, kitchen, utility room and private garden. The service gives people an opportunity to rebuild their lives without alcohol in a supportive and stable environment. At the time of our inspection, four clients were in residence.

Clients followed a 26-week rolling programme. Clients began their rehabilitation treatment at Steade Road. After 13 weeks, staff reviewed their clients' progress and prepared a report for their funder. For the remaining 13 weeks, clients transferred to the Sheffield Alcohol Advisory Service (SAAS), which is the second residential house run by SASS. The transfer marked the start of increased independence as the client could request leave. It also prepared them for returning to their communities.

Steade Road and SAAS shared facilities to provide the same rehabilitation programme, with clients from both locations attending the same sessions and meetings. The programme consists of cognitive behavioural therapy through group work and one-to-one interventions.

Clients attend mandatory sessions and then have the option of attending further therapeutic and social activities. The service does not provide 24-hour cover, clinical interventions or prescribe medication.

What people who use the service say

We spoke with four people using the service. Clients spoke positively about the service and described staff as kind, supportive and understanding. They felt staff treated them with respect and that they were in the best place for their treatment. One client described the house as a place of peace and safety.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found:

• Staff did not ensure the safety of clients by identifying past and current risks. For example, clients may have a history of drug abuse and possible relapse. They relied on conversations, handover information from colleagues and from clients themselves to identify and manage risk rather than following an individualised risk management plan.

• Staff did not to follow their own incident reporting policy dealing with some incidents informally and documenting them in clients' contemporaneous notes. This meant they could not identify trends.

However:

• Staff demonstrated a good understanding of procedures for safeguarding clients from abuse and the team had a nominated safeguarding lead who dealt with all referrals and alerts.

• Permanent and sessional staff had completed core skills training to their required level.

Are services effective?

We found:

• Although staff used a recognised tool to complete clients' care plans, they had not completed three of the four care plans reviewed.

• Staff did not have a clear understanding of the Mental Capacity Act and its application to clients using the service.

However:

• All staff received support and professional development through regular managerial supervision, which included an appraisal process. This meant staff had the skills necessary to carry out their duties and that the manager could assess the quality of care given.

• Sessional staff had undertaken further training for their own personal development, including mentoring and coaching, person-centred care, effective interpersonal skills and motivational interviewing.

• The partnership arrangements ensured a multidisciplinary approach. Interagency work with the SASS alcohol recovery

Summary of this inspection

community and the 'families together' project provided clients with further support, activities and training. Staff had formed effective working relationships with external agencies to support clients during and after their rehabilitation

Are services caring?

We found:

• Staff established a therapeutic relationship with clients and enabled them to be involved in their care.

• Clients told us that staff treated them with respect and kindness and supported them emotionally and in a practical manner throughout their stay within the service.

• We saw positive interactions between staff and clients and evidence of good client involvement across the service.

Are services responsive?

We found:

• Discharge planning included an aftercare package to support clients for up to five years following rehabilitation.

• The house was warm and welcoming. It offered clients the comfort of a home, companionship when needed and privacy when needed.

• Clients had access to a range of therapeutic and community based activities provided by the organisation.

• Staff tried to meet the needs of all people using the service. For example:

▪ clients with mobility problems were offered a choice of room or adaptation of a room to meet their needs.

▪ separate cooking arrangements could be used to accommodate different faiths.

▪ staff would read and explain induction information to clients who couldn't read.

However:

• Staff did not document informal complaints raised during the daily 'feelings' meeting or how these complaints were resolved.

Are services well-led?

We found:

• The clients' induction pack provided clear information on confidentiality and sharing of information. However, staff did not ask clients for permission to share information with the National Drug Treatment Monitoring System (NDTMS).

Summary of this inspection

However:

• Staff felt supported by the organisation, their manager and colleagues. Morale was good and staff found their work fulfilling.

• The service was responsive to feedback from clients, staff and external agencies.

Detailed findings from this inspection

Mental Health Act responsibilities

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

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

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

Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act was not part of core skills training or personal development. Staff knew there was an organisational policy but were not confident in its application. This was because staff assumed that their clients had capacity when they entered treatment and seldom had cause to doubt it.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

The house provided a warm and welcoming environment. It was clean and well maintained and appropriate for use as a rehabilitation service. During their treatment, clients adhered to a behavioural code of conduct. We saw a 'house rules' meeting take place, during which clients agreed what behaviours they considered important. Staff and clients held this type of meeting within the first two weeks of induction for new clients. Clients from the Steade Road service and SAAS took part in this meeting and the house rules applied across both locations.

Staff allocated client bedrooms according to gender, with female clients on one floor and male clients on another. There was a bathroom on each floor, which clients based on that floor shared. Clients had a key to their room. This respected clients' right to privacy and dignity.

Sheffield Council completed the infection control audit and we observed posters promoting hand-washing techniques on an information board.

Safe staffing

Permanent staff comprised of a part time manager, a deputy manager, a therapeutic worker, and part time administration support. In addition, there were three regular sessional workers. These staff also worked at the SAAS residential rehabilitation service. The two locations, which were within easy walking distance of each other, formed part of the Sheffield Alcohol Support Service (SASS). The rehabilitation services also shared facilities to provide the same therapeutic programme to both sets of clients.

Permanent staff had low sickness rates. Sessional workers or permanent staff covered any sickness. In an emergency, the service had access to staff working at the Alcohol Recovery Community, which was also part of SASS. This meant the service could always cover client group work.

Permanent and sessional staff had completed identified core skills training to their required level. For example, all staff had undertaken counselling training but only the permanent members of staff who were qualified counsellors had undertaken CBT training. Core skills training also included equality, diversity and inclusion, alcohol awareness, health and safety at work and emergency first aid at work.

Assessing and managing risk to patients and staff

Staff did not always fully identify risks that could result in harm to clients, staff or others. In all of the records we reviewed, staff had not fully explored potential risks on admission. The assessment paperwork had unanswered questions, or contained minimal detail. It did not seek all information, which would identify some clients' risks or the necessary detail to assess them effectively. For example, staff did not explore risks associated with domestic violence, previous use of other substances, blood borne viruses or details relating to children.

Where staff had identified risks, none of the clients' records detailed any interventions to manage these risks. Staff told us that they would verbally discuss amongst themselves how to manage risks to clients. However, staff did not record this or use risk management plans. This meant that there were no assurances that all staff knew about individual client risks or how to minimise them. For example, we looked at the records of a client who had a history of harm to others. Although staff had identified that this could pose a risk, they had not detailed how they would manage this risk. The service did not periodically review clients' risk assessments.

Substance misuse services

Some specific activities did have comprehensive risk assessments. These occurred when a client requested leave or a visit. Staff completed a risk assessment detailing the concerns, the likelihood of risk occurring and the impact. This included actions that either staff or the client would take to minimise the risk. Clients provided staff with details of where they were going using a register to sign in and out of the premises.

Clients had to observe a curfew period during the first two weeks of induction, while settling in to a new routine. This was between the hours of 6pm and 7am. Staff met with any resident breaching the curfew to discuss their behaviour and commitment to rehabilitation The service did not run a prescribing clinic. Staff encouraged clients to register with a local doctor's surgery, who would take responsibility for prescribing all medication and providing health care. Clients had responsibility for managing their own medication and kept their medication locked securely in their rooms. Following an incident earlier in the year, the service introduced a new medicines management processes based on individual risk.

The service had an identified safeguarding lead. All staff had undertaken basic level safeguarding adults training, which was mandatory. In addition, permanent staff had also undertaken training in safeguarding children. All staff we spoke to had a good understanding of safeguarding procedures and knew when to make referrals to the safeguarding lead. There had been no safeguarding referrals made in the last 12 months.

The service had a lone worker policy to safeguard staff.

Track record on safety

There had been no serious incidents in the last 12 months.

Reporting incidents and learning from when things go wrong

The service had a formal incident reporting system. However, staff discussed incidents informally with their manager and recorded the incident in the client's file rather than follow their policy. This meant it was difficult to track whether or not the service had any incidents in the past 12 months. All staff received feedback from incidents across the organisation either informally or in team meetings. They were aware of changes made to support clients based on individual risk as part of lessons learned. The service manager would debrief staff immediately after an incident, for example after an eviction. Staff held group sessions to support clients after an incident if appropriate.

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

Assessment of needs and planning of care

Staff completed an assessment prior to a person's admission. This included an assessment of a person's alcohol use using the Alcohol Use Disorders Identification Test (AUDIT). Staff used this recognised tool to assess whether or not there was a problem with dependence.

They did not use the Severity of Alcohol Dependence Questionnaire (SADQ) or other tools, which measure the severity of the dependence.

The assessment paperwork included questions relating to a person's physical health. These were limited to current medications and previous complications. This was because the service provided therapeutic care only and encouraged clients to take responsibility for their own physical health needs. Staff would remind clients to attend appointments and support them if needed. In the event of an emergency, clients accessed the nearest accident and emergency department or contacted the emergency response services.

The referring service assessed a person's motivation to change prior to agreement by commissioners for funding a place. All clients also attended a pre-entry workshop before their admission date where staff could address concerns regarding motivation.

The client's designated worker then conducted an induction. The service used a 'recovery star' care plan tool to gather information in key areas, for example, physical health, relationships, substance misuse and social activities to create a recovery focused care plan. Staff had completed this tool in one of the four records looked at, identifying a range of areas personalised to the individual. The other three records contained blank care plans. However, one of these records belonged to a client admitted to the service the week before our inspection. It was unclear from the records we looked at what the client's

actual goals were and how they would achieve them. This meant it would be difficult for a client to understand how they could progress with their recovery. The service also did not review the care plans throughout a client's stay.

Clients attended a one-to-one session with their worker on a weekly basis. All the records we looked at showed contemporaneous notes. These notes were personalised and explored barriers to a person's recovery. However, care plans and risk assessments did not reflect that these discussions had taken place.

The service used paper records for clients. These were stored securely in the manager's office, which was on the first floor of the house. Staff could readily access the notes when needed.

Best practice in treatment and care

Clients attended group and individual cognitive behavioural therapy (CBT) focused sessions that followed British Association for Counselling and Psychotherapy guidelines. CBT is a talking therapy that aims to manage problems by changing thoughts and behaviours associated with the problem. It is a recognised therapy for alcohol misuse. Treatment within CBT focused on a key component of acceptance and commitment therapy. Staff used a 'valued directions' tool for interventions that explored the values that are important to the client. The key worker helped the client identify valued life directions that promoted a meaningful life and supported soberness.

The service worked with clients to help them to develop and sustain recovery capital that was appropriate to their individual needs. Recovery capital predicts the likelihood of achieving sustained recovery and is dependent on internal and external resources. The factors that contribute to recovery following treatment included:

• the personal and psychological resources a person had

• the social supports that were available to them

• the basic foundations of quality of life (i.e. a safe place to live, meaningful activities and a role in their community).

The service did not measure recovery capital as it was individual to each client.

The service manager carried out all audits for the service. Staff attended organisation wide meetings, as well as staff away days, during which they received feedback and best practice guidance on the outcomes of audits.

Skilled staff to deliver care

Permanent members of staff had appropriate counselling qualifications that enabled them to deliver CBT to clients.

The manager was undertaking further management training funded by the organisation. The team had access to specialist training and could request courses relevant to their role. For example, sessional staff had undertaken further training for their own personal development. This included mentoring and coaching, person centred care, effective interpersonal skills and motivational interviewing.

Staff had the skills and experience necessary to carry out their duties and deliver care. All staff received support and professional development through regular supervision every eight weeks. Supervision included an ongoing appraisal process. This meant staff had clear goals and objectives, which their manager reviewed regularly. This allowed the manager to identify improvements and assess the quality of care staff provided.

Multi-disciplinary and inter-agency team work

Effective partnership arrangements ensured a multidisciplinary approach. Staff had formed effective working relationships with external agencies to support clients during and after their rehabilitation.

Staff encouraged clients to register with the local GP during their stay making it easier for them to attend appointments. If a client's mental health deteriorated, staff would support them and make referrals to mental health services. The service had good links with mental health services, local GP, safeguarding teams and mutual aid groups. For example, Alcoholics Anonymous, Al-Anon family support, Al-Ateen and SMART recovery. The majority of clients maintained their own tenancies while in rehabilitation. Staff referred clients who did not have housing to a local authority housing association for priority housing.

Interagency work within SASS comprised of the 'families together' project, waypoint training and the 'alcohol recovery community'. Staff and clients could access activities, aftercare, support and training when necessary.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

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

Substance misuse services

Good practice in applying the Mental Capacity Act

The MCA was not part of core training or personal development. Staff knew that the service had a MCA policy. Although staff had an awareness of mental capacity, they had limited knowledge of their responsibilities under the MCA. Staff assumed clients had capacity when they entered treatment and seldom had cause to doubt this was the case.

Are substance misuse services caring?

Kindness, dignity, respect and support

We saw positive interactions between staff and clients. Staff were kind and approachable, treating clients with empathy and respect. This helped establish a therapeutic relationship. We observed clients to be relaxed and well supported in their treatment with staff understanding their individual needs. Clients told us they felt supported both emotionally and in a practical way.

The service had a clear confidentiality policy in place that both staff and clients respected, in order to protect individual clients during and after their stay in the house. For example, no one revealed clients' identities when answering incoming phone calls.

The involvement of people in the care that they receive

Clients took responsibility for their treatment during their stay with the service.

A member of staff facilitated the morning 'feelings' group, which clients from both locations attended. Clients had time to discuss how they felt and what support they thought they may need that day. We saw that everyone participated in turn and listened respectfully to their peers. If a client was feeling particularly low, staff offered counselling in addition to the planned daily activities. Clients attended all the mandatory group work as part of their recovery and could choose to opt in or out of other activities as they wished.

Family members had limited involvement with the service or in their relatives' care and treatment. However, clients had contact with their families during their rehabilitation if they wanted.

Staff did not offer clients copies of their care plans. They told us that a client could have a copy if they requested one.

Are substance misuse services responsive to people's needs?

(for example, to feedback?)

Access and discharge

The service had no targets in respect of waiting times. They had two clients currently on their waiting list. One was not mentally prepared for rehabilitation straight way and the other prospective client was awaiting funding confirmation. Following referral to the service, the manager arranged with the client to begin the induction process. The service offered mid-morning appointments at a time agreed with the client. Due to alcohol dependency, it was important to offer times that a client could realistically expect to attend.

Clients received informal information as well as a welcome pack and could attend a pre entry group. Clients accessed the service following alcohol detoxification.

During the first few months with the service, staff encouraged clients to regain their independence and relearn life skills if necessary. Planning for discharge happened in the final three months, when the client transferred to SAAS for their final 13 weeks of treatment. Staff and client then developed an after care package with links to support services. This was available for five years following completion of residential rehabilitation.

One client had left residential rehabilitation in the last year as an unplanned exit. Staff evicted the client for drinking alcohol, which breached the service code of conduct. Staff breathalysed clients daily as part of their treatment plan. Clients could be subject to random tests if staff suspected they had been drinking. The service ensured that anyone leaving unexpectedly had somewhere to go and remained safe. The client handed in their keys to the house before leaving ensuring the safety of remaining residents. We saw evidence that staff provided the referral organisation with details of therapy engagement undertaken by a client who left in this manner.

The facilities promote recovery, comfort, dignity and confidentiality

Substance misuse services

The facilities promoted the steps needed for independent living. Clients had responsibility for their own cooking, cleaning and washing. Their rooms were large, well maintained and could be personalised with pictures and ornaments. Clients had free access to their rooms during the day. The house offered a warm and comfortable home to the client. There was companionship from other clients if needed or privacy if needed. Staff did not provide cover overnight but clients could contact staff if an emergency arose.

Clients and staff planned and discussed activities during the clients' meeting, including the monthly community activity. During the day, clients had to attend all mandatory sessions. They could then access further optional therapeutic activities or make their own plans.

Meeting the needs of all people who use the service

The service provided welcome packs in other formats if needed. If a client could not read, staff would read and explain information to them. Staff arranged to accommodate clients with specific religious needs. For example, a Muslim client could have a room appropriate for daily ablutions, access to halal cookery utensils and food storage, and access to a mosque.

Staff noticed a client was having mobility issues and offered an alternative room on the ground floor. However, the client preferred to stay in their current room, so the manager arranged for the fitting of handrails instead.

Listening to and learning from concerns and complaints

The service has a complaints policy. Clients had not made any formal complaints in the past 12 months. Staff dealt with and resolved any informal complains during the clients' meeting. Information about how to make a complaint was included in the welcome pack given to clients.

Are substance misuse services well-led?

Vision and values

The service did not have a mission statement. Their aim was to promote recovery and work with clients to develop the skills necessary to make recovery a reality. Staff felt included as part of the wider organisation, attending meetings and being kept up to date with developments on a regular basis.

Good governance

As the service was small, staff tended to discuss their practice and any matters informally on a daily basis. This meant that staff did not always follow policies and procedures. For example, whilst there was clear learning from serious incidents, staff did not appear to follow the governance structure for reporting all incidents. Staff dealt with some incidents informally and did not record them according to policy. This meant they could not identify trends. Overall, there was a lack of effective local audit systems in relation to risk assessments and care plans. However, safeguarding, supervision and mandatory training processes were all in place.

The residents' induction pack provided clear information on confidentiality, the sharing of information and obtained the clients consent. However, consent to share information with the National Drug Treatment Monitoring Service (NDTMS) was not sought. Substance misuse services submit specific data to NDTMS, who produce reports on the service outcomes to the service commissioners. The commissioners and Public Health England can then monitor the effectiveness of these services and ensure they meet the needs of the local population. Consent to NDTMS has a specific format, which informs the client about the role of NDTMS. The induction pack did not include this. This meant that staff shared client information without the appropriate consent form being in place.

Leadership, morale and staff engagement

The service manager had been in post less than a year and said he felt well supported by the chief executive officer. Staff told us they felt well supported by their colleagues, manager and the organisation. The service had no vacancies and low sickness rates among permanent staff.

Morale was good and staff felt their work was rewarding.

Staff were aware of the whistleblowing policy and said they would use it if they felt it was necessary.

Commitment to quality improvement and innovation

Substance misuse services

The chief executive of the organisation held a clients' meeting for feedback on the service twice a year. Feedback from these meetings helped to improve the service.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

• The provider must ensure that all staff must do a comprehensive risk assessment of all clients, produce a risk management plan and review and updated both regularly.

• Staff must produce a comprehensive, holistic and recovery-focused individual care plan for each client and review it regularly with them.

• The provider must obtain consent from clients in order to share information with the National Drug Treatment Monitoring System (NDTMS).

Action the provider SHOULD take to improve

• The provider should ensure that staff adhere to policies and procedures for reporting incidents.

• Staff should have a working knowledge of the Mental Capacity Act

• Staff should document informal complaints raised during the 'feelings' meeting and their outcomes.

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 (RA) Regulations 2014 Safe care and treatment Safe care and treatment. The records we reviewed contained very basic risk assessments. These were not detailed and there was no risk management plan. The risk assessments were not reviewed. This was a breach of regulation 12(2) (a) Assessing the risk to the health and safety of clients receiving the care or treatment.

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Person-centred care Care plans were incomplete, not recovery-focused and not regularly reviewed. This was a breach of Regulation ((3) (b) Designing care and treatment with a view to achieving clients' preferences and ensuring their needs are met.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Accommodation for persons who require treatment for substance misuse

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Good Governance

Appropriate consent to share information with the National Drug Treatment Monitoring System (NDTMS) was not sought from clients.

This was a breach of Regulation 17 (2)