Osbrooks

Quality Report

Osbrooks
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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	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Inadequate

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

Letter from the Chief Inspector of Hospitals

I am placing the service into special measures.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Professor Ted Baker
Chief Inspector of Hospitals

Overall summary

This was the first inspection of the service. We rated it as inadequate because:

- The provider failed to ensure that information on client risk was centrally located in the client file.
- Care plans did not include all risks identified at the initial assessment. The client files did not include the risk assessments; nor did they contain records of risk reviews or risk management plans. This meant that not all client records contained consistent information regarding risk - including assessment documentation and prescribing information. As a result, this important information was not easily accessible to staff to inform the care that they provided.
- The provider failed to ensure that staff always responded to warning signs and deterioration in people's heath or changing risks.
- The provider failed to ensure that all staff were properly trained in using detoxification or withdrawal management tools and could therefore manage detoxification safely.
- The provider failed to ensure that all re-accreditations, such as the managers nursing registration, were completed in time and all staff had up to date DBS checks completed.
- The provider had failed to ensure that out of date fire safety equipment had been replaced.
- Not all staff were aware of the admission criteria, nor did they always follow them.
- We were not assured that the records were an accurate record of the medicines prescribed and administered or declined, nor a full reconciliation of the client's medicines on admission.
- Up-to-date care plans were not always present or complete in the client files. We found the care plans to contain pre-populated generic information and whilst short- and long-term goals were identified there were limited steps on how to achieve them.
- Whilst staff used recognised rating scales to assess and record severity and outcomes, not all staff were trained in using them.
- The provider failed to ensure that effective records were kept in order to ensure the safe management of the service, included staffing rotas, documents about the running of the service and client records including medication charts.
- Governance policies, procedures and protocols were not regularly reviewed and often out of date or had passed their renewal date.

However:

- The full-time staff had completed their mandatory training, including safeguarding, and all staff received an induction when they joined the service, which included the completion of the Care Certificate.
- Staff completed some comprehensive assessments with clients on admission to the service, including

Summary of findings

consent to treatment, client details, breathalyser reading, medical and social background, alcohol dependence questionnaire and basic physical observations.

- Staff provided a range of care and treatment interventions suitable for the client group. These included medication, activities, counselling and therapy. A structured timetable of therapy and activities was offered to clients Monday to Saturday.
- Clients told us that the staff treated them with compassion and kindness and that the staff understood the individual needs of clients and supported clients to understand and manage their care or treatment.
- The service held monthly quality and innovation meetings for staff and had evidence of initiatives to improve the service, such as an improvement log.
- Clients were made aware of the risks of continued substance misuse and harm minimisation.

The inspection team identified concerns that were placing, or could place, the clients at Osbrooks at risk. CQC sent a Section 31 Letter of Intent to the provider following the inspection. A letter of intent describes these concerns to the provider and asks that the provider responds to CQC with plans to rectify the issues immediately otherwise further enforcement action could be taken. The areas which CQC asked the provider to address were:

1. The provider must ensure that Clinical Institute Withdrawal Assessment for Alcohol – Revised (CIWA-Ar) assessments scores are appropriately responded to and provide evidence that all staff understand the intervention required according to the CIWA-Ar score.
2. The provider must ensure that the correct tools are used when assessing client's withdrawal and that all staff are aware of which tool to use depending on which substance treatment plan the client is on.
3. The provider must ensure that the GP assessments for each client are contained in the client files and accessible to all staff working with the client.
4. The provider must ensure that all known risks and identified risks are recorded, and appropriate action is taken to mitigate the risk and that this is recorded in the risk plan for all clients.

The provider responded in a timely manner describing the adequate and immediate actions taken to ensure the safety of clients at the service in relation to these four areas of concern. Details of the concerns and the provider's response are contained within the report findings.

Summary of findings

Contents

Inadequate

Osbrooks

Services we looked at
Substance misuse services

Summary of this inspection

Background to Osbrooks

Moving Forward Osbrooks provides a private residential detoxification and rehabilitation service where clients fund their own treatment. Moving Forward Osbrooks provides medically monitored detoxification and a therapeutic recovery programme based on the 12-steps model. It has been registered at its current location with the CQC since December 2018 and operational since January 2019. The service was previously registered at a different location, which closed in May 2018.

There is a registered provider in place who also acts as the service manager.

The service is delivered in a large Grade II listed manor house near Dorking, Surrey. The building is set in 14 acres of grounds, with a large rear garden, complete with swimming pool, hot tub and gym.

The service is registered to provide treatment to up to 10 clients over the age of 18. There was accommodation for six clients on the first floor on the main building, with one shared room and all the others single rooms. Some with en-suite and some shared bathrooms. One bedroom was adjacent to the office on the ground floor for clients who were undergoing the early days of detoxification. There were also two bedrooms designated for staff use with a shared bedroom. Therapy, activity and communal rooms are located on the ground floor. There was also a small outbuilding which contained a gym.

The service has a contract with a local GP surgery to deliver prescribing for a medically monitored detoxification. This means that clients may be given medicine to manage their withdrawal from substances, supported by staff - but do not require 24-hour medical supervision.

All clients who have used the residential services could access after-care for up to three years. After-care consists of attendance at the daily groups and support from staff.

Clients at the service self-funded their treatment. They either self-referred or were referred to the service by an agency. The service did not take NHS funded clients or referrals of people detained under the Mental Health Act. Clients typically stayed at the service for 28 days.

There were five beds occupied at the time of our inspection.

This was the service's first inspection.

Moving Forward Osbrooks is registered to provide the following regulated activity: Accommodation for persons who require treatment for substance misuse.

Our inspection team

The inspections team comprised: four CQC inspectors, one with a background in substance misuse services, including a registration inspector who was shadowing and a member of the medicines team.

Why we carried out this inspection

We undertook an unannounced, comprehensive inspection of this service as part of our routine programme of inspecting registered services.

Summary of this inspection

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- carried out a tour of the location and looked at the quality of the environment and observed how staff were caring for clients
- spoke with three clients who were using the service and reviewed six comment cards completed by clients
- spoke with one family member of a client who previously used the service
- spoke with the service manager and three other members of staff, including a group facilitator
- looked at five care and treatment records of clients
- looked at a range of policies, procedures and other documents relating to the running of the service.

After the initial visit a member of the Care Quality Commission's medicine management team visited the property to undertake a specific check on medicine management.

What people who use the service say

We spoke to three clients who were receiving residential services and collected six comment cards completed by clients.

The clients we spoke to were complimentary about the service, the treatment and care they received. They told us that they felt safe, supported and that their individual client needs were met.

Clients commented that they found the staff compassionate, respectful, approachable and the staff's own previous experience with substance misuse helpful to ensure open and rewarding discussions. Clients found staff to be open to different routes of recovery and offered personalised care. Clients were pleased that there was opportunity for their families to be involved in their care and treatment.

Clients commented that they found the treatment and daily activities to be enough to meet their needs. Clients were aware of the complaints process and liked the environment and food.

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?

Inadequate

We rated safe as inadequate because:

- The provider failed to ensure that all client records contained consistent information regarding risk and that all information was easily accessible for staff to locate in client's files, including all assessment documentation and prescribing information. In response to CQC's Letter of Intent, the provider took immediate action and made changes so that all risk assessments and the GP assessment were placed in one accessible client file.
- The provider failed to ensure that there were robust risk assessments in place for all clients, with all risks included from initial assessments, that they were regularly reviewed, and that management plans were put in place. In response to CQC's Letter of Intent, the provider took immediate action and made changes so that all risk assessments were kept centrally.
- The provider failed to ensure that all warning signs and deterioration in people's heath or changing risks were responded to. In response to CQC's Letter of Intent, the provider took immediate action. Staff received further training and the provider put in place processes to ensure client safety.
- The provider failed to ensure that all staff were properly trained in using detoxification or withdrawal management tools. In response to CQC's Letter of Intent the provider re-trained staff in using the correct withdrawal monitoring tools and how to respond to the client's withdrawal symptoms.
- The provider failed to ensure that all re-accreditations were completed in time and all staff had up to date DBS checks completed.
- The provider failed to ensure that out of date fire safety equipment had been replaced.
- Cleaning rotas were not always dated or completed. However, the premises looked clean.
- During our inspection there were enough staff on site for clients but the service did not keep a record of which staff had worked when, so we were unable to get assurances around safe levels of staffing cover.
- Some staff were not fully aware of the admission criteria and these were not followed for some clients. For example with the admission of a client for an opiate detox. This may mean that they are accepting clients that they cannot safely manage.

Summary of this inspection

- We were not assured that the records were an accurate record of the medicines prescribed and administered or declined nor a full reconciliation of the client's medicines on admission.

However:

- The full-time staff had completed their mandatory training, including safeguarding, and all staff received an induction when they joined the service, which included the completion of the Care Certificate.
- Whilst the service did not have a clinic room, it did have equipment to carry out some basic physical examinations.
- Staff made clients made aware of the risks of continued substance misuse and harm minimisation.

Are services effective?

Inadequate

We rated effective as inadequate because:

- Because the service was not following its own admission criteria, it admitted clients who might be at high risk during detoxification. The staff employed by the service did not have the expertise in substance misuse that would be required to provide adequate care for such a client group.
- Care plans were not always present or complete in the client records that we reviewed. The provider later explained that there were many versions of care plans and some could be out of date, whilst other versions were kept on the computer. We found the care plans to contain prepopulated generic information and whilst short- and long-term goals were identified there were limited steps on how to achieve them.
- Not all client risks were carried across from initial assessment onto care plans, risk assessments were not all kept on the client's files, nor was there evidence of risk reviews.
- The office was unlocked and client information, such as information on the white board was accessible for all to see.
- Whilst staff used recognised rating scales to assess and record severity and outcomes, not all staff were trained in using them. In response to CQC's Letter of Intent staff received training to use these.

However:

- Staff completed comprehensive assessments with clients on admission to the service, including consent to treatment, client details, breathalyser reading, medical and social background, alcohol dependence questionnaire and basic physical observations.

Summary of this inspection

- Staff provided a range of care and treatment interventions suitable for the client group. These included medication, activities, counselling and therapy. A structured timetable of therapy and activities was offered to clients Monday to Saturday.
- All new staff had undertaken an induction and all full-time staff had completed the Care Certificate.

Are services caring?

Good

We rated caring as good because:

- Clients told us that the staff treated them with compassion and kindness and that the staff understood the individual needs of clients and supported clients to understand and manage their care or treatment.
- Staff involved clients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that clients had easy access to additional support.
- Staff informed and involved families and carers appropriately.

Are services responsive?

Good

We rated responsive as good because:

- The service was easy to access. Staff planned and managed discharge well.
- The design, layout, and furnishings of the ward supported clients' treatment, privacy and dignity.
- The service met the needs of all clients, including those with a protected characteristic or with communication support needs.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

However:

- Not all rooms were single rooms, nor did clients have lockable space for their belongings. However, there was secure storage in the staff office.

Are services well-led?

Inadequate

We rated well-led as inadequate because:

- The manager of the service did not have a full understanding of all that was needed to run the service safely and effectively.
- Our findings from the other key questions failed to demonstrate that governance processes operated effectively in the service

Summary of this inspection

and that performance and risk were managed well. This included medicine management, client confidentiality, HR processes, appropriate training around alarms and their use and the use of the admission criteria.
- The service was operating outside of its statement of purpose and staff were unable to name the organisation's visions and values but staff were clear that the service had a clear vision of helping clients recover from addiction.
- Policies, such as the Mental Capacity Act policy were not regularly reviewed and often out of date or had passed their renewal date.

However:

- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- The service collected and analysed data from clients on their discharge.
- The service held monthly quality and innovation meetings for staff and had evidence of initiatives to improve the service, such as an improvement log.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had received training in the Mental Capacity Act through electronic learning and some were confident talking about capacity issues.
- The manager told us that client's capacity to consent to treatment was always considered at their initial assessment. Within the assessment and admission process, the client's consent was sought for the service to provide a summary of their care to the client's GP.
- Not all staff were aware of available advocacy services for clients.
- The service had a policy on the Mental Capacity Act which staff are aware of and could refer to. However, the policy had passed its review date in 2017.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Substance misuse services	Inadequate	Inadequate	Good	Good	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Good	Good	Inadequate	Inadequate

Inadequate

Substance misuse services

Safe	Inadequate
Effective	Inadequate
Caring	Good
Responsive	Good
Well-led	Inadequate

Are substance misuse services safe?

Inadequate

Safe and clean environment

- The service was provided from a large Grade II listed building, set in large well-maintained grounds. There were warning signs throughout the building mitigating the associated risks of an old building, such as low hanging beams and uneven flooring. Staff told us that all clients were taken on 'mind your head' tour on arrival. However, the building was not purpose built and whilst some risks had been mitigated, the building could still pose a potential risk to clients and staff, particularly those with mobility issues or undergoing detoxification treatment.
- There were group or communal rooms which were suitable for the service, including two client lounges and an activity room. The service was well-kept and comfortable but a little untidy with old plates, cups and glasses around the house, pool and gym.
- The outside swimming pool was located behind a small unlocked, gate. Clients were individually risk assessed to use the pool, and limited to two hours a day, when staff would supervise them. There was a sign at the pool warning clients that they use the pool at their own risk. All full-time staff had received training in pool safety. Clients were informed by staff that using the pool outside of these hours would result in the termination of their treatment. We found the safety sign and sign warning clients of the use of the pool had fallen off the wall and were face down. We spoke to the staff about this during the inspection and said that they would be re attached.
- There were cleaning rotas in place. However, we noted that they had not been signed or dated for the upstairs rooms.
- Clients had access to the kitchen and full use of the facilities, which allowed clients access to food and drinks all day.
- During the inspection we noticed that the COSHH cupboard padlock was unlocked. COSHH stands for 'control of substances hazardous to health' and in this setting refers to cleaning substances that may be harmful. We also found the laundry powder located in the food larder, which could be hazardous. This was pointed out during the inspection and we were told the cupboard would be locked and the washing powder moved to a more suitable location.
- Clients could be given individual alarms. During the inspection we tested these alarms and observed that they could not be heard at across the property, nor did staff consistently respond when they were activated.
- Clients were free to come and go through the front door, which was locked from the outside for security.
- The service accepted both male and female clients. The bedrooms for males and female clients were in separate areas. However, during our visit we saw that a male client was being accommodated in the female wing, so that he was closer to the staff bedrooms for assistance. This meant that the female client was accommodated in the detoxification room and this prevented the client undergoing detoxification from being located in the detoxification room.
- Clients in the detoxification room accessed the main house through the office.

- Some client bedrooms could be locked from the inside, but not the outside, nor unlocked from the outside and clients did not have secure lockers in their rooms. However, clients could store possessions in the office in a locked cabinet.
- The fire risk assessment incorrectly had the name of the previous location on it and the nominated individual on the assessment no longer worked at the service. We saw that the fire extinguisher in the kitchen had expired in 2009, we raised this with staff during the inspection who said it would be replaced. After the inspection, the service was able to locate its up to date first risk assessment for the service, which was completed by the service manager.
- The most recent ligature risk assessment identified where the potential ligature risks were and what level of risk they presented. This risk was mitigated by the service's exclusion criteria, which stated that referrals of clients at higher risk of suicide and self-harm, or with a diagnosis of a severe mental health problem, would not be accepted. However, during our inspection we saw that the service was accepting clients with a risk of suicide.
- Staff told us that they complete a daily environmental check of the property.
- The service did not have a clinic room. However, the service had the necessary equipment to carry out some basic physical examinations, such as blood pressure monitoring, breathalysing and urine drug screens.

Safe staffing

- Since the service was registered with the CQC, there have been five permanent staff members at Osbrooks. At the time of our inspection the team consisted of three full time members of staff: the service manager, who was a registered nurse, a deputy manager and an additional support worker, who lived at the property. The service did not use agency staff. The service also employed four other staff members on a sessional basis to provide therapy. Therapy included Reiki (Reiki is a form of alternative medicine called energy healing), counselling, DBT and CBT, one of the therapy sessional staff were registered and accredited by the BACP (British association for counselling and psychotherapy) and support with the twelve-steps model, which are best practice/evidence-based treatments for clients undergoing detoxification or treatment for substance misuse.
- The service had a vacancy for a registered nurse and told us that they were actively recruiting for the position. This was a priority due to the expansion of the service and more clients being admitted. The service was still relatively young and had only ever had five clients at one time.
- Due to the lack of a staffing rota or records, we were unable to get assurances as to what staff undertook overnight shifts. Staff told us that if someone was going through the early stages of detoxification then either the service manager or deputy manager would stay overnight, otherwise the service was not staffed 24 hours a day, seven days a week. However, at the time of our inspection, one member of staff lived at the service.
- We checked all staff files and found that two staff members did not have current Disclosure and Barring Service (DBS) checks. We alerted the manager during our inspection who said these would be applied for immediately, after the inspection we received confirmation that these had been applied for and a copy of the risk assessment for the full-time staff member to keep working without a current DBS, with mitigating actions such as the staff member to not work unsupervised with clients. We also found that the service manager's nursing registration had lapsed. After the inspection we saw evidence that she had now reapplied for her registration.
- The service had an agreement with a private GP who undertook an assessment of clients who required medication for detoxification or withdrawal. Clients who required medication were taken to see the GP following their admission. The GP hours were Monday to Friday 8am to 8pm, 9am – 5pm on Saturday and 9am – 1pm on Sunday. There was no medical cover outside of these hours and in the event of a medical emergency the service would call either 111 or 999. The private GP service could also provide follow up appointments with clients, if required. The private GP practice had links to the local community mental health teams and would be able to make a referral to these if they felt it was necessary.

- The provider was in the process of employing another nurse, but currently did not employ any, so support workers and non-clinical staff administered medicines to the clients. All staff administering medicines had recently received training on the safe use of medicines.

Mandatory training

- All three permanent members of staff had completed mandatory training. One of the sessional staff had also completed mandatory training as it was hoped that once they were trained they could assist more in the service, if needed.
- All full-time staff had completed lone working training and all staff were required to have completed their basic induction before undertaking lone working.
- Full time staff had completed training in and understood their responsibilities in relation to the Mental Capacity Act 2005. We also saw evidence of training and staff discussion around their understanding of the Mental Capacity Act at the April staff meeting.
- All permanent staff had completed an induction at the start of their employment with the service, which included the completion of the Care Certificate, as well as the completion of mandatory training.
- The service had a lone working policy, the manager told us that risks to staff being left on their own were mitigated by two staff members staying over if there was any risk identified.

Assessing and managing risk to clients and staff

- Clients either self-referred to the service or were referred through an agency. Staff at the service carried out an initial assessment to ascertain suitability for the service. Then only those clients who required medication for a detoxification were seen by the GP.
- The service operated an admission criterion, which described the inclusion and exclusion criteria. At the time of inspection clients with primary drug detox needs were excluded from the service. We saw clients admitted to the service who did not meet the admission criteria, such as clients who were admitted for a drug detoxification, when the service stipulates clients must be admitted for treatment for alcohol and possible secondary drug dependence. We also saw a client under 18 and a client who was admitted to the service with a heightened risk or suicide and a client with severe co-morbidities, which are both contained in the exclusion criteria. However, not all staff we spoke to were aware of the admission criteria.
- We had concerns that the service was not recognising and responding to warning signs and deterioration in people's health or changing risks. We saw that one client had received a higher CIWA-Ar score. CIWA-Ar is a ten-item scale used in the assessment and management of alcohol withdrawal. We were concerned that CIWA-Ar withdrawal scores were not being appropriately responded to. After the inspection, the service provided us with assurances that they have updated their processes so that all clients are to see the doctor regardless of level of SADQ score or indication of low level of alcohol dependence.
- During the inspection we saw incorrect detoxification or withdrawal assessment tools being used on two out of five client files that we looked at. This would mean that any monitoring was not suitable or safe for the treatment that the client was receiving, and warning signs could be missed. Following the inspection, as a result of our section 31 Letter of Intent, the service provided us with assurances that staff had received training in detoxification and withdrawal tools.
- Staff told us that clients were made aware of the risks of continued substance misuse and harm minimisation and we saw evidence of this in care plans. We saw evidence of a client who left the service in an unplanned discharge being given a warning about the dangers of continuing substance misuse. Staff were given a presentation during the May monthly quality and innovation meeting regarding the high risk of overdose and death if clients use after leaving.
- Staff told us that laminated crisis plans were created with clients and contained numbers to call and harm minimisation information.
- The service had a code of conduct for clients to read in the handbook, a copy of which was provided to clients on their admission.
- Clients were permitted to smoke in the grounds but not in the property.

Use of restrictive interventions

- Clients' belongings were searched when they were first admitted to the service and after they returned to the property after community leave.
- Clients handed in their phones, which were securely stored. Clients were permitted to use their phones between 4pm and 10pm.
- Clients were provided with an information pack prior to their admission, which detailed a list of items which should not be brought to the service.

Safeguarding

- The provider reported that there were no safeguarding incidents within the service over the past 12 months.
- The manager of the service was the designated safeguarding officer.
- Not all staff that we spoke to had had experience recognising and reporting safeguarding, although staff knew the process for escalating any safeguarding concerns to the manager.
- Staff told us that risk assessments were completed for any clients who had children, however we saw in one client's records that the space to enter information about any children had been left blank, despite the client having children. Staff later told us that the risk assessments were kept separately from the client's files.
- Staff had completed their safeguarding training as part of their induction to the service.
- The service had a safeguarding policy, which had been reviewed in the last 12 months.

Staff access to essential information

- The service used paper files for client records, which were stored in a locked cabinet in the staff office. We found that information about clients was often kept in different places, which could leave staff unable to locate important client information.

Medicines management

- Medicines were stored securely in a locked trolley and cabinet within an office. Where clients looked after their own medicines a small locked tin was provided. Staff monitored the room temperature and had processes to monitor the fridge when in use. However, the trolley was not immobilised, and the dedicated medicines fridge was not lockable. Also, to reduce risk staff told us clients may be given strips of their medicines rather than the original container when self-medicating, and so the clients did not have the administration instruction. This was pointed out to the provider at the time of the inspection, who said they would change this process to ensure client safety.
- On assessment and admission clients were asked to bring with them enough of their current medicines for the length of their anticipated stay. Medicines to support detoxification and modifications to the clients' current medicines were prescribed by the supporting private doctor and dispensed by the services preferred community pharmacy. Three medicines were available as homely remedies. Homely remedies are medicines that can be purchased and administered to clients without a prescription for short term treatment of minor conditions. However, for one client the information provided by the private doctor lacked enough detail about how to reduce the dose of a client's current medicine.
- Following the private doctor's assessment of the client service staff told us they prepared a medicines administration record (MAR) for each client. We reviewed the MARs for two clients both were incomplete, for example strengths of medicines or medicines that were self-administered were not always recorded. One client had declined to take one medicine, however, this was not recorded in the care plan or MAR. Therefore, we were not assured that the records were an accurate record of the medicines prescribed and administered or declined nor a full reconciliation of the client's medicines on admission.
- The service had client information leaflets for medicines frequently prescribed to support detoxification. However, they lacked their source or were not dated. Therefore, we lacked assurance that they were from a reliable source or current.
- The two clients care plans we reviewed contained completed physical health and specific detoxification monitoring forms. However, for one client the incorrect detoxification tool had been used. Then, when another medicine dose was reduced that may lead to detoxification side effects, the relevant detoxification tool was not used. Therefore, we were not assured that appropriate physical health monitoring was undertaken.

Inadequate

Substance misuse services

- The alcohol detoxification prescribing we reviewed consisted of a fixed dose reduction regimen over a set number of days. Additional "when required" doses were incorporated into the prescribing. This allowed the service to administer additional doses if the detoxification tools indicated this would help the client.
- The service had started an audit programme including the use of medicines. Through this process they had identified the need for a specimen signature list and a medicines fridge which they had actioned. They had also identified the potential need for a controlled drug safe and register which they were looking into during the inspection. Whilst the service encouraged self-medication they were not monitoring clients to ensure they were taking their medicines as prescribed.

Track record on safety

- There were no serious incidents reported by the provider during the previous 12 months.
- Staff we spoke to knew the process for reporting serious incidents to the service manager.

Reporting incidents and learning from when things go wrong

- Not all staff were aware of what incidents needed to be reported to the Care Quality Commission.
- Staff discussed learning from incidents at the monthly meetings and we saw actions being taken to make improvements and act on learning identified. Staff discussed incidents at team meetings.
- Duty of candour is a legal requirement that means that providers must be open and transparent with clients about their care and treatment. This includes the duty to be honest with clients when something goes wrong. The provider did have a duty of candour policy. However, the policy had passed its review date.

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

Inadequate

Assessment of needs and planning of care

- We looked at care records for all five clients at the service. Care plans were present for three clients, one client had no care plan and one was incomplete. The provider later explained that there were many versions of the care plans and some could be out of date, whilst other versions were kept on the computer. The care plans that were present were up to date but we found the care plans to contain prepopulated generic information. We saw allergies being recorded on the care plans. After the inspection the provider told us that if care plans were missing it was because they were stored on the computer and going forward will ensure that all care plans are printed and placed on the client files.
- Clients' short and long-term goals were identified in care plans but with limited steps on how to achieve them. Often there were gaps in the care plan, such as information about what led to addiction or missing detail of what substances clients had previously been using. In terms of aftercare provision, we saw only limited discharge planning in the care records. Staff told us that they completed care plans within three days of the client being admitted.
- The GP partnership made the prescribing decisions. None of the records that we looked at showed evidence of the initial GP assessment, prescribing rationale, medical review or care reviews. After the inspection, the service provided assurances that in future all GP assessments would be printed and placed in the client's hard copy files.
- The service undertook an initial assessment of the clients. This was a comprehensive assessment including consent to treatment, client details, breathalyser reading, medical background, social background, severity of alcohol dependence questionnaire. We saw evidence of basic physical observations being done, (blood pressure, temperature and pulse). If necessary, for example the client required medication for a detoxification, clients were then seen by the GP within 24 hours and the GP then undertook a further comprehensive assessment, including a physical assessment if required and any necessary blood tests, including blood borne virus testing.
- A daily handover sheet was completed which detailed what the clients were doing, but this was not included in

the clients' records. However, there was no system to record daily progress such as progress towards recovery, activities attended or whether there had been family contact.

- Client risks were recorded in their initial assessment, however in the care records we reviewed these had not always been carried over into client risk assessments or care plans. Some risk assessments were kept separately to the client's files' and the service stated that, for clarity, going forward, all risk assessments would be kept on the client file. We found no risk assessment reviews nor risk management plans. The provider told us after the inspection that these were kept seperately. However, we did find a risk management plan for those people identified as being at risk for unexpected exit from treatment.
- Clients were invited to complete a daily log book, which included their mood, happiness, sleep, and lifestyle such as diet, which they shared with peers in sessions or their key worker.
- Clients current level of risk, (high, medium or low) was recorded on a white board in the office for all staff to see. The office is unlocked, meaning any client and the client who is accommodated in the detoxification room access the office and could see this confidential and sensitive information. After the inspection, the provider told us that they had removed the whiteboard from the office and ensured all patient records were kept in a locked cabinet.

Best practice in treatment and care

- The service offered a structured timetable of therapy and activities for clients Monday to Saturday. The treatment and therapies provided for clients was based upon the twelve-step program. The twelve-step program is a set of guiding principles outlining a course of action for recovery from addiction, compulsion or other behavioural problems.
- At weekends there were fewer activities. However, there were outings to local places, which the service called sober situations and opportunities for clients to have their families visit. Sober situations were opportunities for clients to experience difficult situations such as pubs or restaurants without drinking. Clients told us that they were happy with the amount of activities and the timetable.
- Staff provided a range of care and treatment interventions suitable for the client group. These included medication, activities, counselling and therapy. Therapy included Reiki (Reiki is a form of alternative medicine called energy healing), counselling, DBT and CBT, one of the therapy sessional staff were registered and accredited by the BACP (British association for counselling and psychotherapy) and support with the twelve-steps model.
- Staff told us that they hold keyworker sessions with each client at least once a week, depending on the client's needs.
- Blood borne virus testing was routinely offered by the partner GP surgery when needed for those clients who attended for an initial assessment.
- Staff used recognised rating scales to assess and record symptom severity and outcome of alcohol detoxification, such as clinical institute withdrawal assessment (CIWA-r).

Monitoring and comparing treatment outcomes

- The service collated information every three months on discharge. The March summary showed that four clients responded, and the score was nearly 100% client satisfaction with their treatment.

Skilled staff to deliver care

- The service provided all staff with a comprehensive induction. The service had only been operating from Moving Forward Osbrooks since December 2018 and the permanent staff were all relatively new to the service
- All the prescribing GPs had the Royal College of General Practitioners certificates (part 1) for 'alcohol and drug management' or were supervised by a GP who held the qualification.
- The two full time staff had both completed the 'Care Certificate'. The Care Certificate is an identified set of standards that the health and social care workers adhere to in their daily working life. Staff in the service included a counsellor, a staff member who had over 12 years' experience with the 12 steps programme and a therapist who offered complimentary therapies. There was also a staff member trained in CBT. One of the therapy sessional staff were registered and accredited by the BACP (British association for counselling and psychotherapy)

- Appraisals had been arranged for the full-time staff for later in the year as both staff members were relatively new to the service.
- The service provided and ensured that all full-time staff had completed mandatory training.
- Not all staff had received regular supervision. Where supervision had taken place, we saw that things like training needs were discussed. However, staff reported that they could raise any issues they had regularly with the manager and at the monthly team meetings and that they felt supported.
- Most of the staff had personal experience of recovery from addiction.

Multi-disciplinary and inter-agency team work

- Staff told us that there was a range of services that they could signpost clients to on discharge, such as drug and alcohol services in the area.
- The provider also had links with local substance misuse fellowship groups in the area.

Good practice in applying the MCA

- Staff had received training in the Mental Capacity Act through electronic learning and some were confident talking about capacity issues.
- Clients' capacity to consent to treatment was assessed at their initial assessment. Within the assessment and admission process the clients' consent was sought for the service to provide a summary of their care to the clients' GP.
- Not all staff were aware of available advocacy services for clients.
- The service had a policy on the Mental Capacity Act which staff were aware of and could refer to. However, the policy had passed its review date in 2017.

Are substance misuse services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

- Clients told us that staff treated them with compassion, respect and kindness.
- Clients were required to sign a contract on admission and clients were given information about what would be expected of them during their time at the service. Clients were also given books known as the health and happiness planners to write down their thoughts each day and this was discussed either with their allocated key worker or at the daily morning reflections meeting.
- All staff that we spoke to were dedicated to client recovery and had a kind, caring, compassionate and respectful attitude when discussing clients' needs. Staff were passionate about delivering a high standard of person-catered care to clients within a friendly family environment.
- Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes and that they felt supported and valued by their colleagues.
- Staff directed clients to other services when appropriate and, if required, supported them to access those services.
- Clients who were placed in the downstairs detoxification room accessed their room through the staff office. There was a client whiteboard containing client information which would be accessible for anyone walking through this office. The office was unlocked and also the access route to the detoxification room.
- Clients ate their meals together and either staff cooked them, or the clients cooked for each other.

Involvement in care

- Clients were given a pack on admission that included a handbook with information on the treatment program, the facilities and the boundaries for receiving treatment at the service. Information was also contained in the admission pack and on the wall about the complaints procedure and contacting the CQC.
- Clients were made aware at the outset of treatment that they would be expected to hand in their mobile phones in and could only access between 4pm and 10pm. Clients understood that this was to enable them to focus on their treatment and to help support them.
- Clients were encouraged to give feedback through a variety of forums, a weekly community meeting, there was an anonymous jar for clients to leave their thoughts and through a questionnaire at the end of their treatment.

- All clients who had completed treatment at the service could access three years of aftercare. This included attendance at the daily groups and support from staff.
- Clients on admission were asked for their consent to contact their GP and we saw evidence of this being done.
- Staff actively engaged people using the service (and their families/carers if appropriate) in planning their care and treatment. We saw evidence in the care plans of the clients' opinions and wishes.
- The service did not routinely support clients to access external advocacy and not all staff were aware of what advocacy services could be available.

Involvement of families and carers

- Family visits and telephone contact was encouraged by the service. Families were encouraged to visit on Sundays, but the service were willing to facilitate visits outside of this. Staff actively engaged with people using the service and their families and carers. Families were invited at the end of the treatment to joint sessions. Staff obtained the client's permission to discuss elements of their treatment with families.

Are substance misuse services responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

- At the time of our inspection there were five clients receiving treatment at the service. One for an opiate detoxification, two for alcohol dependency and two for other substances. The service did not accept any NHS referrals and all clients were self-funded.
- Staff we spoke with were unclear about the service's admission criteria. The manager confirmed to us that the current criteria was not always applied.
- The service had reported that it had not had to signpost people to alternative services, as they had been able to accept all new referrals.
- Following the initial assessment by the team at Moving Forwards Osbrooks the client was taken to the partner GP practice for an assessment, if they were deemed to require medication for a detoxification.

Discharge and transfers of care

- The service had a discharge checklist and form to complete when clients left the service and it was the provider's procedure to follow up all clients with a call one and two weeks after their discharge.
- The service had had two unexpected early discharges. These had been discussed at the monthly staff quality and innovation team meeting. Learning had been identified from one unplanned discharge and crisis planning amended, so that clients were given the laminated crisis plan within three days of admission.

The facilities promote recovery, comfort, dignity and confidentiality

- Client bedrooms were comfortable and well-maintained. Some clients were able to lock their bedrooms from the inside, but there was no way of opening these from the outside by staff. This could pose a risk to clients if they had locked the doors and had a medical emergency that staff were unable to respond to. Clients did not have secure lockable areas for their personal possessions but could leave them in a locked drawer in the office. Clients were able to access their rooms all day. There was one double room and the rest were single rooms with a mixture of shared bathrooms and en suite.
- There was one bedroom located on the ground floor which was accessed either through the office or around the outside of the property. This room was usually reserved for clients undergoing the first week of the detoxification. However, this was not the case during our visit.
- There were two comfortable lounges and an activity room. The property also had extensive grounds, a gym, swimming pool and a hot tub.
- Hot drinks and food were available for clients throughout the day. Clients reported that the food was good and plentiful.

Clients' engagement with the wider community

- Staff supported clients to maintain contact with their families and carers.
- Clients were encouraged to attend 12 step fellowship meetings in the community three evening a week. A

fellowship meeting is a meeting of men and women who share their experience, strength and hope with each other that they may solve their common problem and help each other's recovery.

Meeting the needs of all people who use the service

- The service was wheelchair accessible on the ground floor only. The only bedroom which was accessible was the detoxification room, clients with mobility issues completing detoxification would not be able to access other bedrooms in the building after the competition of their initial detoxification..
- The service was able to meet any necessary dietary requirements for clients.

Listening to and learning from concerns and complaints

- The manager informed us that one formal complaint had been raised since the service opened. We saw learning arising from this being discussed at the monthly staff meeting.
- Clients told us that they knew how to make a complaint, and this was clearly highlighted in the client handbook on admission. Information was also displayed on a poster in the living room for clients.

Are substance misuse services well-led?

Inadequate

Leadership

- The registered provider was also the service manager and had overall management of the service. The registered manager didn't have a clear understanding of all that was needed to run the service safely and effectively.
- The service advertised that a qualified nurse was on duty. However, at the time of inspection the manager and only current employed qualified nurse was in the process of re-submitting her registration. She did tell us that she was recruiting for a full-time registered nurse
- The service had admitted clients for opiate detox which was not covered in their current statement of purpose. CQC requested that the SOP was updated to reflect this.
- Due to the size of the service, the manager was visible in the service and approachable for clients and staff.

Vision and strategy

- Staff were unable to name the organisation's vision and values; however, all staff were clear that the service had a clear vision of helping clients recover from addiction.
- Staff were focussed and positive on supporting client recovery.
- Staff had the opportunity to contribute to discussions about the strategy for their service and felt that the monthly staff meetings gave them the opportunity to do so.

Culture

- Staff felt respected, supported and valued and staff felt positive and proud about working for the provider and their team.
- Staff spoke unanimously about it being a positive place to work.

Governance

- There was a lack of governance around ensuring procedures were in place to safeguard and manage changing client risk.
- There was a lack of effective governance regarding the management of medicines. We found incomplete medicine administration records, client information leaflets with no source or date and the incorrect detoxification or withdrawal tools being used.
- The system for managing where client information was recorded and stored was confusing. Risk assessments and GP assessments were not stored in client files, and there was no evidence of care plans being reviewed. We asked the provider to address these issues urgently and improvements were made. There were no progress notes kept on the client's progress through treatment.
- The HR processes for recruiting and managing staff were incomplete. The manager had not completed her revalidation with the Nursing and Midwifery Council, not all the staff had Disclosure and Barring Service (DBS) checks and there was no record of hours, shifts or even days worked by staff.
- We found a range of out of date policies and procedures which had not been reviewed. This included documents which used the previous service name, and HR records for staff who had left the service mixed with current staff records.

- There was a clear agenda of what must be discussed at a facility, team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed.
- The service kept a risk register which included environmental risks. The register detailed the risks, such as the swimming pool, the grounds and the gym, however it did not include detail on when the risk was added to the register. The register contained information for when the risk reduction should have been completed by but was not complete for all risks. This included no date on when staff should have enrolled and completed their life guarding course. However, all staff had received basic pool safety training.

Management of risk, issues and performance

- The service had completed a hazard analysis, which analysed potential risks and adverse events, such as loss of gas/electricity, or a fire and identifying the potential risks and any action which could be taken, however risk assessments such as the one for the cast iron heat storage oven was undated, and actions identified on the housekeeping audit had not been completed – such as changes to the windows.
- Monthly quality and innovation meetings were held at the service. These discussed what had gone well, what had not gone so well, any complaints and feedback, unplanned discharges, lessons learnt, a policy of the month that all staff had to review, suggestions, training or CPD requirements.
- The service had an audit schedule, which covered maintenance, medication, MAR charts, administration, windows, laundry, COSHH, housekeeping, privacy, care planning and training. However, we did not see evidence on inspection that these were regularly completed.

Information management

- Staff had access to the equipment and information technology needed to do their work. There was also WIFI available for clients' use. Mobile phone signal could be unreliable in the area but there was also a landline telephone.
- Information governance systems included confidentiality of client records. There was an allocated locked cabinet for client files.
- The service had not submitted any statutory notifications to the CQC. We saw an incident recorded where a client had had an accident outside the property, an ambulance had been called and they had received treatment from the paramedics at the property, but the service had failed to notify the CQC. Not all staff were aware of what incidents needed to be reported to the CQC.

Engagement

- Clients and their families had opportunities to give feedback on the service they received in a manner that reflected their individual needs.
- Clients and staff could meet with the service manager and give feedback.

Learning, continuous improvement and innovation

- The service had evidence of initiatives to improve the service, such as a service improvement log. This analysed any feedback, suggestions or complaints received by the service and suggested a solution. Such as a new process being introduced for returning clients, following feedback from current clients.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- The provider must ensure that all client records contain consistent information regarding risk and that all information is easily accessible for staff to locate in client's files, including all assessment documentation and prescribing information.
- The provider must ensure that there are robust risk assessments in place for all clients, with all risks included from initial assessments, they are regularly reviewed, and management plans put in place.
- The provider must ensure that all warning signs and deterioration in people's heath or changing risks are responded to.
- The provider must ensure that all staff are properly trained in using detoxification or withdrawal tools.
- The service must ensure that the safety equipment is replaced if it is not suitable or has expired.
- The service must ensure that effective records are kept in order to ensure the safe management of the service, including medicines management, staffing rotas, documents about the running of the service and client records including medication charts.
- The service must ensure confidentiality of client information.
- The provider must ensure that staff are sufficiently trained in responding to alarms and that the alarms are appropriate for the service
- The provider must ensure that all clients have care plans, created in a timely manner, which are holistic, complete and personalised.
- The provider must ensure that all staff are aware of the admission criteria and that the criteria is followed or updated.
- The service must ensure that all staff are aware of what statutory notifications must be reported to the CQC and that all notifiable incidents are reported without delay.
- The provider must ensure that all reaccreditations are completed in time and all staff have up to date DBS checks completed.
- **On the basis of this inspection, the Chief Inspector of Hospitals has recommended that the provider be placed into special measures**.

Action the provider SHOULD take to improve

- The provider should ensure that all cleaning rotas are dated and completed.
- The provider should ensure that the COSHH cupboard remains padlocked when not in use and that other potentially hazardous chemicals are stored in a way that ensures client safety.
- The provider should ensure that client progress is fully recorded in the client's notes.
- The provider should ensure that all staff received regular and beneficial supervision.
- The provider should consider whether the building is fit for purpose.

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 The provider failed to ensure that all client records contain consistent information regarding risk and that all information is easily accessible for staff to locate in client's files, including all assessment documentation and prescribing information. The provider failed ensure that there are robust risk assessments in place for all clients, with all risks included from initial assessments, they are regularly reviewed, and management plans put in place. The provider failed to ensure that all warning signs and deterioration in people's heath or changing risks are responded to. The provider failed to ensure that all staff are properly trained is using detoxification or withdrawal tools. This was a breach of regulation 12(a) The service failed to ensure that the safety equipment was replaced when it had expired. This was a breach of regulation 12(d)

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service failed to ensure that effective records are kept in order to ensure the safe management of the service.

This section is primarily information for the provider

Requirement notices

The service failed to ensure confidentiality of client information.

The provider failed to ensure that staff are sufficiently trained in responding to alarms and that the alarms are appropriate for the service

This was a breach of regulation 17(1)(2)(a)

The provider failed to ensure that all clients have care plans, created in a timely manner, which are holistic, complete and personalised.

The provider failed to ensure that all staff are aware of the admission criteria and that they criteria is followed or updated.

The service failed to ensure that all staff are aware of what statutory notifications must be reported to the CQC and that all notifiable incidents are reported without delay.

This was a breach of regulation 17(1)(2)(c) and (d)

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider failed to ensure that all reaccreditations were completed in time and all staff have up to date DBS checks completed. This was a breach of regulation 18(2)