SALUS - Withnell Hall - Health, Wellbeing & Addiction Treatment Centre Limited

Quality Report

Withnell Hall
Bury Lane
Withnell
Chorley
PR6 8BH
Tel: 01254 200000
Website: www.info@saluswithnellhall.co.uk

Date of inspection visit: 21,22,31 January 2019
Date of publication: 12/07/2019

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?	Requires improvement
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Inadequate

Summary of findings

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

We rated Salus Withnell Hall as inadequate because:

- The service was not offering safe or effective care. Staff did not follow the policy that set out the pre-admission process and not all clients had had a comprehensive assessment of their risks and needs. Not all care plans fully reflected all clients' needs nor were they based on a full assessment of each client's risks and needs. The provider had not completed physical health checks of clients when clients may be still going through some withdrawal from alcohol or opiates. The service did not provide routine physical health checks. Staff did not always share important information on discharge.
- The provider did not maintain and check the premises to ensure that they were safe for clients. Staff did not have access to an alarm system to summon assistance throughout the premises. The fire risk assessment confirmed that staff should be trained in the use of fire extinguishers, hose reels and basic fire protection. This had not been completed. There was no planned date on the fire risk assessment for this training. A fire door on the bedroom corridor was broken.
- The provider did not have effective policies, procedures and training related to medicines management.
- The provider did not implement a fit and proper recruitment process and pre-employment checks and procedures were not followed when employing staff. Staff had not received an induction to the service.
- There were insufficient, appropriately qualified, trained and supported staff on duty throughout the day, night and at weekends to meet clients' needs. Staff had not received mandatory training to carry out their role safely and effectively. Staff did not receive regular supervision and no staff had had an appraisal of their performance in the last 12 months. Not all staff had a clear understanding of the Mental Capacity Act and the implications of this on their practice.
- Staff did not fully assess clients' physical health needs. The privacy and dignity needs of individual clients were not taken into consideration and appropriate measures had not been taken to ensure all clients were afforded privacy and dignity within their shared dormitories.
- The service did not offer clients access to an advocate and no information about advocacy was displayed throughout the organisation.
- The provider's approach to improve the quality and safety of its services and standards of care was not effective. The governance systems were not fully embedded, established or operated effectively. Staff had undertaken a clinical audit for care records but

Summary of findings

had not recorded what action they had taken to make the improvements identified as being needed. Systems to assess, monitor and mitigate risks to clients' health, safety and welfare were not embedded and records relating to clients were not complete.

However:

- Clients were made aware of the risks of continued substance misuse through the therapy programmes, including the risks associated with unplanned exit from the programme.
- Staff worked well with outside agencies involved in individual client's care and treatment. The clients were temporarily registered with a local GP who visited weekly.
- People with lived experience volunteered, and some were employed by, the service.
- Feedback from the clients who used the service was positive about the way staff treated them. Clients were positive and complimentary about the support and care they received from staff. Staff spent time with clients to help them understand their care, treatment and condition. Staff listened to and responded to clients positively; treating each client with dignity, respect, compassion and in a caring manner.
- Staff supported clients during referrals and transfers between services for example, if they required treatment in an acute hospital or temporary transfer to an in-patient psychiatric ward or other service.
- There was a choice of good quality food catered to individual dietary need on request.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Substance misuse services	Inadequate 	

Summary of findings

Contents

Inadequate

SALUS - Withnell Hall - Health, Wellbeing & Addiction Treatment Centre Limited

Services we looked at
Substance misuse services;

Summary of this inspection

Background to SALUS - Withnell Hall - Health, Wellbeing & Addiction Treatment Centre Limited

SALUS Withnell Hall is a 27-bed residential addiction treatment centre providing psychosocial rehabilitation to men and women over 18 years of age. It is based close to Chorley in Lancashire and is set within in a rural location.

At the time of our inspection there were 14 clients. The inspection was announced before the inspection dates.

SALUS Withnell Hall has been registered with the CQC since July 2014.

The service was last inspected in August 2016. We did not rate the service at that time. The service is registered to provide accommodation for people requiring treatment for substance misuse.

There is a registered manager and a nominated individual. The nominated individual holds shared responsibility with the adjoining independent residential detoxification service. There is a partnership agreement between the two services with arrangements for shared governance and management.

SALUS Withnell Hall provides a service to people in the North West of England and further afield. It provides access to NHS funded and private clients.

Our inspection team

The team that inspected the service comprised of two CQC inspectors, an assistant inspector as well as a pharmacy specialist and another inspector who had been seconded to the CQC pharmacy team.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited the unit, looked at the quality of the environment and observed how staff were caring for clients
- spoke with five clients who were using the service
- spoke with the registered manager and managers on the unit
- spoke with two other staff members
- received feedback about the service from one care commissioner
- attended and observed one group meeting

Summary of this inspection

- collected feedback from four clients using comment cards
- looked at eight care and treatment records of clients
- looked at five staff personnel files
- carried out a specific check of the medication management on the unit
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with five clients during our inspection. We also left comment cards for clients to complete and received four responses.

The clients that we spoke with were mostly positive about the staff and their care and treatment. Clients talked about the support the staff gave them and that staff were available to them when needed.

The responses on the comment cards were positive. However, one client commented that there were constraints on private space especially to complete their individual group work.

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:

- Staff did not always assess the risks to the health and safety of clients receiving care and treatment. Pre-admission assessments were insufficient and they did not identify risks that should have been considered to help staff decide whether it was safe to admit a client or that should have been taken into account during their stay. Staff did not fully assess clients' physical and mental health needs to ensure their needs could be met. Care plans and risk management plans were not sufficiently detailed to ensure the safety and wellbeing of individuals.
- For one client who posed a risk of self-harm or suicide, the risk management plan was not implemented in an appropriate way. The plan did not make it clear how these risks would be managed and addressed. Staff did not check sufficiently on the client; especially during the night.
- Staff did not do enough to ensure that the physical environment was safe for clients and staff. The fire risk assessment confirmed that staff should be trained in the use of fire extinguishers, hose reels and basic fire protection. This had not been completed. There was no planned date on the fire risk assessment for this training. Environmental health and safety audits and checks did not identify maintenance issues and the fire and health and safety policies did not reflect the practices in place. Staff did not have access to alarms to summon assistance in an emergency.
- Staff were not fully skilled to deliver care because new staff had not received an induction and not all staff had completed mandatory training. Only one out of nine staff had received first aid training.
- Male clients had to walk through female areas to access the bathroom and there were no quiet areas or female only areas.
- Staff did not always follow good practice in medicines management. The provider did not have effective policies, procedures and training related to medication and medicines management. There was no system in place to check the competence of staff to administer medicines safely.
- The service did not have enough staff on duty throughout the night and at weekends to meet the needs of clients.

Summary of this inspection

- Staff reported incidents to the manager but the manager was unsure of the incident reporting process due to the new governance structure and new policy in place.

However:

- Clients were made aware of the risks of continued substance misuse through the therapy programmes, including the risks associated with unplanned exit from the programme.
- Staff kept 'blanket restrictions', imposed on all clients regardless of each individual's risk, to a minimum.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Staff did not always ensure that client records were complete and accurate. Some records did not contain a care plan or a record of assessments. In others, staff wrote care plans as goals; with no actions as to how the goals would be implemented by staff. Assessments of need and planning of care did not address all the potential risks to clients or provide a full overview of their holistic and physical and mental health needs. Staff had not ensured that clients with physical health needs had a care plan in place to describe how staff would meet those needs; for example, for a client who had had epileptic seizures in the past.
- Not all staff had a clear understanding of the Mental Capacity Act and the implications of this on their practice.
- Best practice in treatment and care was not always implemented. Physical health checks were not routinely in place. Group work was only provided Monday to Friday.
- Appropriate recruitment and pre-employment checks had not been completed and staff had not received an induction. Staff had not received an annual appraisal of their work performance and did not receive regular supervision.

However:

- Staff supported clients encouraged them to live healthier lives. The clients were temporarily registered with a local GP who visited weekly.
- People with lived experience volunteered and some people with lived experience were employed by the service.
- We saw good examples of staff working well with outside agencies involved in individual client care and treatment.

Are services caring?

Good

We rated caring as good because:

Summary of this inspection

- Feedback from the clients who used the service was positive about the way staff treated them. Clients were positive and complimentary about the support and care they received from staff.
- Clients were involved and encouraged to be partners in their care and in making decisions. All clients on discharge completed feedback forms.
- Staff spent time with clients to help them understand their care, treatment and condition.
- Staff listened to and responded to clients positively treating each client with dignity, respect, compassion and in a caring manner.
- Staff acted upon issues raised by clients.
- Clients left us five comment cards. Clients said they felt well cared for, they got a lot from the groups and the staff team were very supportive.

However:

- The service did not routinely empower and support clients to access appropriate advocacy. There was no information displayed throughout the unit.
- Families and carers were not routinely consulted with and or involved in the clients' care and treatment.

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

- Pre-assessment information was insufficient in detail to allow staff to determine if the service could meet the needs of the client safely.
- Facilities did not promote privacy and dignity. Clients shared dormitories with no privacy and bedrooms were not secure.
- One client with additional and physical health needs did not have a care plan in place to manage their epilepsy to ensure they were safe. This client had to use a shower room next door in the detoxification unit due to their physical health needs not being fully assessed and care planned.
- Staff had not taken action to address suggestions made by clients on the feedback forms. This included access to a counsellor and the provision of day trips out.

However:

- Staff supported clients during referrals and transfers between services; for example, if they required treatment in an acute hospital or temporary transfer to an in-patient psychiatric ward or other service.

Summary of this inspection

- There was a choice of good quality food catered to individual dietary need on request.
- Staff demonstrated an understanding of the potential issues facing vulnerable client groups.
- Clients completed feedback forms on completion of their treatment and these were summarised monthly. Most of the comments were positive. Suggestions made by clients on the feedback forms had not been actioned.

Are services well-led?

Inadequate

We rated well led as inadequate because:

- Not all of the team leaders had the right skills and knowledge to run and manage the service to provide high-quality sustainable care. The nominated individual had been in that role for three months at the time of the inspection.
- The governance structure was in its infancy with a lack of input and oversight from the registered manager. For example, staff had no strategy in place. Systems to train, support and supervise staff were not embedded.
- Managers did not collect, analyse or use information in a way that enabled them to assure themselves of the quality or safety or care provided. Managers had not used the results of audits to improve practice nor did they make regular checks to ensure that improvements to care, treatment, risk and health and safety of individuals were embedded into practice.
- Records relating to clients were not always accurate or complete.
- Systems to ensure the safe management of medicines were not embedded and policies and procedures did not reflect practice.
- Clients' privacy and dignity was being compromised by the layout of the dormitory areas.
- Systems and checks in place were insufficient to ensure the environment was safe and suitable for purpose.

However:

- The nominated individual was employed in October 2018 and they had oversight of the service. They had completed an audit assessment and had an action plan in place for improvements.
- Staff felt valued and supported, and managers promoted a positive culture.
- Staff understood the arrangements for working with other teams, internally and externally to meet the needs of the clients.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported clients to make decisions on their care for themselves. Clients consented to care and treatment on admission. The service had a policy on the Mental Capacity Act, however the registered manager was unsure what they would do if a client did not have capacity.

Eight out of nine staff had completed training in their responsibilities in relation to the Mental Capacity Act 2005.

Overview of ratings

Our ratings for this location are:

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

Inadequate

Substance misuse services

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

Are substance misuse services safe?

Inadequate

Safe and clean environment

The premises were clean and appropriately furnished. There was an identified infection control lead within the team. Clients were expected to assist in cleaning the unit as part of their rehabilitation and they all had identified jobs throughout their stay. There was a cleaner employed and they provided cleaning for both the rehabilitation facility as well as the detoxification unit at the same location.

There was poor line sight throughout the building because it was an old, large property. Staff did not have access to alarms to summon assistance in an emergency and there were no mirrors positioned throughout the building to mitigate blind spots. The environment was not suitable for clients that presented as a high risk to themselves or others due to the layout of the bedrooms and the presence of potential ligature anchor points present, as well as the location of the staff sleeping in the room that was positioned within the female bedroom area.

These features were a particular concern because the service did not take adequate precautions to ensure that it did not admit clients who might be at risk of self-harm or suicide or have safeguards in place if they did. There was no ligature risk assessment available at the time of inspection. This was provided three days after the first day of the inspection. There was a suicide prevention policy and procedure and a ligature risk and management policy as well as access to two ligature cutters. The ligature and risk management policy stated staff needed to complete a ligature risk assessment where clients' risk assessment identified they presented with the risk of self-harm or suicide.

On the day of our visit, all clients were accommodated in shared bedrooms. Some of the rooms had en-suite facilities. The male and female areas were on the same floor; separated by a door. There were separate and segregated male and female shower facilities as well as separate toilet areas located in the male and female corridors. There were locks fitted on all the bathrooms, toilets and shower rooms. Males had to pass female bedrooms if they wanted to access the bathroom. The provider ensured a sign was used to identify when it was being used by a male. There was no female only day spaces due to the limited rooms available in the downstairs area.

There was an accessible bathroom with a toilet on the first floor which was within the male area and there was access to an accessible toilet on the ground floor. There was a lift available for clients with mobility needs however; there were steps throughout the female bedroom corridors. The provider told us that the mobility needs of clients was considered as part of the referral assessment and that clients with restricted mobility needs would be offered the option of being placed in an accessible bedroom serviced by the lift and therefore would not be required to navigate the stairs. If this was not acceptable to them or was assessed as being a risk, the provider would support them to find an alternative service.

Staff had undertaken an environmental health and safety audit as well as a fire risk assessment. The fire risk assessment confirmed that staff should be trained in the use of fire extinguishers, hose reels and basic fire protection. This had not been completed. There was no

planned date on the fire risk assessment for this training. There was a fire warden identified daily but only four out of eight staff had completed the mandatory training to enable them to act as a fire warden. This meant that there was often no fire warden on duty throughout the night and at weekends. A member of staff slept in the premises at night, and on reviewing the staff rota provided, there were many occasions where there was no identified fire warden on duty. The fire extinguishers had been tested and were in date. During our tour of the building, we identified a fire door on the male bedroom corridor that was not working.

Staff did not undertake regular checks to identify any maintenance issues. During our tour of the premises, we found window restrictors on the first floor were broken and missing from bedroom windows. These had been fitted to most of the windows throughout the building and the nominated individual agreed they should have been checked and replaced. Staff had completed portable appliance testing of equipment and these checks were up to date.

There was a shared clinic room and they had a grab bag available. A grab bag is an easily accessible bag that contains equipment and medication to treat someone in a medical emergency. Staff recorded daily checks of the grab bag. Staff knew how to use it and knew where it was located.

The service had a doctor's room that had access to an examination couch and equipment for physical health checks.

Safe staffing

The service did not have enough staff on duty throughout the night and at weekends. There were enough staff to meet the needs of clients during the day and they used agency staff to manage unforeseen staff shortages. There was a minimum of five staff on shift throughout the week working a five-shift pattern. However, there were only two staff on at the weekend and the rota showed a gap of half an hour between 12.30 and 13.00 hours where there was no one identified on the rota. This meant that there was one member of staff on duty at the weekend from 7am until 12.30 and one member of staff on duty from 13.00 until 23.30. This member of staff slept in at the premises from 23.30. This meant there were insufficient staff on duty during the night to continue observations of clients who were identified as at risk of suicidal ideation. An example of this was a client was on observations during the day and this was stopped overnight and recommenced in the morning when the risks to this client had not reduced.

The manager and deputy worked Monday to Friday. Many of the clients returned home at the weekend dependent on their progression within their rehabilitation which reduced the numbers of clients in the unit.

We checked five staff records. There were no documented records of any interviews that had taken place in any of the five records. Only one staff member had two references provided, the other four had no references from previous employment. Four of the five staff members' records had checks completed by the disclosure and barring service and one was working under supervision awaiting the check. There was no evidence to show that staff had received an induction in the personal staff files we reviewed.

There was one cook vacancy which they had advertised and made an appointment to.

Mandatory training

Staff had not all received their mandatory training to keep clients safe from avoidable harm. Mandatory training figures provided at the time of inspection showed gaps in staff having completed their training. Where figures showed as 'in progress', this meant they had started their training but had not completed it.

- Data protection: one out of nine staff had completed with eight in progress.
- Fire warden: four out of nine staff had completed with five in progress.
- Health and safety: one out of nine staff had completed with eight in progress.
- Managing conflict: two out of nine had completed with seven in progress.
- Manual handling of objects: two out of nine staff had completed with seven showing in progress.
- Equality and diversity: all nine staff were in progress.
- Epilepsy awareness: all nine in progress.
- First aid: one out of nine had completed with eight in progress.

Assessing and managing risk to clients and staff

We reviewed eight care records and found that clients were not fully assessed prior to being admitted to the service.

Inadequate

Substance misuse services

The pre-admission assessment did not contain sufficient information to allow an informed decision as to whether the provider could meet the needs of the clients and to manage any identified risks. Clients had not always received a pre-admission assessment.

A client who was at risk of self-harm had no risk management plans in place. Risk assessments had not been produced and/or updated following clients stating they had suicidal ideation. There was insufficient detail in the care records we reviewed to allow staff to provide appropriate care and treatment to keep clients safe. Clients that reported suicidal ideation had been placed on hourly observations. However, records we reviewed confirmed that hourly observations stopped when staff retired to bed and recommenced at the start of the shift in the morning. The risks to the clients had not reduced and the decision to stop observations was not based on clinical risk.

The service responded to the warning signs and sudden deterioration of clients by contacting emergency services as well as liaising with mental health services. However, staff might not be aware of clients' physical and mental health risks because care plans had not been produced to manage individual risks. This was the case for a client with a history of seizures and one client with epilepsy. Clients were referred to the unit from various sources. The information transferred from the referrer did not always reflect the past medical history of clients being admitted into the unit.

Clients were made aware of the risks of continued substance misuse and harm minimisation during their daily meetings and at their 1-1 meetings with staff. There were no documented recovery plans in place. The manager informed us that the client's GP would be contacted and informed of their discharge.

The service minimised the use of blanket restrictions. Clients were informed before admission of banned items. Clients had limited access to their mobile phones between 6pm and 10pm. Clients signed an agreement to agree to this and were made aware of this before their admission.

SALUS was a smoke free and vaporiser free building. There was a smoking shelter for clients who wished to continue smoking outside of the building. Clients were not offered nicotine replacement therapy.

Safeguarding

Staff knew how to protect clients from abuse and the service worked well with other agencies to do so. Staff had received training on how to recognise and report abuse and they knew how to apply it. The service had a safeguarding lead and this was a recovery coordinator. The safeguarding lead had not received any additional training in this area. We saw that referrals had been made to the local authority in Lancashire and within the client's local authority where required. Staff knew how to identify adults and children at risk of, or suffering, significant harm. This included working in partnership with other agencies and staff were aware of where and how to refer onto as necessary.

However, safeguarding information was not visibly displayed for clients to refer to if needed.

Clients were asked to complete an, 'everyday health and well-being form' each evening. Clients posted these into a box and staff reviewed their comments before every morning meeting. This allowed clients to report any information they had of concern; be it individual to them or worries about other clients within the unit. However, the information was not reviewed until the morning which meant clients did not always have the opportunity to discuss their concerns at that time when something may have been important.

The service had an Equality and Human Rights Act policy in place and staff were required to complete mandatory training in this area. However, the training records showed none of the staff had completed this. Clients attended a 'moving on' group work session within the first four weeks of being admitted to the service and this included a session addressing gender issues.

We saw one good example of staff working effectively with outside agencies. This included contact being made with one individual's local mental health and crisis teams to arrange a more appropriate placement to meet their mental health needs. Client information was shared with detailed information providing a timeline of incidents to seek the most appropriate intervention at that time. Detailed recordings were made in client notes for this individual, where contact had been made with outside agencies.

Staff access to essential information

Staff kept paper records of clients' care and treatment. These were stored in a locked cupboard within the staff

office. Records within the notes were clear and easily available to all staff providing care. However, the records were not fully completed or up to date with essential information from the pre- admission assessment. Some information was missing and potential risks were not always explored fully. Care plans were incomplete. They contained identified goals but not the actions needed to enable clients to meet their goals and needs. Staff completed a handover twice daily to update all staff on duty about any issues in relation to clients' care and treatment and this was recorded in a handover book.

Medicines management

We looked at the systems in place at the service for medicines management. We checked four sets of prescription charts and spoke with care staff who were responsible for medications.

We looked at how controlled drugs were managed and found that one client's controlled drug patch was not destroyed in accordance with the Misuse of Drugs legislation. We found that the service was not always using their own employed members of staff but the adjoining service staff to witness when a controlled drug was administered to a client, which was not in accordance with their own policy.

We found medications were not always administered in a safe manner. The service dispensed medication into an envelope when clients left the unit for home leave, which is not in accordance with the Medicines Regulations. Paracetamol had been administered to one client without a four-hour interval and a second client had been given nine doses in a 24-hour period, which is over the recommended daily dose, increasing the risk of harm. Medicine administration record charts were not always transcribed correctly by staff and there was no record of who had written them. Medicine administration record charts had missing signatures, which meant it was not possible for staff to know if a client had had their prescribed medications. Homely remedies, medicines that can be purchased and administered to clients without a prescription were given to clients for longer than the 24-48-hour period stated in the policy, prior to staff seeking medical advice.

Track record on safety

The service had a critical and serious incident policy in place. Incidents were reported using an IR1 form and these were reviewed by senior managers and reported to the governance team to ensure appropriate action had been taken and to review any learning from the incidents reported.

In the 12 months before we inspected the service reported no serious incidents. Two such incidents occurred during the period of the inspection and these were reported to CQC. One was where a client was having repeated seizures and another where a client had attempted to ligature after he had been transferred to the neighbouring detoxification unit – which was a separate registered entity. Staff from the rehabilitation unit continued to provide care to the client who had been transferred to the detox unit. This blurred the boundaries as to the responsibility for care between the two units.

Reporting incidents and learning from when things go wrong

Staff were not always aware of what incidents to report. They reported incidents to the manager and deputy manager. The service had recently implemented a new incident reporting system which fed into the clinical governance framework where incidents were reported and discussed at monthly meetings. However, the registered manager when questioned was unaware of these changes.

The service's nominated individual managed client safety incidents and monitored and reviewed them when they had been reported by staff. Senior managers investigated incidents with the registered manager and shared lessons learned with the whole team. When things went wrong, staff apologised and gave clients honest information and suitable support.

Staff understood the duty of candour and there was a policy and procedure for staff to follow. Staff were open and transparent, and gave clients using the service and families a full explanation when something went wrong.

Staff met to discuss feedback in relation to incidents in team meetings handovers and within supervision.

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

Requires improvement

Assessment of needs and planning of care

Inadequate

Substance misuse services

We reviewed eight care and treatment records. In five of these records, there was no assessment of the client's needs, including their holistic, physical and mental health needs. This meant that recovery and care plans could not meet each client's individual needs. Care plans were statements and goals but contained no information for staff on how to support clients in achieving these. One example was where a care plan stated, 'management of anger' there was no detail written to explain how this was going to be addressed and/or achieved and managed by the staff team.

The daily notes that we reviewed contained detailed information around the client's recovery and journey. The recovery and care plans did not identify who the person's key worker/care co-ordinator was.

Staff did not review needs and recovery plans, including risk management plans, regularly or update them when necessary. Staff did not always develop a risk management plan for those clients identified as being at risk. Plans for unexpected exit from treatment were not present.

One client file that we reviewed contained conflicting information around dates of self-harm and suicide attempts. Further information had not been gathered pre-admission to establish clients' recent medical histories and/or physical health needs. We also found another client had been initially assessed as having a history of suicidal attempts. No other information had been gathered to establish further detail and/or risk information to enable staff to assess their suitability for admission as per their admission criteria. Staff had failed to carry out physical health checks

Best practice in treatment and care

Staff encouraged clients to live healthier lives. They encouraged clients through offering support, advice and information about behaviours, exercise, weight loss and dealing with issues relating to substance misuse.

As mentioned above, we concluded that staff had insufficient information about clients' healthcare needs. The clients were temporarily registered with a local GP and the GP visited the service weekly to review clients where needed. The service did not test for blood borne viruses routinely but this testing could be done by the GP. Clients were not routinely provided with Naloxone kits on discharge. Naloxone is an emergency medicine that can be used if a client overdoses on opiates.

The service provided psychosocial interventions through group work. There were two different sessions; one for clients that were in the service for up to four weeks (moving in process group work am and pm) and then a six-week rolling programme (moving through). Clients were encouraged and expected to maintain their daily living skills and each had a cleaning role allocated every morning and life skills was a session provided in the group work.

Staff participated in and completed local clinical audits. However, staff had not always acted on the results when improvements needed were identified. An audit of care records identified gaps in the records but did not specify the actions needed and there was no timescale for improvements to be made.

Monitoring and comparing treatment outcomes

Staff completed Treatment Outcome Profile forms with clients. This was a form that collects information about clients' drug or alcohol use and lifestyle and measures the progress a client makes in treatment. Staff also sent information to the National Drug Treatment Monitoring Service which collects information on substance use nationally.

Skilled staff to deliver care

There were six members of care staff who were all recovery workers.

The organisation had a new management structure and the appointment of a new nominated individual was made in October 2018.

Staff had not received regular supervision from appropriate professionals. The governance structure identified that management supervision should be monthly, clinical supervision monthly and a staff meeting monthly. A supervision and appraisal record calendar had been produced for 2019 with supervision taking place bi-monthly. Staff had not received an appraisal. Plans were in place to structure the appraisals so that they were all completed by the end of March 2019. There were regular staff meetings.

The service did not provide all new staff with a comprehensive induction. The service had an induction check list that should be completed when new staff started in their role. However, the five staff records we reviewed showed that the checklist had not been completed.

Inadequate

Substance misuse services

The service did not ensure that all staff had completed mandatory training. The manager was unable to confirm what mandatory training staff should receive. A staff mandatory training log and individual log was provided by the nominated individual which identified many gaps in the mandatory training. The manager and deputy manager had not completed their mandatory General Data Protection Regulation training.

Managers had identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. All staff had been enrolled on a health and social care National Vocational Qualification and other staff had previous qualifications in substance misuse and lived experience. The two managers were working toward a diploma in management of residential care.

The managers did not ensure that robust recruitment processes were followed. Only one out of five staff file we checked had references sought. There were no records of interviews undertaken and job descriptions were not available and/or signed. One of the five records identified one individual who was awaiting a current Disclosure and Barring Service check and was required to work under supervision.

Managers recruited volunteers when required and supported them for the roles they undertook.

Multi-disciplinary and inter-agency team work

There was a handover meeting at every shift change that included information about each client. Staff from different disciplines worked together as a team to benefit clients.

Staff liaised with GPs and referrers but the information sought prior to admission was not always comprehensive and the referral forms completed were basic in the information sought prior to admission. A local GP visited the service weekly and reviewed clients and there was a service level agreement in place.

We saw one detailed history of a client that included historical information taken from their stay at another provider. This informed the multidisciplinary team of the risks associated to the management of their care and treatment. Staff liaised with social workers, the hospital, community teams, housing and GPs to provide support for the client. The service discharged clients when additional specialist care was needed and worked with relevant supporting services to ensure the timely transfer of information.

Staff planned discharges with clients and supported clients to access ongoing support by working with housing services and community drug services. Staff notified the clients GPs when a client was discharged but did not send a proper summary of the care provided. Staff also directed and helped clients with debt and welfare issues.

Good practice in applying the MCA

Staff supported clients to make decisions on their care for themselves. Clients consented to care and treatment on admission. The service had a policy on the Mental Capacity Act however the registered manager was unsure what they would do if a client did not have capacity.

Eight out of nine staff had completed training in their responsibilities in relation to the Mental Capacity Act 2005.

Are substance misuse services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

Observations and reports by clients that used the service confirmed that staff treated clients with compassion and kindness. They respected clients' privacy and dignity, and supported their individual needs**.** They supported clients to understand and manage their care, treatment or condition and staff made time to sit down with individuals and listen to their concerns and provided responsive, practical and emotional support as appropriate.

Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes without fear of consequences.

Staff directed clients to other services when appropriate and, if required, supported them to access those services.

The service had clear confidentiality policies in place that were understood and adhered to by staff. Staff maintained the confidentiality of information about clients. The service had a record that confidentiality policies had been explained and understood by clients who used the service.

Inadequate

Substance misuse services

There was a consent to share information form in place. This was signed by the client to allow all professionals involved in the care and treatment to be informed and non-identifiable information to be submitted to the National Drug Treatment Monitoring System. Clients were also asked to name other people, families and friends including telephone numbers if they wanted them to be contacted about their recovery journey.

Clients left us five comment cards. Most comments were positive. Clients said they felt well cared for, they got a lot from the groups and the staff team were very supportive.

Involvement in care

Staff involved clients and those close to them in decisions about their care, treatment and changes to the service. Staff communicated with clients so that they understood their care and treatment. This was done on a 1-1 basis and during admission.

The service did not routinely empower and support clients to access appropriate advocacy. There was no information displayed throughout the unit and the registered manager was unsure of any local advocacy services.

Each client using the service did not have a comprehensive recovery plan and risk management plan and care plans in place to demonstrates the person's preferences, recovery capital and goals. The service did not pay sufficient attention to the needs of these individuals.

Staff engaged with clients using the service, their families and carers to develop responses that met their needs and ensured they had information needed to make informed decisions about their care.

Staff actively engaged clients using the service (and their families/carers if appropriate). They provided a service user guide and information leaflets to clients and clients could access information about SALUS on their website on-line.

Involvement of families and carers

Families and carers were involved in decisions about clients' care where clients consented to this.

Staff confirmed they would direct carers to the local authorities should carers need to access information about how to access a carer's assessment.

Are substance misuse services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Access and discharge

There was a clearly documented admission criterion into the service and this was documented in the client information pack as well as the statement of purpose.

Staff obtained pre-assessment information from private clients by telephone interview. We found that some of these initial assessment interviews had not gathered pertinent information or discussed explored important issues fully with the client. Clinical information was sought from the client's GP with consent. They also asked referrers to complete a referral form to minimise the length of time clients waited for care, treatment and or advice. The referral form was a one-page form that only provided the bare minimum of information gathered.

There had been 102 client discharges between April 2018 to October 2018.

There was a discharge policy in place which provided a discharge summary checklist for staff to confirm appropriate services had been informed. This summary did not guide staff to inform the client's GP about their discharge from the service. However, the manager confirmed that on discharge the GP would be notified and an appointment made. However, staff did not send GPs full information about the care provided.

Discharge and transfers of care

Staff supported clients during referrals and transfers between services. For example, if they required treatment in an acute hospital or temporary transfer to an in-patient psychiatric ward and or other service. They also assisted clients to access social, housing and or community mental health and community substance misuse teams on discharge and directed them to appropriate local support services.

The facilities promote recovery, comfort, dignity and confidentiality

Inadequate

Substance misuse services

All clients shared dormitory style sleeping areas; apart from one bedroom that only had two beds in it within the male corridor. The dormitories were separated into a male and female corridor. The design and layout of the bedrooms did not support clients' privacy and dignity. There were designated male and female showers however, if a male wanted to access the bath, this was in the female area. There was signage available to place on the door to let others know if it was being used by a male or female and there was a lock on the door.

Clients could not secure their bedroom areas and although there were storage lockers for clients to be able to store their finances and valuables, these were not used due to keys not being available. The staff bedroom was located on the female bedroom area and this room was unlocked.

There were few rooms that could be used by staff to meet clients. Group work took place in the dining room or a large lounge. Two porta cabins could be used as additional space to see clients in if these were needed.

There were minimal quiet areas for privacy but there was an extensive large garden area which clients could access and where clients could be independent of staff. There was a gym available to clients. Once a client had been assessed to be safe to use the equipment, they were free to use the gym outside of the group work timetable.

There was a dining area that doubled up as a group work room. This provided access to hot drinks and snacks available outside of group times. However, seating arrangements and the size of the dining room would not allow all the clients to sit and eat their meals together if the numbers increased as staff also accompanied clients at lunchtime.

There was a large lounge area available which also doubled up as a group work room.

There was a choice of good quality food including access to special dietary requirements for example kosher or halal meat, vegan, diabetic and liquid diets if these were needed.

There was a data information leaflet to inform clients about why their information was collected, how it was stored and provided information to clients if they wanted to access their records.

Clients' engagement with the wider community

Staff supported clients with activities outside of the service, such as visits to the local town, assisting clients to access local housing services and supporting clients to go for weekend home visits where necessary. Staff supported clients to maintain contact with their families and carers. Staff encouraged clients to develop and maintain relationships with people that mattered to them, both within the services and the wider community. When appropriate, staff ensured that clients had access to education and work opportunities.

Meeting the needs of all people who use the service

The service was not fully able to meet the needs of one client who was using the service. The client was using the shower facilities within an adjoining registered service because their physical health needs had not been fully assessed before admission.

Staff helped clients with communication and cultural support. However, advocacy was not promoted as there was no information to inform clients of this.

Each client had a named keyworker and received regular 1-1 time with the staff and we saw staff made time to speak to clients individually when needed.

Staff demonstrated an understanding of the potential issues facing vulnerable groups e.g. lesbian, gay, bisexual and transgender, Black and minority ethnic, older people, people experiencing domestic abuse and sex workers and offered appropriate support.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

There were 70 compliments and 10 complaints in the last 12 months with one complaint being upheld.

Clients completed feedback forms on completion of their treatment and these were summarised monthly. Most of the comments were positive and suggestions were also captured although these had not been actioned. One suggestion was to have 1-1 counselling and to have the service fund them to return home and to have day trips introduced.

Inadequate

Substance misuse services

Are substance misuse services well-led?

Inadequate

Leadership

The team leaders did not have the right skills and knowledge to fully run and manage the service to provide high-quality sustainable care. At the time of the inspection, they had been enrolled on a management course for residential care to support them in the management and development of the service. The organisation had employed a nominated individual in October 2018 who provided support, guidance and leadership to the team.

They had introduced monthly managers meetings and a governance structure which albeit was in its infancy, was now in place.

The organisation understood recovery however, there was no shared visions, mission statements and/or values. The nominated individual had a good understanding of the service they managed. Leaders were visible in the service and approachable for clients and staff.

Vision and strategy

The service did have a vision for what it wanted to achieve. A whole service audit had been completed in September 2018 by the nominated individual prior to their appointment. This was to ensure that the processes and quality systems at Salus meet the requirements of applicable regulations. Following this audit, an action plan had been developed with work streams and actions identified and assigned to specific staff members with deadlines set.

Within the staff files we looked at there were no job descriptions. The audits completed in September 2018 had identified the recruitment procedures and practices as an immediate action to be implemented.

The nominated individual was able to contribute to discussions about the strategy for their service where the service was changing.

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Staff felt respected, supported and valued and the staff group were positive about their work.

Staff appraisals had not taken place and plans to implement these were in place by the end of March 2019.

The team worked well together and where there were difficulties the managers dealt with them appropriately.

Governance

The governance system was not effective nor embedded to ensure a systematic approach to continually improve the quality of the service and ensure high standards of care were in place.

There were ineffective governance systems and procedures to ensure that the service was safe, that there were enough staff, that staff were trained and supervised and that client needs and risks were assessed and managed.

Clients' privacy and dignity was being compromised within the layout of the bedroom areas. They did not provide any privacy as clients had shared rooms without any privacy screens or curtains.

There was insufficient monitoring and observations of clients when they needed it due to one staff member being on duty throughout the night and at weekends. The member of staff slept during the night.

Records relating to clients were not complete.

Systems to ensure the safe management of medicines were not embedded.

Staff had not received regular supervision and had not had an appraisal.

There were insufficient numbers of suitably qualified, competent, skilled and experienced staff on duty at all times. Information was not collated to capture information about equality and inclusion. Staff employment checks were not robust.

Systems and checks in place were insufficient to ensure the environment was safe and suitable for purpose.

The clinical governance framework identified the clinical audits that staff should complete. Staff undertook or participated in local clinical audits. However, the audits were not acted upon and were insufficient to provide assurance.

Data and notifications were submitted to external bodies and internal departments as required.

Staff understood the arrangements for working with other teams, internally and externally to meet the needs of the clients. For example, safeguarding, emergency services and external mental health teams and community substance misuse teams and GPs.

The service had a whistle blowing policy in place.

The service had recently implemented a new governance system but the benefits of this were not apparent at the time of the inspection.

Management of risk, issues and performance

The service did not have effective systems for identifying and the management of risks.

There was no clear quality assurance management and performance frameworks in place that were integrated across all organisational policies and procedures.

There was a risk register maintained with six risks identified in September 2018. Staff could submit items onto the risk register through the clinical governance meetings. Concerns we found during the inspection did not match those on the risk register. The internal audit did not feed into the risk register.

The service had plans for emergencies – for example, adverse weather or a flu outbreak.

Information management

The service collected data but it was not clear how the information was used to support all its activities. There was a data protection policy in place but this was generic as reported in the service audit. This meant that the policy did not cover what actions should take place to limit the risk of data loss.

Staff had access to the equipment and information technology needed to do their work. Policies and procedures had all been printed out and were available to staff. Client files were paper-based and staff had access to these within the locked office base.

Managers now had access to information to support them with their management role. This included information on the current performance of the service, staffing, client care and staff training.

Staff made notifications to external bodies as needed.

Engagement

Staff, clients and carers had access to up-to-date information about the work and the services they used – for example, through the intranet and so on. Clients had opportunities to give feedback on the service they received in a manner that reflected the needs of the service.

Clients and staff could meet with members of the provider's senior leadership team to give feedback if needed. However, there were no formal processes in place.

Leaders and managers engaged with external stakeholders – such as commissioners and funding authorities.

Learning, continuous improvement and innovation

The service did not participate in any internal or external quality improvement programmes.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all clients have a comprehensive assessment of their risks and needs and risk management plans are in place.
- The provider must complete physical health checks of clients when clients may be still going through withdrawal from alcohol or opiates.
- The provider must ensure fit and proper recruitment policies and procedures are applied to the recruitment and employment of staff before they work with clients.
- The provider must ensure that all staff who deliver the regulated activity are working within the scope of their qualifications, competence, skills and experience and that care and treatment is delivered in a safe way.
- The provider must ensure the premises are safe and fit for purpose.
- The provider must ensure systems audits and policies are implemented to ensure the safe management of medicines and that staff have received appropriate training to implement this.
- The provider must ensure there are sufficient and appropriately qualified staff on duty throughout the day, night and at weekends.
- The provider must ensure that care plans reflect clients' needs and that these support staff to manage clients 'risks and needs.
- The provider must ensure privacy and dignity needs of all individuals are taken into consideration and appropriate measures are taken to ensure all clients are afforded privacy and dignity.
- The provider must ensure all staff receive regular supervision and an annual appraisal that includes objectives focused on improvement and learning.
- The provider must ensure that staff have completed their mandatory training identified to support staff to carry out their role safely and effectively.
- The provider must ensure that all staff have a clear understanding and the implications for their practice in relation to the Mental Capacity Act 2005.
- The provider must ensure staff receive an induction.
- The provider must ensure the governance system are fully established and operated effectively.

Action the provider SHOULD take to improve

- The provider should ensure all staff are fully aware of how to report incidents and the process is fully embedded to learn from incidents to improve practice.
- The provider should ensure systems are in place to check the competence of staff when administering medication.
- The provider should consider providing routine physical health checks.
- The provider should ensure clients have access to advocacy services and information is displayed throughout the organisation.
- The provider should consider informing clients of the difficulties navigating the bedroom corridors to ensure their needs can be met.
- The provider should ensure staff have access to an alarm system to summon assistance throughout the premises.

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
	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Recruitment procedures were not effective. The provider had not ensured adequate checks were in place to assure themselves that all staff were of good character and safe to work with clients before they started work in the service. Only one out of five staff records identified they had sought references prior to appointment and there were no interview records in staff files. This was a breach of regulation 19(1)(2)(3)(a)

Regulated activity	Regulation
	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Beds in shared dormitories did not provide privacy for the clients. This was a breach of regulation 10 (2) (a)

Regulated activity	Regulation
	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the Regulation was not being met: Staff had not completed their mandatory training. There were no supervision records or appraisals and records of induction training. There was an insufficient number of fire wardens trained and not all staff who sleep in alone in the premises at night had been trained.

This section is primarily information for the provider

Requirement notices

There were insufficient staff numbers on duty at weekends and on nights.

This was a breach of Regulation 18 (1) (2) (a)

Regulated activity	Regulation
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the Regulation was not being met: Staff did not always assess the risks to the health and safety of clients receiving care and treatment. Pre-admission assessment and assessment on admission were limited and did not identify risks when admitting clients to ascertain if their needs could be met. Care plans were missing and information was limited and not sufficient to enable staff to provide safe care and treatment. Where a client had a high risk of suicide, the risk management plan was not fully implemented in an appropriate way. Observations of a client stopped in the night. The admission assessment had noted the risks with differing dates of incidents and attempts but there was no evidence of how these risks would be adequately managed and addressed. Clients physical and mental health needs were not fully assessed to ensure their needs could be met. Care plans and risk management plans were not fully produced to ensure their risk of seizures and the physical mobility needs of individuals could be managed. The provider did not have effective policies, procedures and training related to medication and medicines management including prescribing and dispensing recording. Staff did not follow good practice and/or policies in medicines management. Medication given to clients on home leave/discharge from the service did not always meet the Medicines Regulations 1994.

This section is primarily information for the provider

Requirement notices

Staff did not always accurately record the administration of medicines and did not always use their own employed staff to witness controlled drugs being given and discarded wrongly.

Homely medication was given for longer than 24 hrs to 48 hrs without seeking medical advice as their policy stated.

Information shared on discharge was not always complete.

This was a breach of Regulation 12 (1) (2) (a) (b) (g) and (I)

Regulated activity	Regulation
	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

How the Regulation was not being met:

Clients did not receive care and treatment to meet their needs. Assessments of their needs were not always completed. Care plans were incomplete and did not address physical health needs and how these would be managed. Records identified goals with no detailed actions on how to achieve the goals. One client accessed shower facilities within another registered service as their physical health needs had not been fully assessed before admission. There were no epilepsy and or seizure care plans.

Staff were unaware of the Mental Capacity Act and what they would do if they had a client that lacked capacity.

This was a breach of Regulation 9 (1)(2)(3) (a-d)

Regulated activity	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance

How the Regulation was not being met:

This section is primarily information for the provider

Requirement notices

Systems and processes were not established to operate effectively and the governance structures were not fully imbedded.

Systems and audits to ensure the safe management of medicines were not embedded.

The provider had not ensured that they always acted on the results of audits when improvements needed were identified.

Systems to assess, monitor and mitigate risks to clients' health, safety and welfare were not embedded.

Records relating to clients were not always accurate and complete.

Systems to support supervise and train staff were not embedded.

Environmental risk assessments did not identify issues found on inspection re window restrictors missing and a fire door not working.

Policies and procedures were in place however these were not embedded. Practice did not reflect these policies and procedures eg. medicines, fire policies, suicide policies, recruitment, Mental Capacity Act and incident reporting.

This was a breach of Regulation 17 (1) (2) (a) (b) and (e)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment How the regulation was not being met: People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance and checks in place. **This was a breach of Regulation 15 (1) (c) (e)** We have issued a warning notice in relation to this regulation.