Paradise Lodge Care Home Limited

Nest Healthcare

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Good**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Our rating of this location stayed the same. We rated it as inadequate because:

•The service did not provide safe care. The service did not have a full ligature risk assessment in place.
•The mandatory training programme was not comprehensive and did not meet the needs of clients and staff.
•The service did not assess and manage risk well. Staff did not complete thorough risk assessments for each client on admission. Risk assessments were not regularly updated. Staff did not assess risks including the risk of early exit from treatment and did not complete risk management plans.
•The service did not use information from other agencies to support client's treatment. Information from GP's and others was not used as part of the decision-making process to admit service users or to manage any ongoing risks.
•Audit processes were not in place to ensure that observations were being carried out in line with the providers policy. Staff did not take part in regular audits, benchmarking, and quality improvement initiatives to evaluate the effectiveness of the service they provided.
•Staff did not follow systems and processes to prescribe and administer medicines safely. Staff did not review each client's medicines regularly or provide advice to clients about their medicines. Staff did not complete medicines records accurately. Staff did not store and manage all medicines and prescribing documents safely. National practice was not followed to check clients had the correct medicines when they were admitted. Staff did not recognise and report medicines incidents and there was no learning taking place to improve practice.
•The blood pressure machine and alcometer (used to measure level of alcohol in breath) had not been calibrated.
•Incidents had not been reviewed or thoroughly investigated by competent staff. Incidents and learning from incidents were not discussed at multidisciplinary team meetings or clinical governance meetings.
•Staff did not develop a comprehensive recovery plan for each client that met their substance misuse, mental health, and physical health needs.
•Staff did not use recognised rating scales to assess and record the severity of clients' conditions and care and treatment outcomes.
•The service did not have a clear admission and exclusion criteria. Pre-admission assessments lacked specific detail. Information was missing prior to admission that would have supported risk assessment and recovery planning.
•Leaders failed to implement safe systems and processes to provide safe and good quality care to clients accessing the service.
•The governance system was not structured. Individual elements, such as audits, training and learning from incidents were not collated into overarching systems so that performance, themes, and trends could be monitored and proactively addressed.

However:

•□The service was clean, well-furnished, and fit for purpose.
•□The service had enough staff to provide care for clients.
•□Staff treated patients with compassion and kindness. They respected patients' privacy and dignity.

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

•□The service must ensure staff develop a comprehensive recovery plan for each client that meets their substance misuse, mental health, and physical health needs. (Reg 9)
•□The service must ensure thorough risk assessments are completed for each client on admission, are updated regularly and include the risk of early exit from treatment and risk management plans. (Reg 12)
•□The service must ensure information from the clients GP is used as part of the decision-making process to admit clients. (Reg 12)
•□The service must ensure staff follow systems and processes to prescribe and administer medicines safely. (Reg 12)
•□The provider must ensure that equipment is appropriately maintained and calibrated. (Reg 12)
•□The service must ensure staff review each client's medicines regularly. (Reg 12)
•□The service must ensure staff store and manage all medicines and prescribing documents safely. (Reg 12)
•□The service must ensure staff report medicines incidents. (Reg 12)
•□The service must ensure incidents are reviewed, investigated and learning is identified. (Reg 12)
•□The service must ensure that recognised rating scales are used to assess and record the severity of clients' conditions and care and treatment outcomes. (Reg 12)
•□The service must ensure that comprehensive pre-admission assessments are completed. (Reg 12)
•□The service must have naloxone in stock to reverse the effects of an opiate overdose. (Reg 12)
•□The service must ensure that they have clear admissions criteria in place. (Reg 17)
•□The service must ensure that governance systems and process including audits are in place. (Reg 17)
•□The service must ensure it has a comprehensive ligature risk assessment and ligature risk management plan in place. (Reg 17)
•□The service must ensure its mandatory training programme is comprehensive and meets needs of clients and staff. (Reg 18)

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? .	**Inadequate**
Is the service effective? .	**Inadequate**
Is the service caring? .	**Good**
Is the service responsive? .	**Inadequate**
Is the service well-led? .	**Inadequate**

Nest Healthcare

Detailed findings

Background to this inspection

Nest Healthcare is a residential service located in Clacton-on-Sea, Essex that provides rehabilitation for mental health and substance misuse. The service has five beds. At the time of the inspection there were 4 service users staying at the service.
The service has been registered with the Care Quality Commission since January 2017.

The service is registered to provider the following regulated activities:
•□Accommodation for persons who require nursing or personal care.
•□Accommodation for persons who require treatment for substance misuse.
•□Treatment of disease, disorder, or injury

The service has a registered manager and nominated Individual.

This was our second inspection of the service. We conducted this inspection to follow up our previous concerns found during the first inspection of Nest Healthcare, conducted between 28 July - 6 September 2022.

During our previous inspection of Nest Healthcare, we issued the provider with requirement notices against Regulation 12 Safe care and treatment and Regulation 17 Good governance. We asked the provider to act, to make improvements and keep service users safe from harm. The service was rated Inadequate.

During this follow up inspection, we checked to see if the provider had made the required improvements. Following inspection we issued a Letter of Intent to the provider, as they had not made the improvements required to keep service users safe from harm. The provider was asked to respond to the issues raised and provide an action plan indicating that appropriate action has and will be taken to mitigate risk. Following inspection, the provider voluntarily decided to temporarily cease admissions whilst they improved the quality of staff training and their governance processes.

Following submission of the providers action plan, the initial action plan and documents submitted were reviewed but did not provide us with assurances that appropriate action had been taken to reduce the risk of harm to people using the service. Further information was requested and submitted but this still did not

provide the assurance needed. Following review of the action plan and documents, we were not assured that safety was addressed and so issued further urgent enforcement action to impose conditions on registration.

The overall rating for this service is 'Inadequate' and the service is therefore placed in 'special measures'. Full information about CQC's regulatory response to the serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

What people who use the service say
We spoke with two people who were using the service. Overall, the feedback we received from people staying at the service was positive. Clients said the service was comfortable and clean and they felt safe. Clients felt that staff treated them with kindness and respect, and they could ask for help when they needed it.

The team that inspected the service included two CQC inspectors, one CQC medicines inspector, and one specialist advisor with experience of working in substance misuse.

Before the inspection visit, we reviewed information that we held about the location. During the inspection visit, the inspection team:
• visited the service and looked at the quality of the environment.
• spoke with two clients who were using the service.
• spoke with three staff members: including the manager and support workers.
• reviewed six care and treatment records of patients; and
• carried out a specific check of the medication management.

You can find information about how we carry out our inspections on our website:
https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Inadequate

Is the service safe?

Our findings

Our rating of safe stayed the same. We rated it as inadequate.

Safe and clean care environments
All areas where clients received care were clean, well equipped, well-furnished, and well maintained. However, areas were not always safe.

Safety of the facility layout
Staff completed and regularly updated risk assessments of all areas and removed or reduced any risks they identified. The manager completed an annual environmental risk assessment.
The service did not have a full ligature risk assessment in place. The ligature risk assessment consisted of photographs of ligature points across the building but did not include a risk management plan for the premises to reduce the number of potential ligature anchor points or monitor those that remained. Staff had access to ligature cutters.
The service managed risk and client safety where there was mixed sex accommodation. The service had separate bathroom facilities and clients could lock their bedroom doors.

Maintenance, cleanliness, and infection control
All areas were clean, well maintained, well-furnished and fit for purpose. Furniture appeared new and in good order.
Staff made sure cleaning records were up-to-date and the premises were clean. Support workers completed daily cleaning tasks, cleaning records were up to date and all areas were visibly clean.
Staff followed infection control policy, including handwashing. All staff had completed mandatory training on infection control.

Clinic room and equipment
The service did not have access to a clinic room with space to examine clients. Staff used one of the therapy rooms to undertake client's basic physical health observations. The manager told us that a cabin in the garden was being made into a clinic room. At the time of inspection, they were waiting for Wi-Fi and lockable cupboards to make the room useable as a clinic room.
The service did not have an EpiPen or naloxone available. Naloxone temporarily reverses the effects of an opiate overdose. In the event of a medical emergency staff would call for an ambulance. No staff had completed basic life support training at the time of inspection.
The service stored prescribed medicines in a locked cabinet in the manager's office. The temperature was monitored to ensure medicines were stored at the correct temperature. There was a fridge available to store any medicines that needed refrigeration.
Staff had not fully checked or maintained equipment. The alcometer (used to measure level of alcohol in breath) and blood pressure machines had not been calibrated. The manager told us they had been purchased recently and if they were broken, they would be replaced. Urine testing strips were stored out of their packaging within the same bag.

Safe staffing
The service had enough staff. However, staff had not received adequate training to keep people safe from avoidable harm.
Nursing staff
The service did not employ any qualified nursing staff as the provider felt the client group did not require nursing care.
The service had enough support staff in post both during the day and overnight.
The service had regular bank staff who covered shifts when required and were familiar with the service. The manager told us they rarely used agency staff.
The manager used a needs assessment tool to calculate the number of support workers for each shift.
The service had low turnover rates with most staff having been in post since the service opened.

Medical staff
The service contracted a consultant psychiatrist who completed the pre-admission assessment with the manager and prescribed any medication required. This was conducted remotely but the consultant could visit the service to review clients if needed and was available by telephone and video conference when required. The manager completed an assessment alongside the consultant and did not receive a copy of the consultant's assessment.
There was no alternative cover if the consultant psychiatrist was unavailable. If the consultant psychiatrist had annual leave arranged, the service would not admit any clients during that period. It was unclear how episodes of unplanned leave or sickness would be managed. There was no locum cover arrangement in place.
In the event of a medical emergency staff said they would utilise accident and emergency provision at the local NHS hospital.

Mandatory training
Staff had completed some training. This included basic first aid. The service had 25 training courses for staff to complete, which overall, 98% of staff had completed.

The mandatory training programme was not comprehensive and did not meet the needs of clients and staff. Staff had not received any substance misuse specific training, or basic life support training. Staff had completed medicines management training. However, staff who support people's medicines management should have an annual review of their knowledge, skills and competencies relating to managing and administering medicines. This had not been completed by a competent staff member within the last year.

Assessing and managing risk to clients and staff
Staff did not safely assess and manage risks to clients well, potentially exposing clients to avoidable harm.

Assessment of client risk
Staff did not complete thorough risk assessments for each client on admission. Client risk assessments only included the risk of suicide by strangulation or hanging. No other risks were captured within the risk assessment. Individual client risk assessments did not include risks clients presented to themselves and others, including historic risks. This meant staff were not provided with accurate information of the risks that clients presented and how to mitigate these. We reviewed 6 care records and saw that staff had not assessed risks including the risk of early exit from treatment. No clients had a risk management plan in place.
Staff did not use a recognised risk assessment tool, or review the risk assessment regularly, such as after an incident.
There were no completed risk assessments for alcohol detoxification and concurrent risks such as existing

medicines and illicit substances were not considered. Medicines were not reassessed following an incident such as a fall.
Staff did not consult with any other health professionals to validate the information given or seek further detail to support the pre-admission assessment process. GP summaries were not routinely requested to support the assessment of risk prior to admission. GP summaries were not used to provide information about prescribing or risk of seizures. Information from GP's and others was not used as part of the decision-making process to admit service users or to manage any ongoing risks.
We saw examples of clients being admitted without satisfactory test results such as liver function tests. Liver function tests should be examined to further assess the health of the client and whether any additional support would be required whilst they undergo a detoxification.

Management of client risk
The service did not manage individual client risks well. Clients did not have thorough risk assessments and there were no risk management plans in place. Staff did not know the full extent of any risks to each client and were therefore unable to act to prevent or reduce risks.
Staff did not identify and respond to any changes in risks to, or posed by, clients. Risk assessments were completed on admission for suicide by strangulation or hanging. No other risks were captured.
Staff followed policies and procedures when they needed to search clients or their bedrooms to keep them safe from harm.
The service did not provide informative harm minimisation advice to clients to make them aware of the risks of continued substance misuse.
Clients who were undergoing a detox from alcohol wore a monitoring watch overnight, which measured basic medical indicators, including temperature, pulse, breathing, and blood pressure. If any medical indicators were out of range, an alarm would sound to notify staff.
Audit processes were not in place to ensure that observations were being carried out in line with the providers policy. Observations recorded did not match incident reports. For example, incident reports indicated that one patient suffered a fall in their bathroom at 10:50pm on 22/06/2023. However, the observation record for the time and date of the incident said the patient was asleep and made no reference to the incident. The same client had another fall in their bedroom at 11.00pm on 23/06/2023. however, the observation record for that date and time stated that the patient was on the phone at the time of the fall and made no mention of the incident in the observation record.

Use of restrictive interventions
The service did not use restrictive interventions.

Safeguarding
Staff understood how to protect clients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.
Staff received training on how to recognise and report abuse, appropriate for their role. All staff had completed safeguarding adults training.
Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service had a safeguarding lead identified. However, they had not received any additional training to support them in this role. Staff liaised with the local authority safeguarding board with any concerns or queries.
Safeguarding was not discussed at multidisciplinary team meetings or clinical governance meetings.

Staff access to essential information
Staff had access to client information. However, they did not maintain high quality records.
Staff did not keep detailed records of clients' care and treatment. Records were not clear, up-to-date, or easily available to staff providing care. Clients care record documentation was poor and lacked specific

detail. Information was missing prior to admission that would have supported risk assessment and recovery planning.
The provider had recently installed a new system for electronic care and treatment records. This system should have included all assessment information, risk information and care plans for clients. However, when we reviewed the electronic care records most of this information was missing.
We reviewed client notes for 6 clients and found they were not detailed or comprehensive. Therapists attended the service twice a week to carry out sessions. However, therapy staff did not share the details of sessions with Nest healthcare staff stating this was a confidentiality issue. Therapy session notes were not recorded within electronic care records.
The electronic system was secure and only those with permission were able to access.

Medicines management
The service did not use systems and processes to safely prescribe, administer, record and store medicines. Staff did not regularly review the effects of medications on each patient's mental and physical health.
Staff did not follow systems and processes to prescribe and administer medicines safely. Medicines were prescribed following remote assessment by a psychiatrist and supplied by a local community pharmacy. All clients currently at the service were being treated for alcohol withdrawal.
We saw that allergies were not always recorded and two clients receiving antibiotics did not have any records for the administration of these medicines. No one at the service was administering their own medicines. Medicines administration equipment was found to be unclean and contaminated with tablet residue.
Staff did not review each client's medicines regularly or provide advice to clients about their medicines. There was blanket prescribing of a fixed dose regimen with a sedative medicine for alcohol detoxification, this was not tailored appropriately to personal risk, for example, if a client was prone to falls. Falls policies did not mention the additional risk of the administration of sedatives. As required (PRN) protocols were missing or not personalised and were not signed or dated. Clients were woken up at midnight to administer alcohol withdrawal medication.
Staff did not complete medicines records accurately or keep them up to date. Medicines Administration Records (MARs) had been provided by the manager but not signed or countersigned to ensure they were accurate. Medicines that were being administered were missing from the records.
Staff did not store and manage all medicines and prescribing documents safely. Medicines received into the service were not accounted for in line with policy, including homely remedies. Registers and medicine counts were not always completed. Medicines were not always in their original packing and labelled appropriately including the client's name. Medicines were stored securely in a locked cupboard with access restricted to the relevant staff.
Staff did not follow national practice to check clients had the correct medicines when they were admitted, or they moved between services. Clients admitted to the service did not have a medicines reconciliation performed which is a check of all medicines the client takes to make sure they are appropriate to be continued and correctly documented. There was no policy available for Medicines Reconciliation and Review although this was referred to in the Medicine Management Policy.
Staff did not learn from safety alerts and incidents to improve practice. Staff did not recognise and report medicines incidents and there was no learning taking place to improve practice. Medicine audits were taking place but were failing to pick up issues identified during inspection.

Reporting incidents and learning from when things go wrong.
The service did not manage client safety incidents well. Staff did not report all incidents appropriately. Managers did not investigate incidents or share lessons learned with the whole team and the wider service.
We reviewed four incidents from the 6 months leading up to inspection. Incidents had not been reviewed or thoroughly investigated by competent staff or monitored to make sure that action was taken to remedy the

situation, prevent further occurrences and make sure that improvements were made as a result. One client had 3 falls within 5 days. Although the incidents had been reported, all other sections, including the investigation and outcome section were incomplete.
Reviews of incidents were not systematic and learning from incidents was inconsistent. Learning from incidents was not embedded within the service. Incidents and learning from incidents were not discussed at multidisciplinary team meetings or clinical governance meetings.
During inspection we noted several medicines errors that had not been reported.

Inadequate

Is the service effective?

Our findings

Our rating of effective went down. We rated it as inadequate.

Assessment of needs and planning of care
Staff did not complete comprehensive assessments with clients on admission to the service. Staff did not work with clients to develop individual care plans or update them as needed. Care plans did not reflect individual client needs and were not personalised, holistic or recovery oriented.
Staff did not complete a comprehensive substance misuse assessment of each client either on admission or soon after. Prior to admission clients were assessed by the consultant psychiatrist who completed a pre-admission assessment form, with the manager present. However, the assessment completed by the consultant psychiatrist was not shared with the service, therefore information contained in the document completed by the manager was very limited.
Staff did not routinely ask for liver function tests or GP summaries prior to admission or at any time during admission. The assessments completed by the manager were vague and lacked specific detail. This meant assessments were completed with significant gaps in information and detox may have been unsafe due to contraindicating medication or compromised liver function.
All clients had their physical health observations completed soon after admission. However, staff did not have a GP summary to support their knowledge and understanding of the client's physical health needs. Therefore, it was not possible to respond to physical health needs that had not been known or disclosed by the client.
Staff did not develop a comprehensive recovery plan for each client that met their substance misuse, mental health, and physical health needs. We reviewed 4 client records in respect of their recovery plans. Only one client had a recovery plan completed. Recovery plan goals for this client included to "continue healthy eating" and "get a job", with no timescales, explanation, or interim targets.
Staff did not regularly review or update recovery plans when clients' needs changed.

Best practice in treatment and care
Staff provided some care and treatment interventions suitable for the client group. They ensured that clients had access to physical healthcare.
Staff provided a range of care and treatment suitable for the clients in the service. External therapists provided two sessions per client weekly. Staff structured days to include opportunities to engage in yoga, group walks, individual sessions with staff, mindfulness, reiki, and life coaching.
Staff did not use recognised rating scales to assess and record the severity of clients' conditions and care and treatment outcomes, such as the Clinical Opiate Withdrawal Scale (COWS) which rates common signs and symptoms of opiate withdrawal and is used to monitor symptoms and The Clinical Institute Withdrawal Assessment for Alcohol, (CIWA-Ar), a ten-item scale used in the assessment and management of alcohol withdrawal. Following inspection, the provider sent us an alcohol withdrawal observations chart which they were planning on using with future clients.
Staff supported patients to live healthier lives and access to physical health care, including specialists as required. The service helped with access to local services including physiotherapy and GP and dental services.

Staff did not deliver care in line with best practice and national guidance (from relevant bodies, for example, National Institute for Health and Care Excellence). The service did not follow the national guidance when prescribing medicines and staff had not received adequate training in alcohol withdrawal and substance misuse awareness.
Clients with alcohol dependence had seven to 10 days of detoxification treatment. There were no protocols identifying different prescribing regimes for clients with moderate or severe alcohol dependence, as recommended by best practice guidance (National Institute for Health and Care Excellence, 2011). Clients with alcohol dependence were not treated depending on their withdrawal symptoms and all clients were prescribed the same detoxification regime. Staff did not assess client's withdrawal symptoms using recognised alcohol withdrawal scales. One client who was admitted to the service was started on an alcohol detoxification regime, even though their drinking levels were low (under 21 units per week) and would not have indicated a requirement for detoxification. This alcohol detoxification was started without completing a Clinical Institute Withdrawal Assessment for Alcohol to see if the client required detoxification.
Following inspection the provider sent us an updated Management of Acute Alcohol Withdrawal Protocol, which was not fit for purpose. The protocol did not clearly state who should be excluded from the service, arrangements for aftercare, the protocol lacked detail about the robustness of the admissions process and did not indicate how staff should escalate deteriorating physical health and adverse withdrawals. We requested an opiate withdrawal protocol, which we did not receive.
Staff did not take part in regular audits, benchmarking, and quality improvement initiatives to evaluate the effectiveness of the service they provided. During inspection we were shown a medication audit schedule, which contained dates of medication audits. However, we were not shown any audits that had been completed. Other than an infection control audit, no other audits such as care plan audits or risk assessment audits were taking place. Managers were therefore unable to use results from audits to make improvements.

Skilled staff to deliver care.
Managers did not ensure all staff delivering care had the right skills and experience to meet the needs of the clients. Most staff had no experience of substance misuse services and did not have access to specific training on the subject.
Managers did not make sure staff received any specialist training for their role. Some specialist training required to meet the needs of clients was not available to staff. For example, the provider did not offer training in relapse prevention or harm reduction.
Managers gave each new member of staff a full induction to the service before they started work.
Managers told us they supported staff through regular supervision and appraisals of their work and provided a spreadsheet which showed all eligible staff had received an appraisal in 2023 and staff were receiving regular supervision. However, staff personnel files supervision records showed that that one staff member had last received supervision on 25/07/22 and the other on 14/06/2023.
Managers made sure staff attended regular team meetings or gave information from those they could not attend.

Multi-disciplinary and interagency teamwork
Staff did not have effective working relationships with all other relevant services outside the organisation.
Staff held regular multidisciplinary meetings to discuss clients and improve their care.
Staff from different disciplines within the service worked together as a team to benefit clients. The team had effective working relationships with relevant services locally outside the organisation such as GP surgeries and dentists. However, staff did not always work well with external services required to meet client's needs prior to commencing treatment. Assessments we reviewed during the inspection did not include input from the clients GP. The service did not share information with other healthcare professionals before prescribing and the assessment did not demonstrate that the risks of not sharing information had been explained to the

client.
Staff mostly shared clear information about clients and any changes in their care, during handover meetings. We sampled a number of handover documents. There was clear information regarding client wellbeing. However, therapists did not share information with staff.

Good practice in applying the Mental Capacity Act
Staff understood the provider's policy on the Mental Capacity Act 2005. However, they did not adequately assess or record capacity clearly for clients who might have impaired mental capacity.
Staff received, and were up to date, with training in the Mental Capacity Act.
The provider had a policy relating to the Mental Capacity Act which staff were aware of and had access to.
The manager discussed and checked capacity to consent to treatment with clients on admission as part of the admissions assessment. However, in two of the assessment records reviewed during inspection, the capacity to consent to treatment section of the assessment form that staff should have completed was incomplete.

Good

Is the service caring?

Our findings

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion, and support
Staff treated clients with compassion and kindness. They respected clients' privacy and dignity. They understood the individual needs of clients and supported them to understand and manage their care, treatment, or condition.
Staff were discreet, respectful, and responsive when caring for clients. We observed staff interactions with clients and saw that they were respectful and kind.
Staff gave clients help, emotional support and advice when they needed it. We spoke with two clients who told us that the therapists were great and had given them support to work through issues. Clients felt that staff made them feel their lives mattered and they felt cared for.
Staff directed clients to other services and supported them to access those services if they needed help. The service helped with access to local services including GP and dental services.
Clients said staff treated them well and behaved kindly. We spoke with two clients who told us staff were helpful and supportive and always had time to talk. Relationships between clients and staff were caring and respectful.
Staff understood and respected the individual needs of each client. The service was small with four clients in treatment at the time of inspection. Staff knew the clients well and understood their individual needs and preferences.
Staff felt that they could raise concerns about disrespectful, discriminatory, or abusive behaviour or attitudes towards clients. Clients said they could raise concerns about disrespectful, discriminatory, or abusive behaviour or attitudes without fear of consequences. Clients felt that staff were fair and transparent.
Staff followed policy to keep client information confidential.

Involvement in care
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.
Involvement of clients
Staff introduced clients to the ward and the services as part of their admission. Staff gave new clients a tour of the service, gave them an overview of treatment options and introduced them to therapists.
Staff involved clients and gave them access to their care planning and risk assessments. One patient said they had good discussion with the psychiatrist, he listened, and they felt fully involved in their care.
Staff made sure clients understood their care and treatment and could make decisions on their care. Clients chose which therapy sessions they wanted to go to and could schedule additional therapies such as reiki and counselling if wanted.
Staff involved clients in decisions about the service, when appropriate.
Clients could give feedback on the service and their treatment and staff supported them to do this. Clients could raise any feedback with staff or the manager at any time, we spoke with two clients who said they felt able and confident to do this and all staff are approachable.

Involvement of families and carers
Staff informed and involved families and carers appropriately.
Staff did not involve families as clients could update their families as they wished.

Inadequate

Is the service responsive?

Our findings

Our rating of responsive went down. We rated it as inadequate.

Access and discharge
Staff did not plan or manage discharge well.
The service did not have a clear admission criteria. The exclusion criteria did not exclude clients who were pregnant or had a history of seizures or delirium tremens from treatment at the service. A client's past history of alcohol withdrawal seizures or delirium tremens indicates they may be at high risk of such complications in treatment in the future. Alcohol withdrawal seizures and delirium tremens can result in death. To minimise the risk of this or other complications, staff should have received appropriate training and a prompt medical response to any patient deterioration was required. We were not assured that both were consistently available.
Staff did not plan for clients' discharge. We reviewed 6 care records; none had recorded the clients discharge plans. There was no aftercare package available for clients. Staff we spoke with said they followed up with clients following discharge, but we saw no evidence of this being carried out.
Staff did not plan for early unexpected exit from treatment with clients. No client files had an unexpected discharge plan. This meant that clients wishing to self-discharge earlier than planned may not be discharged in a safe manner, either during or following detoxification.
We could not find evidence that, with consent, relevant information was shared with other healthcare providers involved in clients' care. Policies did not describe how or if, with consent, information would be shared with the client's regular GP on discharge from the service.
The service did not have alternative care pathways or referral systems for people whose needs it could not meet.

Facilities that promote comfort, dignity, and privacy
The design, layout, and furnishings of the ward supported clients' treatment, privacy, and dignity. Each client had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy.
Each client had their own bedroom, which they could personalise and lock for security.
Clients had a secure place to store personal possessions.
The service had a full range of rooms and equipment to support treatment and care. Staff and clients could access the rooms. However, at the time of inspection there was no clinic room.
The service had quiet areas and a room where clients could meet with visitors in private.
Clients could make phone calls in private.
The service had an outside space that clients could access easily. There was a large garden outside for clients to use.
Clients could make their own hot drinks and snacks and were not dependent on staff. Hot drinks and snacks were available for clients to access in the kitchen/dining room. These were available at any time.
The service offered a variety of food. Clients were able to purchase their own food for their individual needs and preferences. Staff and clients cooked meals together.

Meeting the needs of all people who use the service.
The service met the needs of all clients, including those with a protected characteristic or with communication needs.
The service could support and make adjustments for disabled people and those with other specific needs.
The service had a bedroom on the ground floor with an accessible bathroom and all treatment rooms, lounge and kitchen were on the ground floor.
Clients had access to spiritual, religious, and cultural support in the local community.
The service did not have information leaflets available in languages spoken by the clients and local community. There were no leaflets on display anywhere in the building.
The service provided a variety of food to meet the dietary and cultural needs of individual clients. Clients purchased their own food.
Staff had not routinely considered clients' wider needs such as housing, education and employment, family, legal, and financial support as part of the care planning process.
Staff had supported clients to stay in contact with families and carers and encouraged them to develop and maintain relationships with others in the service.

Listening to and learning from concerns and complaints
Clients, relatives, and carers knew how to complain or raise concerns.
The service had received one complaint in the 6 months leading up to inspection. They had a policy in place for how to acknowledge, investigate and respond to a complaint. However, although we were given details of an interview held with the client who made a complaint, there did not appear to be a resolution and policy had not been followed.

Inadequate

Is the service well-led?

Our findings

Our rating of well-led stayed the same. We rated it as inadequate.

Leadership
Leaders lacked the skills, knowledge, and experience to perform their roles. They did not have a good understanding of the services they managed. However, they were visible in the service and approachable for clients and staff.
At this inspection we were concerned about the lack of skills and experience held by managers and the lack of qualifications or experience of managing a substance misuse detoxification service. Managers were unable to answer many of the questions asked of them during the inspection process and were unable to offer a clinical leadership role to other staff members.
Leaders failed to implement safe systems and processes to provide safe and good quality care to clients accessing the service. There was no process to admit clients safely to the service, risk assess clients appropriately, a lack of auditing processes to ensure governance systems operated effectively and a lack of oversight of medication management.
Despite the above issues, managers ran the on-call manager support line for the service and encouraged staff in the service to contact them whenever needed. Managers were visible in the service and approachable for clients and staff.
Vision and strategy
Staff knew and understood the provider's vision and values and how they were applied to the work of their team.
The provider's vision was as "an exclusive, specialist rehabilitation and wellness clinic, offering an exceptional blend of complimentary and clinical therapies". Staff understood this vision.
The service and lacked clarity around the model of care in place. The provider told us they were changing the services Statement of Purpose to include admission of people who have substance misuse and a diagnosis of mild to moderate learning disability. We raised concerns around the additional risks this would bring with an increasingly complex client group added to the challenges the service had with providing care and treatment to clients in a safe way.

Culture
Staff felt respected, supported, and valued. They said the provider promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.
Staff felt valued and positive in their roles. Staff described a happy and content staff team who felt respected and enjoyed their roles. There had been no cases of bullying or harassment reported within the service.
Staff felt respected and were motivated to deliver a good service but did not have effective support or the right systems in place to do this.
The service provided opportunities for development and career progression. Support workers had the opportunity to train as senior support worker.

Governance

Our findings from the other key questions demonstrated that governance processes were not operated effectively at team level and that performance and risk were not managed well.
At the previous inspection, we were concerned that the service did not have governance systems and processes in place and did not assess or audit the quality and safety of the service.
At this inspection, there remained issues with governance processes and audits. Staff completed ineffective risk assessments for each client prior to admission and on arrival. The service did not use a recognised risk assessment tool and risk management plans were not completed. There continued to be gaps in the assessment and admission process. Staff did not have access to a full GP summary before commencing detoxification regimes.
Staff did not follow systems and processes to prescribe and administer medicines safely. Staff did not complete medicines records accurately and kept them up to date. Staff did not store and manage all medicines and prescribing documents safely. Staff did not follow national practice to check patients had the correct medicines when they were admitted. Staff did not review the effects of each patient's medicines on their physical health according to National Institute for Health and Care Excellence guidance.
The service did not manage client safety incidents well. Staff did not recognise all incidents, such as medicines incidents and report them appropriately. Managers did not investigate incidents or share lessons learned with the whole team due to the lack of investigation into incidents.
Recovery plans and associated documents did not contain information required to deliver safe care and treatment. Basic elements were missing or were too brief to be of value. This included lack of detail around individual clients physical and mental health concerns.
No clients had discharge plans or unexpected exit from treatment plans.
The service did not have a full audit programme and were not able to provide us with evidence of audits undertaken. However, we were given a copy of what dates medicine audits and infection control audits took place. Due to the service failing to pick up issues identified during inspection, we were not assured these were effective.
The governance system was not structured. Individual elements, such as audits, training and learning from incidents were not collated into overarching systems so that performance, themes, and trends could be monitored and proactively addressed. The risk register for the service did not identify any of the risks to client safety which we identified during the inspection.

Management of risk, issues, and performance
Teams did not have access to the information they needed to provide safe and effective care.
Staff used an electronic recording system for client records. The system had been recently implemented and was easy to navigate. However, the system was not being updated regularly. Some documents, such as the admission assessment were being completed in paper format but had not been fully uploaded to the electronic recording system.
Information governance systems included confidentiality of patient records. All client files contained a confidentiality and information sharing agreement.
We reviewed two staff personnel files during inspection. One contained no DBS details and no references. There was also evidence of personal information not being stored in line with the principles of GDPR. For example, there was a paper copy of a DBS check located in one staff personnel file.
The service had a risk register in place which staff were aware of. However, the risk register was not discussed at governance meetings and did not reflect the risk to clients.
The provider had not acted on all issues raised at the previous inspection. However, staff who handled and prepared food had received training in food hygiene and mandatory training rates had improved.

Information management
Staff did not collect or analyse data about outcomes and performance or engage in local and national quality improvement activities.

The service did not use outcome measures to record outcomes or performance. The provider told us they followed up with clients post discharge. However, outcomes from these phone calls were not recorded anywhere, so we could not be assured that the service was recording outcomes.

Engagement
The provider did not actively engage with other local health and social care providers to ensure client were fully supported whilst admitted to the service.
The service worked with client's local authority allocated worker to support clients. However, staff had not developed any other links with health or social care providers locally or near to client homes.

Learning, continuous improvement and innovation
The service did not have any quality improvement plans in place.