Oasis Recovery Bradford

Quality Report

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

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

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

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

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

Overall summary

We do not currently rate independent standalone substance misuse services.

We found the following areas of good practice:

- Oasis Recovery Bradford had a safe, clean and well maintained environment. Medication management and storage was good, the service had emergency medication with the appropriate audits in place. There were appropriate staffing levels with a robust process in place to replace staff during sickness, vacancy or unplanned leave.There was medical and management cover twenty-four hours a day, seven days a week. All clients had up to date risk assessments and risk management plans. They were detailed and staff reviewed risks regularly during daily hand overs.
- All clients had a pre admission assessment which was done by a nurse and a doctor. The service had clear criteria for clients entering the service and recognised its limitations.Care plans were detailed, person centred and holistic. They identified any physical health needs and required support. The service had a skilled multi-disciplinary team including doctors, nurses, support workers, recovery coaches and a counsellor. They had good links with external community groups, and services such as mental health services, drug and alcohol teams,

Summary of findings

mutual aid, and housing.The service supported clients after their treatment had completed through an after care service, onward referrals, information about mutual aid groups and peer networks. Consent to share information was sought from clients during the assessment and reviewed regularly throughout their treatment.

- Clients told us staff were caring, kind and compassionate. They felt staff did not judge them and were empathetic to their needs. We found the service was working closely alongside carers offering them support if required. The service had a successful discharge rate, averaging 92% over the last 12 months. For those clients who did not complete their treatment the service offered alternatives or additional support. The service met the needs of its clients, recognising spiritual or cultural requirements. Clients told us they felt comfortable to make a complaint, and we found the service responded to all complaints comprehensively in a timely manner.
- Oasis Recovery Community Bradford was well led, with local governance arrangements in place to ensure good quality care, including a range of performance indicators, policies and procedures and clinical audit. Staff understood and followed safeguarding, incident reporting, and complaints procedures, and worked within the guidelines of the Mental Capacity Act (2005). Staff, clients, relatives and carers were able to give feedback on the planning, delivery and development of the service. The directors completed detailed quarterly quality audits, reviewing the service governance structures to ensure that treatment and care was safe, effective, and continued to improve.

However, we also found the following issues that the service provider needs to improve:

- The service had completed a ligature assessment of the environment, however had not identified all the ligatures in the communal areas.

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Background to Oasis Recovery Bradford

Oasis Recovery Bradford was originally commissioned by the Department of Health in 2009 as the only as the only detoxification unit in West Yorkshire. The service changed provider twice before UK Addiction Treatment (UKAT) took it over in 2016. The 17-bedded detoxification unit is equipped to accommodate people with limited mobility and wheelchair users who can self-care. It can make provision for some additional personal care needs. Oasis Recovery Bradford provides care for males and females aged 18 and above to complete a physical withdrawal from drugs and/ or alcohol, or stabilise their use safely with medical support. At the time of the inspection there were 14 clients receiving care and treatment at the service. The service accepts statutory and private paying clients. At the time of the inspection, private paying clients comprised 80% of the clients receiving treatment.

As well as medical detoxification, the service also provides psychosocial interventions aligned to clients' medical treatment. The interventions include group therapies and one to one work with a full time counsellor.

There was a registered manager in place and a nominated individual. The service is regulated to carry out:

- Accommodation for persons who require treatment for substance misuse as its regulated activity.

Oasis Recovery Bradford was last inspected in March 2016. The service was found to be compliant with the Health and Social Care Act 2008 (regulated activities) regulations 2014.

Our inspection team

The team that inspected the service comprised of three Care Quality Commission inspectors, including the inspection lead, Hamza Aslam, and a substance misuse specialist advisor.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location, asked other organisations for information, and gathered feedback from staff members through an email we asked the provider to send them.

During the inspection visit, the inspection team:

Summary of this inspection

- visited the unit, looked at the quality of the physical environment, and observed how staff were caring for clients
- spoke with five clients
- spoke with the registered manager, operations director and lead clinician
- spoke with five other staff members employed by the service provider, including the lead nurse, deputy manager, counsellor, and a support worker
- attended and observed one hand-over meeting and two recovery group work sessions for clients
- looked at seven out of 14 care and treatment records for clients, including eight medicines records
- reviewed medication management, storage and clinic facilities
- looked at policies, procedures and other documents relating to the running of the service.

Information about Oasis Recovery Bradford

What people who use the service say

We spoke with five clients receiving care and treatment at Oasis Recovery Bradford. The feedback overall was very positive. All clients we spoke to told us the staff were caring, compassionate and none judgemental. They said they felt safe and staff were knowledgeable in their role. Clients also complimented the environment. They told us it was comfortable, clean and sufficient for their needs.

However, two clients told us they would prefer more outdoor space. One client told us they would like to see more activities available, for example community walks.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- The service had a clean, comfortable environment, with appropriate clinic facilities and good medication management. Medicines were stored securely in locked cupboards and on a locked trolley, within a locked clinic room. This included the safe storage of controlled drugs. There were processes in place for the safe disposal of medicines.
- Staffing levels were adequate, and the service had a system in place to manage sickness, absence and leave by using bank staff and regular agency staff. The use of bank and agency staff was low.
- All seven client records we reviewed had up to date risk assessments and risk management plans. We saw staff had updated the records and discussed client risk in the daily handover.
- The service had a doctor on call and a manager on call twenty-four hours a day seven days a week.
- Over 90% of staff had completed their mandatory training.

However, we also found the following issues that the service provider needs to improve:

- The service had not identified all the ligatures in the communal areas on their ligature environmental assessment.

Are services effective?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- All seven care and treatment records we reviewed had care plans, which were individual and holistic. They identified any physical health needs and the plans in place to support those needs. Each client signed all care plans.
- All clients had a full physical health examination during their admission. In addition the client's GP was contacted to get a written statement of any concerns around their physical heath.
- Clients had access to psychosocial interventions including daily support groups and individual support with a qualified counsellor. Psychosocial interventions

Summary of this inspection

- Clients were discussed by the multi-disciplinary team twice daily in handover sessions. Client did not attend but their opinions, thoughts and feelings were fed into the handover through the daily diaries that they completed each evening.
- All staff had regular management and clinical supervision, and all eligible staff had received an appraisal within the last 12 months.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Clients told us staff were caring, kind, compassionate and none judgemental.
- We observed care that was client focused, empathetic and (saw examples of positive, therapeutic relationships being built between clients and staff).
- Exit survey results over the last 12 months demonstrated clients were very satisfied with their care.
- The service worked closely alongside families and carers as part of the treatment clients received.

Are services responsive?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- The service had a 92% successful treatment rate for the last 12 months.
- The service was able to see statutory clients within the 14 days referral to treatment target. Private clients were able to receive treatment as soon as all the information required was received.
- Clients knew how to complain, and there was appropriate information for clients about how to make a complaint. We found the service responded to all complaints within 28 days in line with their policy, offering a comprehensive response and an apology.
- Oasis Recovery Bradford had a full range of accessible rooms to support clients' treatment and care, including a fully
- The service was able to cater to clients spiritual, religious and cultural needs. This included

offering food appropriate to religious needs such as Kosher and Halal.

Are services well-led?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

Summary of this inspection

- Staff had good morale, were positive and highly motivated. Staff demonstrated the services vision, mission and values by the way they spoke and interacted with clients.
- Staff knew who the senior management team were and felt comfortable to address any concerns or issues they may have.
- Sickness levels were low and there were no vacancies at the time of the inspection.
- There were local governance arrangements in place to ensure good quality care, including a range of performance indicators, policies and procedures and clinical audit.
- The service demonstrated ways in which it was trying to improve as a service by implementing a bespoke electronic record keeping system and developing an online aftercare system.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty Safeguards were part of the services mandatory training modules. All the staff had completed this training.

Care records we observed and treatment agreements showed that clients had signed and consented to treatment, sharing of information and confidentiality agreements. Discussions with clients demonstrated that they were all aware of, and agreed with, their treatment and care.

Examples were given where clients did not have capacity to consent to treatment, for example on admission due to intoxication, and the service had waited to complete the admission assessment until the client had regained capacity to make their treatment decisions.

Substance misuse/detoxification

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse/detoxification services safe?

Safe and clean environment

Oasis Recovery Bradford was located within a purpose built two-storey building. The ground floor comprised of therapy rooms, dining room and consultation room, and staff areas. The first floor comprised the client bedrooms, laundry room and the clinic. We found the environment including the clinic to be clean and well maintained. Client areas were comfortable, the fixtures and furnishings were in good condition and there was adequate space for clients to reside within.

The service had accessibility provisions for persons with mobility issues including lift access to the first floor. We reviewed the fire safety of the building and found there were two evacuation points on either side of the building so clients could exit in a timely manner, all clients had personal emergency evacuation plans, and an emergency evacuation chair was located on the first floor. The fire alarms were last tested in January 2017 and the service logged weekly fire alarm tests. The service had annual gas safety checks and portable appliance testing in June 2017 and August 2017 respectively.

The service carried out environmental risk assessments, which identified issues within the service and management plans to address them. Overall, the building was kept safe but we found an example where a television wire within the family room that had not been secured properly to the wall. As the wire was suspended in the air, this meant it could cause a potential risk to children and families visiting the room.

There was a fully equipped clinic room with an examination couch and the necessary equipment to carry out examinations, as well as resuscitation equipment. There were crash grab bags on each floor that were stocked and maintained.

The service conducted a ligature risk assessment whereby it identified ligatures within the service and how staff would mitigate risks. A ligature is a place to which clients intent on self-harm might tie something to strangle themselves. The service had identified the ligature points where clients would be left alone for example the client bedrooms but had not identified all potential ligature points within the communal areas in the ligature risk assessment. However, this service did not accept referrals for clients at high risk of suicide or self-harm, the client risk assessments were comprehensive and up to date, staff and clients had a presence in the communal areas. The service had hourly observations at night, which could be increased if staff had any concerns in relation to a client and had a bedroom next to the staff room should a client require increased levels of observation. In addition, there had been no incidents of client attempting to ligature. The registered manager confirmed that the service would review and update their current ligature risk-assessment identifying this mitigation.

The service could accommodate 17 clients at any one time. The bedrooms were single occupancy, except for one triple bedroom available for clients who preferred to share. As this was a mixed sex unit, staff told us that only clients of the same sex would share a bedroom. All bedrooms had en-suite toilets and shower-rooms and all but one bedroom were situated on the second floor. Clients could lock their bedrooms and they had fobs to gain entry to their own room. Staff also had fobs to gain entry to all the bedrooms. We spoke to male and female clients both of whom told us they felt safe and shared no areas of concern. The service did not have separate lounge facilities for

males and females, however, the service had an additional large therapy room, which had the same facilities as the communal lounge clients could access if they required male or female only space.

The clients did not have an alarm system in their rooms, however, any clients identified as being at risk or unwell were given a walkie-talkie radio. This had a panic button, which alerted staff directly, as well as enabling them to communicate verbally if required. The service had a walkie-talkie policy to which staff could refer to in order for them to work safely.

The staff office was situated on the first floor. All staff told us that blind-spots were mitigated using regular observations, and staff being always visible in communal areas.

The infection control policy for Oasis Recovery Bradford included protocols for hand hygiene, disposal of sharps and clinical waste, the use of personal protective equipment, blood borne viruses and general housekeeping to prevent infection. Cleaning schedules had been signed and dated when the action had been completed. Hand hygiene posters were on display. Staff were aware of their responsibilities, and knew where to access the policy and procedures should they require clarification.

Safe staffing

Oasis had 17 substantive working at the time of the inspection. They included the service manager (registered manager), a deputy manager, recovery coach (a worker who supports the client with their recovery using psychosocial interventions), support workers, nurses and a counsellor. Oasis used three doctors, who work on an on call rota so that a doctor is available at all times. A member of housekeeping staff and maintenance worker were in addition to these staff.

The service had four whole time equivalent nurses with no vacancies for these posts. The nurses covered two 12 hour shifts per day, seven days a week. The service had five whole time equivalent support workers at the time of the inspection including one newly recruited member of staff. There was one support worker alongside the nurse over the two 12 hour shifts in the day.

The service had additional an support worker working Monday to Friday 9am till 5pm, and 11am till 5pm on the weekends. Due to the increase in referrals, the service had newly recruited two support workers to cover a 4pm until 12am shift seven days a week. The increase in staffing meant staff could spend more therapeutic time with clients and manage the risks more effectively.

The recovery coach, deputy manager, centre manager, counsellor, and administrator worked on weekdays only. However, the service manager or lead nurse were always on call. The operations director said he could be on call where the service manager and lead nurse were unavailable.

In the last three months, between May 2017 July 2017, there were 51 shifts filled by bank and agency staff due to sickness, leave and absence. There were no shifts not filled within the same time period. The registered manager told us they had a strong group of regular bank and agency staff to cover short falls within staffing when it occurred.

The nursing staff were responsible for administering the client medication and overseeing the clients' treatment and care, after the initial admission assessment by the doctors. The centre staff could contact them by telephone or email and the doctors would attend the centre if required. There was management cover twenty-four hours a day, seven days a week. There were no reported incidents in the last 12 months where a doctor or member of management could not be contacted.

At the time of the inspection overall mandatory training figures demonstrated a compliance rate of over 90%. Training that had a 100% compliance rate included, safeguarding children, safeguarding adults, risk assessment awareness, basic life support and Mental Capacity Act. There were no training modules that had a compliance rate below 75%.

Assessing and managing risk to clients and staff

Oasis Bradford had a clear admission criteria. It did not accept detained clients and could not accept people that had a high level of physical support needs. The service did also not accept clients who were at high risk of suicide or self-harm. Many of the clients may suffer outlier issues to their addiction such as mental health issues to which the service had embedded training around supporting people with 'anxiety', 'depression' and 'understanding mental health'.

All clients had a pre-admission assessment, which supported the risk formulation. Where the service required

further information around risk to complete a comprehensive risk assessment, they made the appropriate steps in contacting relevant agencies, for example, mental health teams, GP and probation. For statutory clients the referring agency sent all the care notes prior to the assessment. Using this pre-admission assessment and referral information, the service identified whether they could manage the risks pertaining to the individual in line with their admission criteria .and offer the clients a place at the unit for treatment.

Risk was reviewed by the doctor and the nurse at the admission assessment that was completed on the day the client was due to enter the service. Risk information was reviewed twice daily at the morning and evening handovers by the staff, including the nurses. Each client was discussed in turn using information from staff general observation, nurses' physical observations and client feedback through daily diaries. This information was forwarded to the doctor to review following each handover.

We reviewed seven out of 14 risk assessments and management plans. We found all the risk assessments and plans to be comprehensive, up to date, and reviewed regularly. We found a recent example where a client had become at risk of having seizures; this had been updated within the risk management plan and clinical notes 24 hours after the incident had happened. We saw this was also discussed within the handover.

The service managed their medication safely. Fridge temperatures were monitored and the environment was maintained and kept clean. We reviewed eight out of 14 client medication cards, all of which had appropriate documentation and relevant up to date signatures. Medicines were stored securely in locked cupboards and a locked trolley within a locked clinic room, this included safe storage of controlled drugs. Controlled drugs are medicines that are more liable to misuse and therefore need close monitoring. We checked a sample of medicines stored in the service and found these were in date and matched stock records. An accurate register was in place to record the handling of controlled drugs. We viewed records that demonstrated the controlled drugs were disposed of appropriately. The service had a controlled drugs accountable officer who was also the performance and compliance manager.

There were procedures in place for children to visit. These were included in the visiting policy, which stated that the child is the responsibility of the parent and that visits would take place in the family room.

The service had local safeguarding protocol to protect adults and children, which was outlined within their policies. There was a safeguarding children and adults policy to which staff could refer to. Staff understood their responsibilities under safeguarding and knew who they could contact if they had any concerns or issues. Staff also recognised the responsibility to notify the Care Quality Commission in the event of safeguarding and deaths. Since the service had been taken over by a new provider there had been no safeguarding alerts made to the local authority.

We reviewed five staff files and found all staff had had appropriate enhanced disclosure and barring checks done prior to employment. These checks inform the employer of any historic or current criminal convictions, including safety registers that the individual may be subject to.

Track record on safety

Since UK Addiction Treatment became the provider for Oasis Recovery there had been three serious incidents between January 2017 and July 2017. The incidents included two client deaths and an emergency evacuation due to a fire, none of the serious incidents were related.

One incident required the service to implement their business contingency plan. Due to a fire in the neighbouring building the service had to evacuate its clients over safety concerns. The operations director told us the service could not have done anything differently, and the business contingency plan was followed accordingly. As a result clients were still able to carry out their detoxification safely until they were allowed back into the building. Staff told us the incident was well managed and the service worked together in order to continue care and treatment.

Reporting incidents and learning from when things go wrong

All staff were aware of the types of incidents that should be reported, including environmental concerns, accidents, medication errors, aggression and violence, and safeguarding. They confirmed that the incident book was

Substance misuse/detoxification

kept in the office and this was completed immediately by the person witnessing the incident. They stated that they were encouraged to report all incidents and felt supported to do so.

We saw staff were regularly reporting incidents, and all incidents were investigated. We found these were discussed during daily handover meetings and team meetings where appropriate. There was an example of an incident where a medication error had taken place and the outcomes included staff re-training in medication management, as well additional support through supervision. This evidence was corroborated within the supervision notes.

We found good examples of learning from incidents within team meeting minutes, handover minutes and supervision notes. The service had newly established a monthly in newsletter in July 2017 which managers told us would be a platform where learning could be shared.

Duty of candour

Providers of healthcare services must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology.

The service had a Duty of Candour policy in place, which clearly informed staff what their obligations and duties were under this regulation. Staff understood their roles and felt that they were always honest and open with clients. Where a serious incident had occurred the service had formally apologised to the family and people involved, and offered their support where appropriate, for example, bereavement counselling for family and carers.

We reviewed one incident where a medication error had taken place. After it had been investigated the member of staff involved issued an apology to the client outlining what had occurred and the actions that had been taken as a consequence.

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

Assessment of needs and planning of care (including assessment of physical and mental health needs and existence of referral pathways)

The service developed a care plan with its clients within 48 hours of their treatment through a care plan meeting. The care plans were then regularly reviewed during 'care plan reviews', whereby clients discussed their outcomes with what goals had been achieved and what further work needed completing. The recovery coaches and the counsellor conducted the care plan reviews. This fed into the psychosocial part of clients' care and treatment.We reviewed seven out of 14 care and treatment records. We found care plans to be holistic and person centred. All the care plans had been reviewed regularly and were up to date. Clients were offered a copy of the care plans and they were signed by both the clients and member of staff.

A pre-admission assessment was completed with clients, which included a detailed history of the

client including physical and mental health, relationships, offending behaviour, and social circumstances including housing, employment and education. The service also contacted the GP to get a statement of any physical health complications or issues which the service needed to be made aware of. Routine blood tests were completed but the consultant requested additional blood work prior to admission where there were other physical health concerns. Blood borne virus testing and vaccination was offered on admission to the service and then referrals made to the client's local GP to complete the treatment.

Upon admission, all clients undertook a full physical health check which included; blood pressure, blood sugar, pulse, urine screening, height, weight and oxygen saturation levels. During the rest of the detoxification the clients had regular basic physical health check done on a daily basis including, blood pressure, pulse and urine tests. If there were any concerns further detailed checks were carried out.

The doctor discussed the medication options for the detoxification with the client, and provided them with information around these medications. The detoxification

was overseen by the doctor remotely. The doctor prescribed the agreed medication regime, and the nurse administered this medication and monitored the client. The nurse would discuss any concerns and changes in medication with the doctor on an ongoing basis.

At the time of the inspection the service were using paper records. All the records were kept securely within a locked room which only staff could access. We found staff were updating contemporaneous records frequently and reflecting any significant changes within the care plans and risk assessments. Staff told us this duplication of work required more time.

The service were due to move over to a new electronic record keeping system after the inspection. All staff had been trained in the new system which was bespoke for substance misuse services like Oasis Recovery Bradford. The registered manager told us they would phase in the new system and begin to use it for new clients entering the service. The service was due to implement the new system immediately after our inspection. The new system aimed to streamline the record keeping to a more effective system. All the staff we spoke to were positive about moving over to the new system and recognised the benefits.

Best practice in treatment and care

The service offered medication to assist detoxifications for clients suffering both alcohol and drug dependency. The detoxification offered ranged between seven to 28 days depending on the substance or substances the client was detoxifying from. This incorporated a full therapeutic programme to coincide with the medication detoxification.

The psychosocial interventions delivered in one to one sessions and in a group setting were evidence based and recommended by the National Institute for Health and Care Excellence, including motivational interviewing and cognitive behavioural techniques. There was a four-week rolling group programme with two therapeutic groups per day. This included a 'process group' facilitated by staff to support clients to understand their immediate issues, explore them with input of their peers and then come up with actions to help them to resolve the issue. Other groups included relapse prevention, the effects of detoxifying, exploring emotions and relationships, mind mapping, life skills and an educational group. The third and final group of the day was a recreational activity designed to end the day on a positive with the recovery community in the service, for example a quiz or a walk.

The service had recently employed a full time counsellor to offer more structured one to one sessions. This approach used psychological models such as cognitive behavioural therapy to support clients' individual needs.

The client completed daily diaries so staff were aware on a daily basis how they were feeling mentally, emotionally and physically, and how well they were engaging with the therapeutic programme. These were used as guide for additional support, like a one to one, increased observations, or to contact the doctor regarding a change of medication. We observed a handover where staff discussed individual clients based on their diary and what support could be offered.

We viewed eight medication treatment charts in use at the time of the inspection and found that these were accurately completed. They included the use of clients own medicines and administration instructions for medicines taken on an "as required" basis.

The nationally recognised withdrawal scales used by Oasis Recovery Bradford included the clinical institute withdrawal assessment revised scale for alcohol, the clinical institute withdrawal assessment scale for benzodiazepines, and the clinical opiate withdrawal scale.

The service had the means to monitor nutrition and fluid intake for clients. They had monitoring charts available for staff. At the time of the inspection there were no clients who were being formally observed for nutrition and hydration.

Routine audits were carried out for care and treatment records and medication management. The audits were reviewed by both the registered manager and operational manager and discussed in the bi-monthly clinical governance meetings.

Skilled staff to deliver care

The service had a range of skilled staff to support the delivery of care and treatment to its clients. These included, nurses, doctors, a qualified counsellor, a recovery coaches, support workers and staff trained in dialectical

behavioural therapy. The service also linked into other organisations or groups including mutual aid groups, community substance misuse services and mental health services.

Oasis Recovery Bradford had a training matrix mapped against the specific roles for all staff, and

all mandatory training and specialist training was either in progress or completed. Training included supporting staff in understanding other issues which may impact clients involved in substance misuse such as understanding mental health, anxiety and depression.

All staff received monthly management supervisions from the centre manager. The nursing staff also received quarterly clinical supervision from the lead nurse. The lead nurse received clinical supervision with the consultant. Supervision ensures that staff are competent to fulfil their role, that they are adequately supported and that any underperformance can be identified. For nursing staff, clinical supervision was also a requirement of their registration. All staff had received an appraisal in the last 12 months. Staff that had newly started had a provisional appraisal date scheduled in. The doctors had the appropriate practising privileges in place and all three doctors had their practising licence revalidated with the General Medical Council.

Multidisciplinary and inter-agency team work

A multidisciplinary team worked with clients from the pre-assessment stage through to discharge from the service. The team included doctors, nurses, a counsellor and support workers. The service liaised with external stakeholders where appropriate and these included the G.P, mental health teams, criminal justice teams, housing providers, mutual aid groups, and other voluntary organisations. The service also had links with organisations for onward referrals after the treatment was over. We were given examples of how staff referred clients onwards to mental health services out of the area.

Staff had two handovers daily, in the morning and evening. We observed a morning handover and found it to be comprehensive and succinct. Nursing staff reviewed the clinical aspect of each client including medication, physical health and any concerns or areas of progress. The recovery coach and counsellor discussed in turn the therapeutic and psychosocial element of each client's care. They covered mental well-being, diaries, group engagement, observations, and concerns. All the notes were shared with the doctors. Any risk information was also discussed within the handover and additional measures were put in place where appropriate.

Each client had a clearly identified named nurse whose role was to liaise with their community GP regarding any health concerns and any medication. They also had a named recovery coach, whose primary role was to take ownership of the relationships with those involved in the clients care, including the referring agency and community care co-ordinators if it was a statutory referral.

As well as the daily hand overs the team had monthly meetings where they discussed the service as a whole. We reviewed team meeting minutes and whilst, there was no set proforma for the agenda, the meetings covered areas such as risk, audits, developments, training, access and discharge.

Good practice in applying the MCA (if people currently using the service have capacity, do staff know what to do if the situation changes?)

Mental Capacity Act and Deprivation of Liberty Safeguards were part of the services mandatory training modules. All staff had completed both modules.

There were no clients subject to Deprivation of Liberty Safeguards. Although clients were not allowed to leave the premises as part of their treatment, they could leave the service if they wished as they were assessed as having capacity to make decisions, even if it was an unwise one. Clients were made aware if they left the premises it would be considered as self-discharge.

Care records we observed and treatment agreements showed that clients had signed and consented to treatment, sharing of information and confidentiality agreements. Discussions with clients demonstrated that they were all aware of, and agreed with, their treatment and care.

Examples were given where clients did not have capacity to consent to treatment, for example on admission due to intoxication, and the service had waited to complete the admission assessment until the client had regained capacity to make their treatment decisions.

Equality and human rights

Substance misuse/detoxification

The protected characteristics of the Equality Act 2010 requires services to ensure people using or working at the service are not treated unfairly. The characteristics include, gender, sexuality, race, religion and disability.

The service conducted an equality impact assessment in June 2017 on its policies and procedures. This assessed whether the service was able to meet the needs of all the people who used it. Some examples provided by the service on how it could meet the needs of the people who used it based on the protected characteristics included having accessibility for people with disabilities or mobility issues, and providing nutrition appropriate to clients religious or cultural beliefs.

A blanket restriction the service had was to search clients' belongings during admission. This was a non- invasive search and the clients were made aware of this prior to the admission. The service conducted this search so that no illicit substances could be brought into the service which would jeopardise the detoxification treatment of other clients.

Management of transition arrangements, referral and discharge

The target for all statutory referrals was 14 days from referral to an admission. The service met this target. Private referrals generally took less time from the point of referral to admission as this was based on how quickly the service could get the relevant information from the GP.

Clients were aware of their length of stay prior to admission and this was reflected within their care planning. Clients could extend their treatment, however, this was based upon individual need, funding, and availability.

Clients had a structured discharge out of the service. As many of the clients were private paying, the service offered a graduation pack which included all the relevant information pertaining to the locality of the client, including mutual aid groups, recovery teams, mental health services and other voluntary organisations. Statutory clients were discharged back to the local community team they arrived from with a formal handover to the clients care coordinator.

All clients had the opportunity to return to the service for additional support or advice after their treatment. The operations director told us they were in the process of recruiting a new member of staff who would be responsible to set up an improved aftercare system. They were planning to set up a social media platform so clients could keep in contact with the service for further care. It also offered the opportunity for continuous peer support and networking.

All client care records had a detailed plan if the client left treatment early, including who should be contacted and the address they would return to. Harm minimisation information and mutual aid meetings information were also given on discharge.

Are substance misuse/detoxification services caring?

Kindness, dignity, respect and support

All the clients we spoke with were overall very positive about their care and treatment at Oasis Recovery Bradford. They told us staff treated them with kindness and compassion. They felt staff were empathetic, understood their needs and were non- judgemental. Three clients identified staff as being knowledgeable and all the clients we spoke with told us they felt safe.

We observed staff to be friendly and found they interacted with clients well. They understood their clients' individual support needs, which was demonstrated during the daily handovers and group work. If a client needed additional one to one on the day they could request it and the service provided this support.

Staff and clients were aware of the need to respect people's privacy and showed a great awareness of the need for confidentiality, particularly in groups where personal information might be shared as part of the therapeutic process. A confidentiality agreement was observed in the treatment contract, and was discussed in the pre-admission assessment.

Three clients told us they would like to see more regular community activities such as community walks being made available to them. They felt this supported their recovery and treatment.

The involvement of clients in the care they receive

Clients were fully informed through a clear admission process, which included a pre-admission assessment, a full admissions assessment and a full orientation to the

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service. This enabled clients to understand the ethos and restrictions of the service. The admission handbook was in all client bedrooms throughout their stay, and was available on line prior to admission.

Each client was allocated a named worker who was responsible for working with the client through their treatment journey, including completing the care plan and one to one therapeutic interventions for continuity. All clients had current, signed care plans and agreed discharge plans should they leave the service unexpectedly.

All clients completed an exit survey upon their discharge from Oasis Bradford. The survey enabled management to evaluate the experiences of clients to drive improvement throughout the service. We reviewed the combined exit survey outcomes, between 1 October 2016 and 31 August 2017, which included:

- Seventy one per cent of clients felt their treatment was 'very good', and 22% felt it was 'good'.
- Seventy nine per cent of clients felt they were 'very involved' in their care and treatment, and 17% felt as though they were 'involved'. Only 1% of clients felt that they were "not very involved", and no clients said they were "not involved" in their care and treatment.
- Ninety seven percent of clients said they 'always' gave consent for their care and treatment, with 2% saying they 'often' gave consent.
- Eighty five percent of clients felt their needs were 'always met' within their care plan, 95% of clients said they were 'always' treated safely, and 91% felt they were 'always' treated with respect.

The figures for the exit survey demonstrated positive results across all the questions that were asked of clients. Clients could provide informal feedback throughout their stay, this was captured in one to ones and community group meetings.

We found the service worked closely with family and carers and involved them in the care and treatment of clients. During handovers staff discussed any family issues which may impact on clients' wellbeing, as well as which carers wanted updating and which carers were coming to visit.

Are substance misuse/detoxification services responsive to people's needs?

(for example, to feedback?)

Access and discharge

At the time of the inspection there were 14 clients receiving care and treatment. The service could take up to 17 clients at any one time. The service had clear admission criteria, which included the client having a willingness to engage in the service and to agree to the treatment contract. It also ensured they were not detained under a section of the Mental Health Act, and they had a detailed discharge and aftercare plan in place.

The average length of stay for client detoxing from alcohol and drugs ranged between 10 to 20 days. There was a maximum of a 28 day treatment package available for clients which included therapeutic work. The length of stay could be changed during the treatment should the needs of the client change.

The service took both statutory and private (self) referrals into the service. The majority of referrals were private clients which accounted for 80% of the clients during the time of the inspection. Over the last 12 months, private clients accounted for 66% and statutory clients were 34% of referrals into the service. The service manager told us since the new provider had taken over the service there had been a significant increase in private clients. We found referrals for the service came from a number of areas which included, North Yorkshire, Manchester, Lincolnshire and Blackpool. The service target to take on statutory clients was within 14 days. They met this target in all circumstances unless there was a delay receiving the referral information. Private clients could receive treatment as soon as the essential information was received from their GP.

The service could admit clients seven days a week, however, weekend admissions were planned and the service increased their staff to appropriate levels should there be a weekend admission. In the last six months there were 31 weekend admissions.

We reviewed the discharge data for the last three months and found :

- In May 2017 there were 47 admissions with three non-completions. This meant the service had a 94% successful completion rate.

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- In June 2017 there were 34 admissions with eight non-completions. This mean the service had a 77% successful completion rate.
- In July 2017 there were 50 admissions with five non-completions. This meant the service had a 90% successful completion rate.

Where there service identified 'non-completions', this meant clients did not always fully complete their treatment due to self discharge, breach of contract, or completing their medical part of their treatment early but not remaining for the psychosocial element of it. Figures over the last 12 months demonstrated the service had an average 92% successful treatment completion rate. All clients were offered additional support if they left their treatment early. This included a transfer to another treatment facility, an appointment made with their GP, information and/or referral to mutual aid groups, telephone support and onward referral back to the community referring service (statutory clients).

The facilities promote recovery, comfort, dignity and confidentiality

Oasis Recovery Bradford had an accessible clinic room, including a couch and space to examine clients. It also had a full range of rooms to support clients' treatment and care. This included rooms available for one to one appointments, a lounge for group activities, a family room, a dining room including facilities to allow clients to get involved in community chores like washing up, laundry rooms for clients and staff, and a whirl-pool bath to help clients relax and alleviate some of the discomfort that clients can experience during detoxification.

Confidentiality, policies and procedures were discussed with clients on admission and in the weekly community groups. Clients had a large outside space for clients to have access to. This provided an area for clients who wished to smoke to do so. One client told us that this may have a negative impact for clients who do not smoke and the service should provide an alternative space or more outdoor walks. The exit survey results over the last 12 months demonstrated 40% of the clients rated the accommodation as 'very good' and 38% rating it as 'good'.

Clients had access to snacks, and drinks 24 hours a day, and had a chef to cook lunch and dinner. Eighty five percent of clients rated the food as 'always being sufficient' with only 3% rating the food as 'rarely sufficient'.

All client bedrooms had TVs as well as the two lounges. Clients had access to board games and afternoon activities. Two clients told us they felt there could be more community based activities during the afternoons and evenings. At the time of the inspection the service had afternoon walks scheduled in. The service manager told is it was difficult to facilitate more frequent community activities due to clients being at different stages of their detoxification and having different risks. We found clients were able to create their own groups and activities, we found one example of a spa evening that had been set up by the clients.

Clients could personalise their bedrooms, we saw examples where clients had put memorable pictures around their room.

Meeting the needs of all clients

The service had accessibility for people with mobility issues or disabilities. There was lift access to the first floor bedrooms. They also had adapted bedrooms which included modified wash facilities and pull cord alarms.

Information leaflets were widely available throughout the service. Information was available in easy read. Leaflets in languages other than English could be accessed if required. Leaflets included how to make complaints, local community services, information about the service, clients' rights and activities that were happening within the service

The service was able to provide food according to clients' cultural and religious needs. The service manager told us they could cook food that was Halal, Kosher, vegan, or they could adapt the menu to meet a client's needs. Any dietary needs were established at the pre-admission assessment.

Clients also had access to spiritual and religious observations. We saw an example of the service inviting a priest to visit a client who wanted some spiritual support.

Listening to and learning from concerns and complaints

The service had a complaints policy which outlined their responsibility in responding to complaints. Information on how to complain was in the client treatment contract and the admission handbook which all clients had a copy of. Complaints information was accessible throughout the service and the clients we spoke with told us they felt comfortable to make a complaint should they need to.

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Clients told us they would discuss issues informally with staff before proceeding to make a formal complaint. Complaints were also collated through the client exit surveys and on a daily basis through the client daily diaries.

In the last 12 months there were six formal complaints made to the service, none of which were upheld. We reviewed three complaints and found all three were investigated and responded to within 28 days and led by the operations director. All three complainants received a written outcome including the evidence for and against their concerns. All complaints also had an apology from the service that the client felt the need to make a formal complaint.

Are substance misuse/detoxification services well-led?

Vision and values

The registered manager told us the visions and values of the service had been adopted from the previous provider and agreed by staff and the board. Oasis Recovery's mission statement was to provide high quality, outcome focused drug and alcohol addiction recovery services nationwide. Their vision was, every person and family suffering from drug and alcohol addiction has a free choice to fully recover from their addiction and achieve their potential.

The core values comprised:

- We act with integrity and show respect
- We are all accountable
- We are passionate about our business, our service and our clients
- We have humility and hunger to learn
- We love success
- We strive for simplicity.

Although staff could not tell us about the core values, they were able to demonstrate it with the passion they spoke about the service and through their interactions with clients. Staff were aware of senior management within the service and their roles. Staff felt senior management were visible and approachable.

Good governance

The senior management team for Oasis Recovery Bradford comprised the service manager, lead nurse, director of quality, operations director and lead clinician. The hospital had an embedded governance structure with a number of routine meetings, which allowed senior managers to have oversight of quality and key performance indicators. The clinical governance meetings were held bi-monthly and were well attended by all of the senior management team. We reviewed meeting minutes for quarter one and two of 2017 and found that during the meeting the service were reviewing key performance indicators, audit outcomes, incidents and governance changes within the organisation. The senior management team had access to an electronic dashboard, which provided live figures from the exit surveys completed by clients leaving the service. The team reviewed the data to drive improvement and changes within the service. An example of this is the service installed televisions in all client rooms, as it was identified though feedback that clients wanted to improve their comfort whilst having their treatment.

Staff attended monthly team meetings as well as daily hand over meetings. The team meeting did not have a set agenda, however, we saw the team discussed, audits, exit and entry into the service, training and supervisions. Items from the team meeting could be fed into the clinical governance meetings. Although the team meeting minutes did not learning from incident embedded as part of their team meeting, we found examples of staff taking actions as a result of an incident happening.

We reviewed policies in relation to the running of the service, including the adult and child safeguarding policy, managing incidents policy, duty of candour policy and whistleblowing policy. We found all polices had been reviewed by the service within the last 12 months and were due for their next review in October 2019.

The whistleblowing policy provided staff with a clear escalation process, and the opportunity to raise any concerns internally. It also provided staff with details to address concerns externally if they felt unable to raise concerns internally. The policy encouraged staff to raise any concerns or issues to ensure the safe running of the service. The duty of candour policy made clear how the service would be transparent, honest and communicate any failings towards clients.

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Oasis Recovery ensured that clients' views were sought via entry and exit questionnaires in order to improve their service delivery and the experience of the clients during their treatment.

There were local governance arrangements in place to ensure good quality care, including quarterly quality audits. All mandatory training was up to date and matched the current job descriptions of staff. The service manager monitored compliance with mandatory training and used a system which flagged up any staff which were due undertake training again. At the time of the inspection, the service had an overall compliance rate of over 90%. Staff had regular management and clinical supervision and documents. All staff had received an appraisal within the last 12 months and staff that had been employed for less than 12 months had their appraisal scheduled in.

The service had a risk register that had been reviewed in February 2017. The highest risk was admitting clients with challenging behaviour. Actions to mitigate this risk were for staff to complete relevant training during induction and not to lone work with clients who were presenting as challenging.

Leadership, morale and staff engagement

Staff felt confident in being able to approach the registered manager with concerns without fear of victimisation and were aware of the whistleblowing policy.

Sickness levels were low (below 5%) and there were no vacancies at the time of the inspection. The service had newly recruited two members of staff to work a 4pm until 12am shift. These staff were undergoing their induction at the time of the inspection. This shift was created as the service felt there was a need to have extra staff on site at that time for therapeutic purposes.

All staff we spoke with were highly motivated and spoke positively about their work at the service. They said that morale was good, despite the potentially stressful environment they worked in. They told us that all members of the multi-disciplinary team listened to each other and valued each other's opinion. We observed a handover where this was demonstrated, all staff present had a chance to share their views and everyone within the meeting made positive contributions.

Commitment to quality improvement and innovation

The service was in the process of implementing new ways of working to improve the service delivery. The service were moving to an electronic system to store client care and treatment records. This system was designed specifically for substance misuse services such as Oasis Recovery Bradford. Management told us it would help streamline the record keeping, reduce duplication and improve the quality of documentation.

The operations director told us the provider had newly recruited someone to set up an online platform for all clients accessing the service across the country. This platform would enable more structured aftercare service remotely via the internet. It meant clients could have face time support from the service they received care from even if they lived out of area. It also enabled a peer network platform so clients could support each other through their recovery journey. The operations director felt this service would be in place and embedded at the beginning of 2018.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure all ligature points within the premises clients have access to are identified within the ligature risk assessment. All ligatures and health and safety risks should be safely mitigated or eliminated.