Verve Health Limited

Verve Health

Inspection report

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Date of inspection visit: 12 December 2022
Date of publication: 25/04/2023

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inadequate
Are services safe?	**Inadequate**
Are services effective?	**Requires Improvement**
Are services well-led?	**Inspected but not rated**

Summary of findings

Overall summary

Verve Health is a residential substance misuse service in Norfolk that provides detoxification and rehabilitation treatment for people using drugs or alcohol.

This was our third inspection of the service. This inspection was an unannounced, focused inspection to review key areas of risk relating to client safety, incident management and safe staffing.

At our inspection in July and August 2022, we found breaches under Regulation 9 Person-centred care, Regulation 11 Need for consent, Regulation 12 Safe care and treatment, Regulation 17 Good governance and Regulation 18 Staffing.

During this follow up inspection, we found some improvements had been made. However, we found continued breaches under Regulation 9 Person-centred care, Regulation 11 Need for consent, Regulation 12 Safe care and treatment, Regulation 17 Good governance and Regulation 18 Staffing. Following this inspection, we issued a Notice of Decision to cancel the providers registration.

We did not look at all key lines of enquiry during this inspection. However, the information we gathered provided enough information to make judgements and rate the quality of care.

We have reported and rated in the following domains:

- Safe
- Effective

We have reported in the well-led domain but have not rated in this domain as we did not cover all the key lines of enquiry.

We found the following areas of concern:

- Staff were not working with clients to create individualised care plans. Care plans did not always reflect the needs of clients and were not always personalised, holistic or recovery oriented.
- Staff did not manage risks to people who use the services. Risk assessments continued to not accurately identify risks that had been raised during initial assessment and were not always updated following incidents. Risk management plans did not reflect risks identified within the risk assessments or the initial assessments.
- Staff continued to not have received all basic training for their roles, meaning we could not be assured they were safely carrying out their roles. Overall, 56% of staff had not completed training in substance misuse and did not have basic skills to deliver a safe substance misuse service.
- Managers continued to not support staff with appraisals or supervision, meaning staff performance was not being monitored.
- Managers continued to not provide an induction for all new staff.
- Managers continued to not hold regular full staff team meetings to ensure key information was shared.

However:

- Governance processes had been implemented but were not yet fully embedded within the service.
- Safeguarding training levels had improved, and the service now had a safeguarding lead in place.

Summary of findings

Staff regularly reviewed the effects of medications on each client's mental and physical health. The medical team undertook physical health checks before initiating a treatment and detoxification plan. GP summaries were present in all files.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Residential substance misuse services	Inadequate 	

Summary of findings

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Summary of this inspection

Background to Verve Health

This was an unannounced focused inspection, undertaken due to concerns raised about the safety of clients, the quality of risk assessments, the quality and outcome of investigations and the overall management of governance systems. We did not look at all key lines of enquiry during this inspection. However, the information we gathered provided enough information to make a judgement about the quality of care. We have reported and rated in the following domains:

- Safe
- Effective

We have reported in the well-led domain but have not rated in this domain as we did not cover all the key lines of enquiry.

Verve Health is a residential substance misuse service in Norfolk that provides detoxification and rehabilitation treatment for people using drugs or alcohol. The service has been registered with the Care Quality Commission since June 2021 to provide accommodation for persons who require treatment for substance misuse.

The service does not currently have a registered manager in post. A manager is currently working at the service and has submitted their registered manager application. The last registered manager deregistered in May 2022.

During our previous inspection of Verve Health, we said the provider had not made the necessary improvements required since being inspected in May 2021 to ensure clients were kept safe from harm and we found continued breaches under Regulations 12 Safe care and treatment, Regulation 18 Staffing, Regulation 17 Good governance, Regulation 9 Person-centred care and Regulation 11 Need for consent. Following this inspection, we issued a Notice of Proposal in August 2022 to cancel the providers registration as a service provider.

During this inspection we found some improvements had been made. However, we found continued breaches under Regulation 9 Person-centred care, Regulation 12 Safe care and treatment, Regulation 17 Good governance and Regulation 18 Staffing.

Following this inspection, we issued the provider a Notice of Decision to cancel the providers registration.

What people who use the service say

We did not speak with clients during this inspection. This was a focused inspection to review specific concerns.

How we carried out this inspection

Two inspectors and one inspection manager conducted this inspection; all of whom had a background in substance misuse.

During the inspection, our inspection team undertook the following activities:

- reviewed staff personnel files;
- reviewed six clients care records looking at incidents, risk assessments and risk management plans;

Summary of this inspection

- looked at medicine's management.

We also reviewed a range of information including:

- policies and procedures;
- minutes of meetings and handovers;
- client documentation including daily clinical notes, risk assessments and risk management plans, and physical healthcare documentation, and;
- data held by the management team and the Care Quality Commission.

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.

Areas for improvement

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 that all staff have the necessary skills and competencies to meet the needs of clients and are up to date with all aspects of their mandatory training. (Regulation 18)
- The service must ensure that client records contain all relevant information in order to safely support each client and manage risk. (Regulation 12)
- The service must ensure that clients risk assessments and risk management plans are kept updated and are personalised to each individual client. (Regulation 12)
- The service must ensure that observation records indicate the level of observation and reasoning for levels of observation. (Regulation 12)
- the service must have a clear process for staff to follow in case or medical or clinical emergencies. (Regulation 12)
- The service must ensure that care plans meet client's individual needs and preferences and are personalised, holistic and recovery oriented. (Regulation 9)
- The service must ensure staff have access to regular supervision, appraisal and team meetings in line with the providers policy. (Regulation 18)
- The service must have an adequate induction programme that prepares staff for their role. (Regulation 18)
- The service must ensure that recruitment processes are robust and meet the service policy. (Regulation 19)
- The service must ensure it has effective and embedded risk identification and management processes (Regulation 17)
- The service must ensure it monitors clinical outcomes and the effectiveness of the service (Regulation 17)
- The service must ensure it completes audits of the effectiveness of the service, which assess, monitor and improve the quality and safety of the service (regulation 17)
- The provider must ensure it has a risk register in place, which is updated and reviewed regularly (Regulation 17)

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Residential substance misuse services	Inadequate	Requires Improvement	Not inspected	Not inspected	Inspected but not rated	Inadequate
Overall	Inadequate	Requires Improvement	Not inspected	Not inspected	Inspected but not rated	Inadequate

Inadequate

Residential substance misuse services

Safe	Inadequate
Effective	Requires Improvement
Well-led	Inspected but not rated

Is the service safe?

Inadequate

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

Safe staffing

The service had enough staff. However, not all staff received basic training to keep clients safe from avoidable harm.

Nursing staff

The service had enough nursing and support staff to keep clients safe.

The service had reducing vacancy rates, which had improved since our last inspection. They had recently successfully recruited to vacant positions. At the time of inspection, there was one vacancy.

Mandatory training

The provider continued to fail at ensuring staff were adequately trained. The mandatory training programme did not meet the needs of clients and staff. We found gaps in the skills and competencies of staff. The provider showed us their internal training log, which included 60 mandatory training modules. Overall, 16% had completed risk assessment awareness and 61% of staff had completed medication administration training, 50% of staff had completed basic life support training, less than 1% of staff had completed immediate life support training and no staff had completed training on managing the risk of seizures.

Overall, 44% of staff had completed substance misuse training. This meant staff did not have a full understanding of how to treat clients with complex drug and alcohol needs and could not treat them safely. The provider had arranged for further substance misuse training to be delivered to all remaining staff in February 2023.

Assessing and managing risk to clients and staff

Staff did not assess and manage risks to clients and themselves well, safety planning was not an integral part of recovery plans.

Assessment of client risk

Inadequate

Residential substance misuse services

Staff did not review risks to people who use the service. Staff completed risk assessments for each client on admission. However, they were not reviewed regularly, including after incidents. We looked at risk assessments for 6 clients and found that 3 of the risk assessments did not contain accurate information about the known risks of clients from their admission assessment, and 1 risk assessment had been reviewed, but not updated following an incident to reflect the client's current risks.

Management of client risk

Opportunities to prevent or minimise harm were missed. Staff did not respond promptly to changes in client's physical health. We saw 2 examples within handover documents where clients had appeared unstable when walking and staff had not acted without delay to ensure they were seen by a medical professional. We saw no record that these issues had been followed up with clinical staff.

Staff had continued to not support clients with harm reduction advice. Harm reduction advice was not evident in any of the 6 client files, meaning that clients would not have been made aware about the harm of using substances on discharge. Client files did not contain plans for unexpected exit from treatment or crisis plans. Since the inspection took place, the provider told us they have developed unexpected exit from discharge plans, crisis plans and a discharge information pack, which included harm minimisation information. However, these had not yet been implemented.

Risk management plans did not reflect risks identified within the risk assessments or the initial assessments.

We were not assured that the correct levels of observation were being used for clients. Observation records did not indicate the level of observations required or the reason for the client being observed. Details showing levels of observation, reasons for observation and date of next review were missing from the observation form and the client's case notes. It was not clear if observation records should have been stored in the clients clinical or therapy treatment file. Observation levels were not discussed at handovers. This meant the client may have been observed more or less frequently than required.

Safeguarding

Most staff understood how to protect clients from abuse. However, not all staff had training on how to recognise and report abuse.

The service had a safeguarding lead in place, who had received appropriate training.

Overall, 76% of staff had completed safeguarding adults Level 2 training and 82% of staff had received Level 2 training in safeguarding children.

Staff access to essential information

Staff records of clients care, and treatment were disjointed. Records were not clear, up-to-date or easily available to all staff providing care.

Client notes were in paper form and records for each client were in two separated files for clinical and therapy treatment. The provider told us they had changed this following our inspection and all information was now stored in one central file.

Inadequate

Residential substance misuse services

At the time of the inspection, the provider was in the process of changing to an electronic recording system for all client information.

Medicines management

Staff regularly reviewed the effects of medicines on each client's mental and physical health. Staff assessed all clients on a detox using the clinical institute withdrawal assessment of alcohol scale (CIWAar) or the clinical opiate withdrawal scale (COWS).

We saw 4 occasions where recovery assistants or therapists had administered medication to clients when they had not had their medicines administration training competencies signed off and 1 occasion where the staff member's competencies were overdue. Clinical staff followed systems and processes to prescribe and administer medicines safely.

The clinical team undertook physical health checks including blood pressure checks, breathalysing, and urine drug screening before initiating a treatment and detoxification plan.

GP summaries were present in all files, which included recent blood test results.

Reporting incidents and learning from when things go wrong

The service managed client safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents.

The service had an improving track record on safety. Between 2 November and 12 December 2022, the provider reported 16 incidents internally. The provider had created an incident log, which was in use at the time of inspection which detailed action taken and required sign off by a manager.

Staff knew what incidents to report and how to report them. The provider had recently updated their incident reporting policy and process.

Staff raised concerns and reported incidents and near misses in line with the provider's policy.

There was little evidence of learning from events or action taken to improve safety. Managers investigated incidents thoroughly. However, staff did not always receive feedback from investigation of incidents, both internal and external to the service. Staff had not had regular team meetings to discuss feedback from incidents. Dates had been set for all 2023 team meetings and we saw evidence that some incidents had been discussed during daily handovers.

Is the service effective?

Requires Improvement

Our rating of effective improved. We rated it as requires improvement.

Assessment of needs and planning of care

Inadequate

Residential substance misuse services

Staff completed comprehensive assessments with clients on admission to the service. However, they did not work with clients to develop individual care plans or update them as needed. Care plans did not reflect the assessed needs, and were not personalised, holistic or recovery-oriented.

Staff completed a comprehensive assessment of each client prior to agreeing admission, which was then updated with the client on admission.

Staff requested client health summaries from their home GP prior to admission and ensured blood tests such as liver function tests were completed prior to starting detoxification. Clients had physical observations completed on admission and regularly thereafter by the nurse. This had improved since our last inspection.

Staff continued to not develop a comprehensive care plan for each client that met their mental and physical health needs. Care plans were present in all 6 files reviewed. However, they were not personalised, recovery orientated, holistic and did not identify strength areas for each client. For example, there was no section for the clients to add to their care plan goals. Care plan goals were impersonal and only included goals such as completing treatment or attending mutual aid groups. Staff did not regularly review or update care plans when clients' needs changed.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the client group. They ensured that clients had access to physical healthcare. Staff used recognised rating scales to assess and record severity and outcomes.

Staff provided a range of care and treatment suitable for the clients in the service. The service offered daily activities and therapies such as structured group work, art therapy, goals workshops, 12 step work and access to mutual aid groups.

Staff identified clients' physical health needs, although these were not clearly recorded in their care plans.

Staff helped clients live healthier lives by supporting them to take part in programmes or giving advice. Clients were supported to have access to yoga sessions and mutual aid groups.

Staff used recognised rating scales to assess and record the severity of clients' conditions and care and treatment outcomes. Staff assessed all clients on a detox using the clinical institute withdrawal assessment of alcohol scale (CIWAar) or the clinical opiate withdrawal scale (COWS). However, due to staff not having substance misuse training, we could not be assured on the accuracy of these documents.

The service did not have a programme of audit to review the effectiveness of the service, and so staff could not participate in clinical audit, benchmarking, and quality improvement initiatives. The service was not following up with clients upon discharge to see if they were substance free. The provider told us an audit programme was implemented following this inspection.

Skilled staff to deliver care

Inadequate

Residential substance misuse services

The teams included or had access to the full range of specialists required to meet the needs of clients under their care. However, the majority of staff did not have the right skills and did not know how to use the tools to keep people safe. Managers did not support staff with appraisals, supervision, or an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the clients.

Managers did not give each new member of staff a full induction to the service before they started work. The provider's training matrix showed that no staff had completed the provider's induction. The provider told us following inspection that a new induction assessment had been created which would be mandatory for all new staff.

Managers continued to not support staff through regular, constructive appraisals of their work. However, most staff had not been employed for one year so were not yet due an appraisal. We did not see any records of appraisals or conversations with staff around development in the staff personnel files.

Managers continued to not support staff through regular, constructive supervision of their work. Staff delivering therapy were being clinically supervised through an external supervisor. However, all other staff had not been provided with regular supervision from their line manager. We saw in staff files that supervision did not take place regularly. Out of the 4 staff files we reviewed, 2 staff had no supervision located within their personnel files and 2 staff members supervision was overdue.

Managers had not ensured staff attended regular team meetings or gave information from those they could not attend. We reviewed team meeting minutes for December 2022, but no staff meetings had taken place in October or November 2022. Following inspection, the provider supplied dates for team meetings they planned to hold for the 6 months post inspection.

Multi-disciplinary and interagency teamwork

Staff from different disciplines were not working together to benefit clients. Regular multi-disciplinary team meetings were not being held. The team were developing working relationships with other relevant services outside the organisation.

Staff were still not holding regular multidisciplinary meetings to discuss clients and improve their care. Daily handovers were taking place where discussions around clients were taking place.

Staff were beginning to develop relationships with other relevant services outside the organisation, for example, mutual aid and the local safeguarding authority.

Good practice in applying the Mental Capacity Act

Staff supported clients to make decisions on their care for themselves. They assessed and recorded capacity clearly for clients in most, but not all files we reviewed.

Client's capacity to consent to treatment was discussed during the admission process. We reviewed 6 client files, 1 client file we reviewed did not have the provider's capacity assessment located within it.

Inadequate

Residential substance misuse services

Overall, 68% of staff had completed training in the Mental Capacity Act. This had not improved since our previous inspection.

Is the service well-led?

Inspected but not rated

Inspected but not rated.

Leadership

The service did not have a stable leadership team. Leaders did not have the relevant experience to perform their roles.

The service had appointed several managers over the previous year with none remaining in post for a sustained period of time. The service did not currently have a registered manager in post. a new manager in had been appointed who was applying for this role who told us they had relevant experience and knowledge of managing services.

Culture

Staff did not have access to regular supervision, appraisal or team meetings.

Managers continued to not support staff through regular supervision or appraisals, therefore we were not assured that staff were appropriately supported.

Poor performance was being managed effectively. We saw incidents involving staff behaviour that were raised immediately with the staff involved.

Due to our findings in other key questions, we were not assured that there was a culture of learning and improvement at the service and staff were not involved in discussions relating to implementing lessons learned from concerns or incidents that occurred.

Governance

Our findings from the other key questions demonstrated that governance processes did not operate effectively at team level.

Managers had introduced a new senior management team meeting and Heads of Department meeting, which had a set agenda. The provider held their first senior manager team meeting in November 2022, which included discussion around any incidents, actions to be taken forward and the staff member responsible to take forward those actions. However, as these meetings had not been fully embedded, we could not be assured they were effective at making improvements to the service.

The service did not have an effective audit system in place. Clinical audits, client file audits and staff file audits were taking place. However, there was no discussion or follow up from the outcomes of these audits. The provider developed a compliance and audit policy in November 2022, but this had not yet been implemented.

Senior managers did not follow the service's recruitment policy. We looked at 7 staff personnel files. We found 4 staff only had 1 reference located within their file, whereas the provider's policy was to gain 2 employment references. Files had been audited but the actions identified in the audits had not been carried out. We also found 3 staff start dates were not located within their file so we could not be assured they had Disclosure and Barring Service clearance prior to starting their roles.

Our findings from the other key questions demonstrated that governance processes were not operated effectively, and that performance and risk were not managed well. The provider did not have systems and processes in place to manage risks to both staff and clients. The service was not holding regular staff team meetings. The new manager and operations director had made steps to improve governance processes and procedures. However, these were not yet embedded.

We remain concerned that the service had not addressed, or mitigated concerns found during our previous inspections as our findings from the other key questions have highlighted.

Management of risk, issues and performance

Teams did not always have access to the information they needed to provide safe and effective care.

Managers reviewed incidents and complaints as they occurred. However, further improvements were required to identify and share learning from incidents and complaints as regular team meetings to discuss feedback were not taking place. We saw evidence that some incidents were discussed during daily handovers.

We found significant failures in performance management and audit systems and processes. The service did not have a risk register in place. The provider had introduced an 'improvement plan', following our previous inspections. This was discussed at the senior manager team meeting.

Information management

Staff did not collect and analyse data about outcomes and performance and have not engaged actively in local and national quality improvement activities.

The service did not collect data or measure outcomes and performance. Following inspection, the provider told us they had created a discharge survey to complete with all clients. This meant we could not be assured about the effectiveness or success rate of the service.

The provider was not collecting information about early discharges from the service.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service must ensure it monitors clinical outcomes and the effectiveness of the service

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service must ensure it completes audits of the effectiveness of the service, which assess, monitor and improve the quality and safety of the service.

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider must ensure it has a risk register in place, which is updated and reviewed regularly.

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 18 HSCA (RA) Regulations 2014 Staffing The service must ensure that all staff have the necessary skills and competencies to meet the needs of clients and are up to date with all aspects of their mandatory training

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service must ensure that client records contain all relevant information in order to safely support each client and manage risk.

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service must ensure that clients risk assessments and risk management plans are kept updated and are personalised to each individual client.

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Accommodation for persons who require treatment for substance misuse	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service must ensure that observation records indicate the level of observation and reasoning for levels of observation.

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service must have a clear process for staff to follow in case or medical or clinical emergencies.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Accommodation for persons who require treatment for substance misuse	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The service must ensure that care plans meet client's individual needs and preferences and are personalised, holistic and recovery oriented.

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 18 HSCA (RA) Regulations 2014 Staffing The service must ensure staff have access to regular supervision, appraisal and team meetings in line with the providers policy.

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 18 HSCA (RA) Regulations 2014 Staffing The service must have an adequate induction programme that prepares staff for their role.

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The service must ensure that recruitment processes are robust and meet the service policy.

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service must ensure it has effective and embedded risk identification and management processes