Aspinden Wood Centre

Quality Report

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

Ratings

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.

This was an unannounced inspection to follow up on whether the provider had made the required

Summary of findings

improvements identified during our previous inspections, including the requirements set out in the warning notices served following our inspections in June and October 2017

Following our inspection in June 2017 the provider agreed voluntarily to suspend admission to new clients until improvements had been made.

The warning notice served following the October 2017 inspection required the provider to make improvements to the environment by 19 February 2018.

As the issues had previously been so wide ranging, at this inspection we looked at all our key questions; is the service safe, effective, caring, responsive and well-led.

At this inspection, we found that the provider had made a number of significant improvements and had addressed all the issues identified in the warning notices from the inspections in June and October 2017.

Whilst the provider was on a journey to improvement new systems and processes to ensure the safety and quality of services was not fully embedded and further work was required. In addition, we identified a new concern about the lack of robust pre-employment checks for new staff. We found the following areas that the provider needs to improve:

- Governance systems were not fully embedded; as a result, the provider could not assure itself that it was delivering a good quality service. The provider was not following all of the new systems and processes it had developed.
- The new model of service delivery was not yet fully embedded into day-to-day practice and the measurement of outcomes needed further work.
- The provider did not have formal systems in place for staff, clients or carers to give feedback regarding the service.
- Further work was needed to ensure that there was a positive culture of safeguarding within the staff team.
- The provider was not following safe recruitment guidelines. It had not ensured that staff had given a full work history prior to starting employment or that there was a system in place to alert them when disclosure and barring checks were due for renewal. The service needed to ensure that all staff received regular supervision.
- All but two bathrooms and toilets were still in need of urgent refurbishment. Further improvements were needed to ensure that cleaning records were routinely maintained and that communal toilets were regularly checked to ensure they were clean.
- The provider did not provide information to all clients in an accessible format. Several clients had verbal or written communication needs that were not being met.
- The provider had not ensured that discharge plans were in place for all clients who wanted to leave the service or who were not considered suitable to stay.
- Not all incidents of verbal abuse towards staff were being reported.

However, we found the following improvements had been made since our last inspection in October 2017:

- At our last inspection in October 2017, we found that the systems to ensure the cleanliness, hygiene and maintenance of client bedrooms and bathrooms were not effective. The bathrooms were in need of refurbishment. At this inspection, we found cleanliness had improved and two bathrooms had been refurbished.
- New systems had been introduced to ensure the safety and well-being of clients and staff. Staff were monitoring the 'wet room', which was the communal living area where clients were able to smoke and drink. An interim measure was being put in place to ensure that the front door to the service could no longer be opened from the outside without staff being aware of who was entering the building.
- Staff were able to tell us what action they would take if the fridge temperatures fell out of range.
- Risk assessments were updated following changes in client presentation.
- The physical healthcare of clients had improved. There was good communication with the GP and a new GP contract in place.

Summary of findings

- There were systems in place to ensure that learning from incidents was shared with staff.
- The action plan for fire safety had been addressed.
- At our last inspection in October 2017, we found same sex accommodation guidance was not followed; there was no same sex accommodation policy in place. At this inspection, we found a same sex accommodation policy had been developed and the service was considering how they could implement this.
- The service model had improved, it was now clear that the focus of the service was on harm reduction and recovery.
- The system for supporting clients with their finances had been improved. Staff only supported clients with their finances where there had been agreements put in place because clients lacked capacity.
- The service had made many improvements to its safeguarding procedures,
- Medicines management and administration had improved since our last inspection in October 2017. New staff were in the process of completing medication training and competency assessments.

Following the inspection, we agreed that the provider would assess and admit new clients to the service.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Substance misuse services		

Summary of findings

Contents

Summary of this inspection

Background to Aspinden Wood Centre

Aspinden Wood Centre provides accommodation and 24-hour care and support for up to 26 men and women who have long-term alcohol dependence and complex needs including mental ill health, physical health issues or homelessness. The service operates a harm minimisation approach that allows clients to drink agreed amounts of alcohol. The aim is for the service to promote stability, harm reduction and recovery.

At the time of the inspection there were 19 clients using the service. One client was in hospital.

Clients were placed at Aspinden Wood by local authorities and clinical commissioning groups from all over the country.

Aspinden Wood is registered to carry out the regulated activity:

Accommodation for persons who require treatment for substance misuse.

We carried out a comprehensive inspection that also followed up on concerns identified during the previous inspection in October 2017. At the time of the inspection, a new manager was in place, although on annual leave. The new manager was in the process of registering with the Care Quality Commission. The interim acting manager was still at Aspinden Wood for a period of handover.

Our inspection team

The team that inspected the service comprised of a lead CQC inspector, one other CQC inspector and a CQC pharmacist specialist. There were two specialist advisors, a psychiatrist specialising in substance misuse and a nurse specialising in substance misuse. The team also included an expert by experience. An expert by experience is a person who has personal experience of using, or supporting someone using, substance misuse services.

Why we carried out this inspection

This was an unannounced inspection to follow up on whether the provider had made the required improvements identified during our previous inspections. As the issues had previously been so wide ranging, at this inspection we looked at all our key questions; is the service safe, effective, caring, responsive and well-led.

The unannounced focussed inspections in June 2017 and October 2017 identified concerns regarding omissions of care and treatment that put clients at risk of harm. We took enforcement action and issued two warning notices (Regulation 12 safe care and treatment and 17 good governance) following the June 2017 inspection.

In October 2017 we found that the provider had made improvements in its systems and processes since our inspection in June 2017 but we issued a further warning notice (Regulation 15 premises) and told the provider it must ensure that premises were clean and safe by 19 February 2018.

We also told the provider it must take the following actions to improve its services:

- The provider must have a clear service model in place that clearly identifies the recovery and harm reduction models in use at the service.
- The provider must ensure that effective, consistent and robust governance systems are embedded within the service.

Summary of this inspection

- The provider must ensure that there are effective systems in place for the proper and safe administration and management of medication. Staff who administer medicines must be competent to do so.
- The provider must ensure that appropriate measures are in place to ensure the safety and security of clients and staff within the premises.
- The provider must ensure that staff receive mandatory and specialist training so that they can safely manage the needs of clients. The provider must also ensure that staff receive regular supervision.
- The provider must ensure that the physical health care needs of clients are met and that this is documented.
- The provider must ensure that the risk assessments are updated when clients' needs change.
- The provider must ensure that all actions to minimise the risk of fire and to promote client and staff safety in the event of a fire, are completed.
- The provider must ensure that learning from incidents is shared with staff and that all incidents are reported.
- The provider must ensure that all clients have comprehensive care plans in place that address their needs.
- The provider must ensure that the Mental Capacity Act is used appropriately. They must ensure that staff have completed Mental Capacity Act training.
- The provider must ensure that the new manager is appropriately supported to maintain safety and quality of the service. They must ensure that the manager is registered with the CQC.
- The provider must ensure that there is a policy in place regarding same sex accommodation. The provider should ensure that consideration is given to where bedrooms and bathrooms used by female clients are located.
- The provider should ensure that the staff record clearly, when one to one sessions with clients have occurred.

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.

During the inspection visit, the inspection team:

- looked at the quality of the physical environment, and observed how staff were caring for clients
- spoke with six clients
- spoke with the acting manager and the lead nurse
- spoke with the providers quality assurance lead and clinical lead
- spoke with six other staff members employed by the service provider
- spoke with the GP and looked at six GP client records
- spoke to theshiatsu therapist , external reflective practice facilitator and one volunteer
- attended and observed one hand-over meeting and looked at minutes for the team meeting and clients house meeting
- looked at seven care and treatment records, including medicines records, for clients
- looked at policies, procedures and other documents relating to the running of the service.

Summary of this inspection

What people who use the service say

We spoke with six clients about their care and treatment. They told us that they liked living at Aspinden Wood Centre and that staff were kind and supportive. Five clients told us that they felt safe within the service.

Clients told us that staff discussed the risks of continued drinking and smoking with them.

One client told us that they had stopped smoking and had reduced their alcohol intake; however, they would like to reduce their alcohol intake further.

Clients told us that they knew how to complain and felt they would be able to do this. They were given the opportunity to feedback any concerns informally during the house meeting.

We spoke with clients about their medication. Most clients were able to understand why they were taking medication and what its purpose was.

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 that the provider had made improvements; however, the following issues needed further improvement:

- All but two bathrooms and toilets were still in need of urgent refurbishment. Further improvements were needed to ensure that cleaning records were routinely maintained and that communal toilets were regularly checked to ensure they were clean.
- The provider had not improved its systems to monitor who entered the building to ensure the safety of clients and staff, but it was planning to. During this inspection, staff put an interim measure in place.
- The provider had not ensured that new staff had had the required pre-employment checks completed before they started in post. The service did not have a system in place for ensuring that staff or volunteers had an up to date Disclosure and Barring Check in place.
- Further improvements were needed to ensure that new staff were competent in administering medication and that staff were following all areas of the services medication policy.
- We saw that staff were reporting some incidents of verbal aggression however further improvements were needed to ensure that these were reported consistently.
- The provider had completed most tasks on its fire action plan, but they were awaiting further work by the property owner. Two fire marshals were not always present on shift.

However, we also found practice had improved in the following areas since our last inspection in October 2017:

- Since the last inspection, improvement had been made to the environment. Two bathrooms had been refurbished, with plans in place to refurbish the remaining bathrooms. Clients were supported to maintain their bedrooms to an appropriate standard
- The service had had a recruitment campaign and staffing levels had improved.
- The service had improved its risk assessments and risk management plans. Staff updated these following changes in clients' needs.

Summary of this inspection

- Systems were in place to share learning from incidents with staff.
- Observation levels of the 'wet room', which was the communal living area where clients were able to smoke and drink, had been improved.
- The provider had developed a same sex accommodation policy. The service had started to consider how to implement this but had not yet bought about changes.
- Improvements in the management and administration of medication had been made since the last inspection in October 2017

Are services effective?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Since our last inspection in 2017, the service had ensured that improvements had been made in communication with the GP.
- Since our last inspection in October 2017 the service had made further improvements to care plans that detailed how clients preferred to have their personal care needs met. Clients now had comprehensive recovery stars in place that clearly reflected their views.
- Since our last inspection in October 2017, the service had ensured that clients who did not have capacity to manage their finances had capacity assessments in place and that all other clients managed their own finances. Staff who were new to the service had an introduction to the Mental Capacity Act (MCA) in their induction but still needed to complete their mandatory MCA training.
- Staff identified and appropriately managed clients' nutritional and hydration needs.
- A new GP contract and regular physical observations had improved the physical healthcare support for clients.
- Staff held effective handover meetings at the beginning of each shift. Staff were able to attend regular reflective practice sessions to discuss their work.

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

- The service needed to develop further its model of care to define its harm reduction approach and measurement of outcomes against this. The service did not use standard tools, such as the severity of alcohol dependency questionnaire, to provide a clear measurement of clients' needs and progress.

Summary of this inspection

- Revised systems to deliver regular, good quality supervision needed further embedding to ensure it took place as planned.
- Further improvements were needed to ensure that communication took place with all visiting professionals.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Staff showed positive attitudes and behaviours when interacting with clients.
- Clients told us that staff were supportive and caring.
- Clients knew how to complain and felt that they would be able to do so if they wanted to.

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

- Staff did not always ensure that both verbal and written communications with clients were in a format they could understand.

Are services responsive?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Clients were able to make hot drinks and snacks at any time. The service had a full time cook who cooked nutritional food that was suitable for each individual client's needs.
- Clients were encouraged and supported to maintain and re-establish relationships that were important to them.
- Staff supported clients from different cultures, religions and backgrounds.

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

- There were discharge plans in place for clients who were actively seeking to move on, some others had expressed a wish to move but discharge planning was not taking place and it was not clear why.

Are services well-led?

We do not currently rate standalone substance misuse services.

We found the following issues that the service provider needs to improve:

Summary of this inspection

- Since the previous inspections of June and October 2017 the provider had reviewed and made changes to many of its governance systems, however these needed further embedding to ensure that these systems were consistent, effective, robust and part of the daily routine.
- The provider needed to ensure that it was following all of its own policies and procedures. We found that staff were not following all of the medication policy and that guidance in the ligature risk assessment was not being followed.
- The provider was not ensuring that all staff had regular supervision.
- The provider did not have systems in place to be able to gather feedback from clients, carers or staff.
- The provider had not ensured that it had completed the required pre-employment checks prior to new staff starting employment.

However, we also found areas of good practice, including that:

- Since our last inspection in October 2017, the provider had made improvements to its systems to ensure the cleanliness, hygiene and maintenance of clients' bedrooms and bathrooms. However, further improvements were needed to ensure that bathroom cleanliness was monitored regularly and that the remaining bathrooms were refurbished.
- The provider had introduced a robust and varied programme of audits.
- Staff were committed to the clients and to the service. Staff felt that the managers were open and approachable. Staff were positive about the changes that they had seen in the service.
- Since our last inspection, the permanent manager had applied to become the registered manager.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

At the previous inspection in October 2017, we found that half of the staff team had undertaken Mental Capacity Act training. At this inspection, we found there was a large number of new staff, who had started working at the service. These staff were yet to complete Mental Capacity Act training. However, they received an introduction to the Mental Capacity Act during their induction. Staff we spoke to had an understanding of mental capacity.

At the previous inspection in October 2017, we found that staff supported clients to manage their finances. Staff told us that not all clients had capacity to manage their finances; however where there were concerns regarding their capacity, this was not documented. At this inspection, we found that clients all had access to their finances unless they had been assessed as not being able to manage their finances and appropriate arrangements had been made.

The service had three clients who had a Deprivation of Liberty Safeguard (DoLS) authorisation in place. These were in place to support clients who were assessed as not having capacity to decide where to live. Decisions had been made in their best interest that Aspinden Wood was the most appropriate place for them to reside.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

SAFE

Safe and clean environment

Safety of the layout

- At the previous inspection in October 2017, we found that the front entrance to the building was unlocked and people could enter the building without monitoring. At this inspection, we found that this remained an issue. The provider had requested that adjustments were made to the door to ensure that it could not be opened from outside but these had not yet been installed. During this inspection, staff decided that in the interim they would ensure that the catch would be kept down on the door so that it could still be opened easily from inside but other people would not be able to enter without ringing the bell.
- The provider had a communal living area called the 'wet lounge.' Clients were able to drink alcohol in this lounge. At previous inspections, we found that staff were not observing this room regularly. During this inspection, we saw that this had improved. Staff were carrying out general observations of all clients on the premises at hourly intervals. Staff were able to monitor the lounge via closed circuit television (CCTV) which was displayed in the staff office. The provider allocated a staff member at the beginning of each shift to monitor the CCTV. Staff could increase the frequency of observation if necessary. Staff recorded observations on the daily handover sheets. Staff at the service did regular environmental checks, these occurred twice daily; once in the morning and once in the afternoon. Staff discussed any concerns at handover and staff took actions to address them. For example, the environmental check had identified that someone needed clean bed sheets. Staff provided these sheets shortly afterwards.
- The provider had not mitigated risks identified in their ligature risk assessment. This stated that although the risk of suicide for the client group was low there were actions for the service to take. Actions listed included the use of resuscitation equipment, staff awareness and training. However, there was no resuscitation equipment at the service. The service did not have any ligature cutters.
- The service accommodated female and male clients. At the previous inspection in October 2017, we found that the service did not have a policy in place to manage the gender mix. Clients' bedrooms and bathrooms were not separated according to gender. At this inspection, we saw that staff had discussed this issue with clients and had considered how they would address this with new admissions. Staff told us that the present clients did not want to move bedrooms; however, they would cluster female clients' bedrooms together when future clients were admitted. Staff were having discussions with the property owner regarding the possibility of converting some bedrooms to provide ensuite facilities. The service had developed a same sex accommodation policy.
- Staff and clients had access to alarms and call systems. Individual bedrooms had panic alarms and there were alarms in the communal area. In addition, staff had access to two-way radios that they could carry with them to communicate to colleagues in other parts of the building.
- At the previous inspection in October 2017, we saw that the service had made improvements in fire safety, although further work was needed. At this inspection, we saw that the action plan that staff had developed

following a visit from the London Fire Brigade (LFB) in March 2017 had been largely completed. However, the service was still waiting for the property owner to carry out work on some of the fire exit doors to ensure that they met the required standards. The LFB had recommended that a minimum of two fire marshals were on shift at all times. Staff had not ensured that this had been implemented. On seven occasions in February 2018, two fire marshals were not identified on each shift.

- At the previous inspection in October 2017, we found that personal emergency evacuation plans (PEEPs) lacked sufficient detail for clients who had mobility issues. At this inspection, we saw improvement. Appropriate PEEPs were in plan and these had been practised. At the previous inspection we found that one client who was hearing impaired did not have arrangements to alert them to a fire should they be asleep in their bedroom. At this inspection, we found that the provider had liaised with other stakeholders to meet this need, but suitable arrangements were not yet in place. We escalated this at the time of the inspection, the provider advised that they would purchase the required equipment.
- At the previous inspection in October 2017, we found that clients who smoked in their bedrooms and communal areas had an individual smoking risk assessment. However, these assessments were not robust. At this inspection, we found that these had improved and that there were now measures in place to mitigate smoking in the 'wet room' via the monitoring of CCTV. Staff monitored clients who smoked in their bedrooms through observations. Clients who staff had assessed as being at high risk had fire retardant mattresses and bedding.

Maintenance, cleanliness and infection control

- At the previous inspection in October 2017, we found that staff did not always support clients to clean their rooms. At this inspection, we found that this had improved. The service now had systems in place to ensure that staff supported clients to clean their rooms regularly. The service's environmental checks ensured that if rooms were unclean or there was dirty bedlinen, staff picked this up and action was taken. This meant that staff were ensuring that clients' bedrooms were clean.
- At the previous inspection in October 2017, we found that the environment was not well maintained and this made the prevention of infection difficult. At this inspection we saw some improvements had been made, however further improvements were needed. At the previous inspection in October 2017, a bath seat made of fabric was used. Multiple clients used this seat if they needed to bathe. At this inspection, we saw that staff had ordered new easy-clean seats, however these had not arrived. At the previous inspection, we saw that it was difficult to maintain cleanliness in all the communal toilets and bathrooms due to the age of the facilities and worn out flooring. At this inspection we saw that two bathrooms had been refurbished by the property owner, however, the remaining bathrooms and communal toilets were still in urgent need of an upgrade.
- The service employed cleaners who worked every day. Cleaning records were available; however, there were some gaps in recording with no explanation as to why this was.

Safe Staffing

- The service had undergone a staffing restructure and had recruited many new staff that had recently started. At the previous inspection, the service had 12 permanent staff members; at this inspection, the service had 26 permanent members of staff. This included the manager, deputy manager and a full time nurse. There were no current staff vacancies.The service was able to be flexible with its staffing levels according to client need. The service used regular bank and agency staff who knew the clients well.
- The service had an induction programme for new staff; this included a week's training and an induction pack for staff to work through. All new staff were completing their induction training. The new manager and nurse had completed the induction pack. However, staff that started in post after December did not yet have induction packs in place.
- There were enough staff to carry out physical observations of clients. All staff were being trained in how to carry out physical observations such as blood pressure, body mass index and respirations.

Medical staff

Substance misuse services

- During this inspection, we saw that the provider had made improvements in ensuring that the healthcare needs of clients were met.A new contract with the GP service had started from 1 November 2017. This enabled clients to access additional GP services. The GP attended the service weekly to review all the clients, if clients were unwell, the GP would visit more frequently if required.
- Staff could access the GP out of hour's on-call system when the GP surgery was not open.

Mandatory Training

- At the previous inspection in October 2017, we found that the provider had improved its systems to monitor mandatory training, but less than 75% of staff had completed it.
- At this inspection, the provider had further improved its monitoring systems by updating their training matrix. However, the overall rates of completion had not improved due to the cohort of new staff starting. The service had ensured that there was a plan in place for new staff to complete their training
- At the previous inspection in October 2017, the service had not provided training for staff regarding alcohol withdrawal symptoms or epilepsy. At this inspection, we saw improvements. Alcohol withdrawal training and epilepsy awareness training were both mandatory courses. Staff had completed epilepsy training and a training session within a staff meeting regarding alcohol withdrawal following the October 2017 inspection. Alcohol withdrawal training was scheduled to take place during February and March, 84% of staff were due to complete this, this included information regarding seizures relating to alcohol withdrawal. The service was still to identify when epilepsy training would take place for new staff.
- The provider had included pressure sore tissue viability training as part of their mandatory training for all staff. We saw the service was in the process of designing competencies for all staff in the safe management of falls.

Assessing and managing risk to patients and staff

Assessment of patient risk

- At the previous inspection in October 2017, we saw that improvements had been made to the way that risk was assessed and managed, but further work was required to embed this and ensure that risk assessments were always updated following incidents.
- At this inspection, we saw further improvement. We looked at seven care and treatment records and found that each had a risk assessment, which was person-centred and included risk management plans.
- Some clients were wheelchair users or experienced other mobility issues and required support with moving and transferring. Staff had ensured that all clients had a moving and transferring risk assessment and management plan in place.
- Staff had completed risk assessments for all clients who were self-administering medicines such as inhalers and creams; however, it was not clear when staff would review these specific assessments.
- Whilst at the time of this inspection the service was not accepting new admissions, staff had revised the assessment process and documentation. The new assessment format included a risk assessment for staff to complete prior to admission.

Management of patient risk

- Staff were aware of and dealt with specific risk issues. This had improved since our previous inspections in June and October 2017. During this inspection, we saw that arrangements were in place to provide appropriate support to clients with pressures sores. One client had a pressure sore that district nurses regularly dressed. There had been good communication between the district nurses and the GP regarding the management of this. We saw that staff had informed the GP whenanother client had told them that they were experiencing pain on their skin and had some redness in that area. The GP had been able to look at this and prescribe some cream to try to prevent any further deterioration.
- However, we saw examples of the need for further improvement of the monitoring of the environment. We found that sharp knives were in an open drawer in the

kitchen, despite some clients having a history of threatening staff and other clients with knives. Staff removed he knives when this was drawn to the service's attention during the inspection.

- Staff followed good procedures for the observation of clients. Staff observed all clients regularly and staff recorded their observations. The service did not have a search policy in place regarding searching clients' bedrooms or belongings. This meant that it was difficult for staff to know how much alcohol clients were bringing into the building when returning from shopping trips.
- We saw that staff had regularly reviewed risk management plans and had updated these following incidents and changes in risk.

Safeguarding

- Since our previous inspection in October 2017, the provider had made significant improvements in ensuring that clients were safeguarded. Staff were trained in safeguarding, understood their responsibilities and were able to tell us how they would make a safeguarding referral. The service had safeguarding information on display for clients and staff. The service had a spreadsheet to record safeguarding concerns and to track their progress.
- However, the provider still needed to ensure that a positive attitude towards safeguarding was embedded into the culture of the service. Staff saw safeguarding as a negative process and not one that could benefit both clients and the service.
- The provider did not permit children under 18 to visit clients; on request, alternative arrangements would be made to facilitate visits at another location.

Staff access to essential information

- Staff kept clients' records in both electronic and paper form. All information needed to deliver care was available to relevant staff, including bank and agency staff. Staff could access this through looking at electronic records and recording in the daily records or through looking at the information in the paper files.

Medicines management

- Overall, arrangements for the safe management and administration of medication had improved, but further embedding was required.
- We looked at the provider's arrangements for managing and dispensing controlled drugs (CDs). We saw that CDs were appropriately stored; however, staff were not recording the temperature in the room where they were stored. Staff were not following the provider's own medication policy, which stated that a daily recording of the temperature of the room in which medication was stored should be taken.
- At the previous inspection in October 2017, we found that the provider did not keep a CD denaturing kit for the appropriate destruction of CDs. A denaturing kit renders controlled medicines unfit for further use until they are fully destroyed by incineration. At this inspection, we found that the service still did not have a denaturing kit for the destruction of CDs. The provider was seeking advice from the pharmacy and looking at national guidelines to rectify this. However, the CDs they were currently using were in patch form, which could not be disposed of through a denaturing kit.
- At the previous inspection in October 2017, we saw that the majority of staff had completed medicines management training. At this inspection, we saw that the previous medicines management training had been replaced with a new course. The service had had a large influx of new staff that had yet to complete this training. The nurse was due to deliver this training.
- At the previous inspection in October 2017, we saw that 33% of staff had completed competency assessments regarding medicines administration. At this inspection, the nurse had started to complete competency training for new staff but this was not completed.
- Staff were regularly reconciling medicines. Staff took the medicines administration records (MAR) charts to handover and discussed any discrepancies or gaps. In addition, the nurse carried out weekly medicines audits; the manger regularly audited these. This ensured that clients received their medicines on time and as prescribed.
- During this inspection, we checked medicines storage, medicines administration record (MAR) charts, and medicines supplies. All prescribed medicines were available at the service and these were stored securely

in medicine cupboards within people's rooms. The service used a local pharmacist for all of their medication. This assured us that medicines were available at the point of need.

- During this inspection, we saw that staff recorded fridge temperatures each day. Temperatures were within the correct range. At the previous inspection in October 2017, staff were not able to describe the steps they should take if the fridge temperature was out of range. During this inspection, we saw improvement. Staff were able to tell us the correct procedure to follow if it was found that the fridge temperature was out of range and there was medication stored inside it.

Track record on safety

- The service had had no serious incidents since the last inspection.

Reporting incidents and learning from when things go wrong

- All staff knew what incidents to report and how to report them. At the previous inspection in October 2017, we found that staff were not reporting all incidents of verbal aggression. At this inspection, staff were still not doing this consistently. This meant that the number of incidents did not truly reflect the amount of verbal aggression that staff were receiving.
- The service manager graded all incidents; there were clear guidelines in place as to how to do this and the appropriate action to take. Managers discussed incidents at the regular senior managers' accident, incidents and near misses meeting. Minutes from these meetings showed that incidents were discussed and any updates or actions that needed to be taken and lessons learnt were documented. This meant that lessons learnt were reflected upon and discussed by managers.
- At the previous inspection in October 2017, we found that staff from the service did not receive regular feedback regarding incidents. At this inspection, we saw that learning from these was fed back down to staff through team meetings.
- During the inspection we saw evidence of changes being made because of feedback, an example of this was regarding an incident where a controlled drug had not been signed in correctly. Staff liaised with the local pharmacy to ensure that they labelled drugs more clearly labelled to prevent this from reoccurring.
- The service was reporting all incidents appropriately to the Care Quality Commission. They had not made any safeguarding referrals to the local authority since the previous inspection.
- Staff received regular reflective practice sessions from an outside facilitator. Staff could discuss any incidents within this session and debrief. Staff also discussed incidents within handovers.

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

Assessment of needs and planning of care

- At the previous inspection in October 2017, we found that improvements were needed to assess clients' needs appropriately. At this inspection, we saw that staff had made improvements.
- Staff supported clients to complete drug and alcohol recovery stars. These reflected clients' alcohol use and how they wanted to be supported with harm minimisation. They also included information about their physical and emotional health, accommodation, finances, meaningful activities and relationships. These were holistic and personalised. The client's voice came across in a meaningful way from these recovery stars.
- Clients had personal care plans in place, which described how to carry out personal care and the client's preferences. Staff recorded in clients records when personal care had been offered and if it had been refused or given. Staff also discussed and recorded this information at handover, ensuring that they passed it onto the next shift if someone had refused personal care.
- Staff updated care plans and risk assessments when clients' needs changed or after an incident.
- The provider had revised their admission criteria and conditions, which now included a comprehensive assessment that staff would complete prior to admission. The GP's views were included in the pre-admission assessment. It was now a condition of

admission that clients could not buy alcohol for other clients; however, there was no clear plan as to how staff would manage this for existing clients, or those admitted in the future.

Best practice in treatment and care

- The service promoted a harm minimisation model, but there remained a lack of clarity about what this was, how it operated and how outcomes were measured. The service did not provide a range of care and treatment interventions suitable for the client group. The service was not using any evidence based, National Institute for Health and Excellence (NICE) recommended screening tools to measure and assess clients.
- At the previous inspection in October 2017, we found that staff were not recording GP visits consistently within care records and that there was no system in place to ensure that any actions from previous visits were followed through. At this inspection, we saw improvements.There was a new contract in place with the GP, which had led to increased GP involvement. We met with the GP and looked at the GP's summary notes that they gave to the service, these summarised the visits and actions taken. The GP worked closely with the staff at Aspinden Wood Centre to ensure that the physical health needs of clients were met, for example, when a client's health deteriorated.
- The service was not ensuring that clients had regular one to one sessions with staff. The service had identified individual key workers for clients and had developed a template for keyworkers to follow when holding one to one sessions with clients. Staff told us that these would be in place by April 2018.
- At the previous inspection in October 2017, staff were not completing drink diaries consistently to monitor the amount of alcohol consumed by clients. At this inspection, we saw improvements. Alcohol consumption was being recorded, however further embedding was needed to ensure consistency.
- Staff assessed and met clients' needs for food and non-alcoholic drinks. The service had a full time cook who kept a record of clients' nutritional needs and preferences and ensured that these were followed. Staff recorded clients' daily intake of food and ensured that they assessed clients' body mass index (BMI) monthly. Staff reported any concerns or changes in clients' food intake or BMI to the GP.
- Staff supported clients to live healthier lives through encouraging good nutritional intake. Staff screened for potential cardiovascular risks by measuring clients' vital signs of blood pressure, respiration and pulse monthly. Staff recorded these on National Early Warning system (NEWS) charts. If there were concerns staff took readings more frequently, however staff did not always score the outcome of these. The GP took regular blood tests to check clients' liver function.

Skilled staff to deliver care

- The service had a full time mental health nurse who was the lead staff member for liaising with the GP and any visiting health professionals. The GP made referrals to community nursing, physiotherapists, speech and language therapists or occupational therapists as required. We saw this in clients' notes. Some staff told us it would be helpful if the team included someone with physical healthcare experience.
- At the previous inspection in October 2017, we saw that the service had made improvements in the introduction of specialist training. At this inspection, we saw that the service had made further improvements in the identification of the specialist training requirements for the different staffing levels. However not all staff had yet completed the training identified.
- At the previous inspection in October 2017, the service had introduced a new supervision structure and template. However, this had needed further embedding to ensure that staff were receiving regular supervision. At this inspection, we saw that managers were still not ensuring that staff were receiving regular supervision.
- Staff who were employed in the service for the last year had received an appraisal.

Multidisciplinary and inter-agency team work

- At the previous inspection in October 2017, managers were not ensuring that team meetings were being held regularly. At this inspection, we saw improvement; team meetings had taken place monthly.

Substance misuse services

- Staff shared information about clients at effective handovers. Handover meetings took place three times a day at shift changes.
- Staff were able to access monthly reflective practice sessions, which were externally facilitated.
- The staff team had an effective working relationship with the GP. We saw that the GP reviewed clients regularly and ensured that the GP summary notes were given to the lead nurse. The lead nurse recorded the notes from the GP visit onto client records. The community nurses and GP liaised regularly and we saw that the community nurses had sent the GP photos of a client's pressure sores. However, community nurses did not routinely report on the outcome of their visits to staff, which meant the staff team did not always know what treatment had been carried out. The service needed to find a way to get timely information from community nurses.
- The service had a good working relationship with the local authority. The local authority had identified a link person that staff at Aspinden Wood could contact for advice or support.
- The service had a shiatsu therapist who visited weekly to offer clients a massage session. There were no records made of this session to record which clients had received treatment and how they had responded.

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

- At the previous inspection in October 2017 half the staff team had received Mental Capacity Act (MCA) training. At this inspection, we found that many new staff had started and had not yet received full MCA training; however, an introduction to the MCA was covered during the induction week that staff attended. Staff had an understanding of mental capacity and how they should support clients to make decisions.
- The service had three clients who had Deprivation of Liberty Safeguards (DoLS) authorisations in place. These supported clients who had been assessed as not having capacity to decide where to live. Decisions had been made in their best interest that Aspinden Wood was the most appropriate place for them to reside.
- The provider had guidance on the MCA, including DoLS within their safeguarding policy.
- Staff assumed that clients had capacity (unless DoLS were in place for a specific issue) and gave them support to make decisions themselves. We saw an example of a client who had said that they wanted to move to a particular area, staff had taken them to that location to be able to see it. The client then made the decision that they did not actually want to move there.
- At the previous inspection in October 2017, we saw that staff kept clients' money in the office, staff told us that some clients did not have capacity to manage their finances; however, this had not been documented. At this inspection, we saw that clients kept hold of their own money unless their social worker had assessed that they did not have capacity to manage their finances.

Are substance misuse services caring?

Kindness, privacy, dignity, respect, compassion and support

- Staff attitudes and behaviours when interacting with clients showed they were discreet, respectful and responsive. We observed a staff member who noticed that a client had put gloves on asking them if they were cold, when the client said that they were, the staff member went with them to support them to change into warmer clothing.
- Clients told us that staff supported them to understand the risks of continued drinking and smoking. Some clients were able to tell us why they were taking medication.
- Staff supported clients to access community services and engage in activities. One client was supported to participate in swimming sessions. One client attended a community day service. A volunteer from a local church came to the service regularly with a choir to sing. The service had recently employed two recovery workers with an activities focus who were reviewing activities and exploring how they could further develop these.
- Clients told us that staff treated them well and looked after them.

- Staff understood the individual needs of clients and responded to these. We saw a staff member managing to calm someone down who was angry by taking them aside and talking calmly to them. We also saw that staff had a good understanding of clients' dietary needs.
- Staff and clients said that they felt able to raise concerns about disrespectful or abusive behaviour or attitudes towards clients without fear of the consequences.

Involvement in care

Involvement of patients

- Staff involved clients in care planning and risk assessment. Clients were involved in formulating their drug and alcohol recovery stars and risk assessments; these were person-centred and clearly showed the client's opinion about their care and alcohol use.
- Staff tried to communicate in a way that clients could understand. Some staff had undertaken a basic British Sign Language (BSL) course to be able to communicate with a deaf client, but not all staff had undertaken this training and no staff members were trained in BSL to a more advanced level. For clients with literacy or cognitive difficulties, care plans were not routinely presented in an easy read format.
- At the time of inspection, staff did not routinely involve clients in all decisions about the service, but had plans in place to develop this. The provider was recruiting to a new post, which would develop work with experts by experience. The provider was looking at involving experts by experience to develop leadership training and to be part of the recruitment process.
- Staff enabled clients to give feedback on the service they received through community meetings. However, we saw that these were not always happening regularly and there was no follow up of items discussed from one week to the next.
- During the inspection, we did not see evidence of any information regarding advocacy being available to clients. However, we saw in one client's records that they did have an advocate to support them.

Involvement of families and carers

- Staff informed families or carers if a client was admitted to hospital or became unwell.

Are substance misuse services responsive to people's needs?

(for example, to feedback?)

Access and discharge

Bed Management

- At the time of inspection there were 19 clients at the service, however one client was in hospital. The service had voluntarily agreed not to admit clients following an inspection in June 2017.
- Clients came from all over the country. The local borough had the largest proportion of clients at the service.
- The provider had developed a new admissions process, which staff were to implement once the service was taking new admissions. This stated that new clients would have a six-week assessment period before the provider gave a firm offer of a placement.

Discharge and Transfer of Care

- Clients did not have discharge plans in place unless there was a plan for them to move. We saw that staff were supporting a client to move to an area of their choice. For one client who had been abstinent for some time, the GP had queried whether the service continued to be an appropriate placement, but this had not been followed up by the service. Some clients told us that they would like to leave, however there were no discharge plans in place for these clients. Some clients had received regular placement reviews from commissioners; however, these had not taken place for all clients.
- Staff went with clients to hospital appointments. Staff supported clients who were admitted to hospital. Staff contacted the ward regularly to monitor the progress of clients in hospital.

Facilities that promote comfort, dignity and privacy

- Clients had their own bedrooms, which they were able to personalise. Clients had a safe in their bedrooms where they could store their money and possessions. Some clients had keys to their bedroom and safe, this depended on client choice and needs.

Substance misuse services

- The service did not have a clinic room. The GP examined clients in their own bedrooms.
- The service had two communal lounges where clients could sit to socialise or watch television. One of the lounges was called the 'wet lounge' which clients were able to use to drink alcohol and smoke. The main kitchen had a dining room and conservatory attached to it. Clients ate their meals there and could use it to sit and relax in. There was another kitchen and dining area, which clients could use to make snacks and drinks at any time. Activities and therapies took place in all of the communal areas apart from the wet lounge.
- Clients were able to meet visitors in their bedrooms or in any of the communal areas of the building.
- Clients could use their own phones in their bedrooms or make phone calls from the phone in the staff office.
- Clients had access to outside space at the front and the back of the building. However, there was a lot of rubbish outside, such as large containers of vegetable oil, which staff needed clear. The manager had contacted the local council to have this removed.
- Clients told us that they liked the food at the service. There was a full-time cook during the week and a part-time cook worked at weekends. The cooks ensured that good quality food was prepared that met the individual nutritional requirements of the clients.
- Clients could make their own breakfasts; one client had taken on the role of preparing a cooked breakfast for all clients at weekends.

Patients' engagement in the wider community

- At the time of inspection, no clients were accessing education or work opportunities. One client used to do some voluntary work but this had stopped, staff were unsure of the reasons why. The service used to have someone that came in regularly to support clients in developing their computer skills; however, this was no longer occurring.
- Staff supported clients to maintain contact with families and carers where appropriate. We saw an example of where staff had supported a client had not had contact with their family for many years to get in touch with their family again and to maintain that contact.

Meeting the needs of all people who use the service

- The service had made adjustments for clients with physical disabilities as many of the clients used a wheelchair or walking aids.
- The service did not have any leaflets available for clients regarding alcohol use or smoking cessation. There was no information regarding harm reduction or local mutual aid groups, such as alcoholics anonymous, for those clients who wanted to further reduce their alcohol use and become abstinent. However, there was information available regarding Age UK, activities within Aspinden Wood, the complaints procedure and safeguarding.
- There was a choice of food to meet the dietary requirements of the different religious and ethnic groups to which clients belonged.
- Staff ensured that clients had access to appropriate religious or spiritual support if they wished; a priest visited two clients regularly to support them to maintain links with their faith.
- Staff were able to give examples of how they had supported transgender clients.

Listening to and learning from concerns and complaints

- The service had received one complaint in the past 12 months. Staff were currently investigating this.
- Clients knew how to complain or raise concerns and felt able to do this. Clients had the opportunity to raise concerns in the house meeting.

Are substance misuse services well-led?

Leadership

- Since the last inspection, the provider had appointed a manager who was in the process of registering with the Care Quality Commission. The interim acting manager was still based at the service for a period of handover. Staff told us that the managers of the service were approachable and supportive.
- Senior managers were visible in the service and were approachable for clients and staff.
- The provider was developing a leadership course for managers.

Substance misuse services

Vision and Strategy

- The provider's vision and values were displayed on the home page of the provider's intranet; this meant that staff were regularly able to view them.
- Staff had the opportunity to contribute to the discussions about the strategy for their service. We saw that managers had been asked to help develop a new vision and values. Staff told us they were encouraged to bring forward ideas for the development of the service.
- Managers were able to inform us how they were leading change within the service, whilst being mindful of budgetary constraints.

Culture

- Staff we spoke to were committed to the clients and to the service. Staff informed us that the new team was working well together and they felt comfortable to put forward new ideas and suggestions. Staff felt that managers were open and approachable. Staff were positive about the changes they had seen taking place since the last two inspections.
- Managers dealt with poor staff performance when needed.
- Staff appraisals included conversations about career development and how staff could be supported with this.
- Staff had access to support for their own physical and emotional health needs through an occupational health service. Staff were able to contact a confidential service for support with personal issues as well as work related issues.

Governance

- Since the last inspection in October 2017, the provider had reviewed and made further changes to many of its governance systems; it had also worked on ensuring that these were embedded into practice. However, further development was needed to make sure changes were consistent, effective and robust.
- Senior managers held regular meetings to discuss lessons learnt from incidents, complaints and safeguarding concerns. Managers fed these back down to the staff team through team meetings.
- The service ensured that clients were assessed and treated well. Since the previous inspections in June and October 2017, we have seen many improvements in the assessment and planning of client care. However further improvements were needed to ensure that discharges were planned for.
- Since the last inspection in October 2017, the provider had made further improvements to how staff were trained and how managers were able to monitor this. However further work was needed to ensure that all staff had received the relevant training to their role. Since the last inspection further changes had been made to the supervision structure, however managers needed to further embed this to ensure that all staff were receiving regular supervision.
- At the previous inspection in October 2017, we saw that the systems to ensure the cleanliness, hygiene and maintenance of clients' bedrooms and bathrooms were not effective. At this inspection, we saw improvements. We saw that some bathrooms had been refurbished but that the others were still in need of being refurbished.
- At the last inspection in October 2017, we found that the provider had put systems and processes in place to ensure the quality and safety of the service but that further work was needed to ensure that these systems were consistent, effective, robust and embedded. At this inspection, we found that the provider had made further developments of the quality assurance systems to ensure they were able to operate a safe and effective service. However, staff had yet to implement some of these systems and further embedding was still needed for existing ones.
- The provider had not ensured that all staff had the required pre-employment checks. We looked at the human resource records of five members of staff. Three records showed that the staff members had had gaps in employment history and there was no record to explain the reason for these gaps.

Management of risk, issues and performance

- The provider had an organisational risk register. The highest risks on the risk register were regarding staff recruitment, accommodation needs, financial voids and cash flow. These matched the concerns expressed by staff. Managers could escalate concerns regarding service risks when required.

- The provider had a business continuity plan in place for emergencies, this included details of action that staff should take in specific scenarios, such as the loss of the premises or outbreak of an infectious illness.

Information Management

- Staff had access to the equipment and information technology needed to do their work. The IT system generally worked well, although at times it could be difficult to access the system. The service had an administration assistant who was able to answer the majority of phone calls during office hours.
- Information governance systems included confidentiality of client records.
- Managers had access to information to support them with their management role. This included information on the performance of the service, staffing and client care.
- Staff made notifications to external bodies, such as the Care Quality Commission, where appropriate.

Engagement

- Staff had up to date information regarding the work of the provider through the intranet. The provider had previously asked staff for feedback via a staff survey; however, this had not taken place for the last two years.
- Staff kept clients updated through house meetings, however the provider was not always ensuring that these were occurring regularly and did not follow up actions raised at previous meetings. Staff did not give clients any other means to be able to feedback regarding the service. The service did not have any means to gather feedback from relatives or friends.

Learning, continuous improvement and innovation

- Staff were given the time within reflective practice sessions and team meetings to consider opportunities for improvement. Staff told us of some areas of improvements that they would like to make and said they felt able to approach managers with these ideas.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to meet the regulations:

- The provider must ensure that the service model is embedded into the service, which clearly identifies the recovery and harm reduction models in use at the service and how outcomes will be measured.
- The provider must ensure that effective, consistent and robust governance systems are embedded within the service. The provider must ensure that consideration is given to where bedrooms and bathrooms used by female clients are located in line with their same sex accommodation policy.
- The provider must ensure that all the appropriate pre-employment checks are carried out before staff start employment. They must ensure that there is a system in place to know when contracted staff and volunteers are due for a Disclosure and Barring check.

Action the provider SHOULD take to improve

- The provider should ensure that effective systems are in pace for the proper and safe administration and management of medication. Staff who administer medicines should be competent to do so.
- The provider should ensure that the refurbishment programme for bathrooms and toilets is continued.
- The service should ensure that discharge plans are in place for all clients who wish to leave the service or where it is unsure if it is the most suitable placement.
- The provider should ensure that staff, clients and carers are able to give feedback regarding the service.
- The service should ensure that verbal and written communication is delivered in a way that is accessible for each client's individual needs.
- The provider should ensure that it is adhering to all the recommendations stated in the ligature risk assessment.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider did not have established systems or processes in place, to effectively ensure compliance with the requirements of the Act.** **Regulation 17 (1)(2)(a)(b)(e)**

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The provider did not undertake pre-employment checks for staff as required in schedule 3 of the Health and Social Care Act 2208 (regulated activities) Regulation 2014.** **Regulation 19(1)(a)(2)(a)3(a)**