Oasis Recovery Community Bradford

Quality Report

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

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

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

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

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

Overall summary

We found the following areas of good practice

- The environment at Oasis Recovery Community Bradford was clean, safe and well maintained and there was adequate staffing in the service. The low use of agency staff meant that patients received consistent care and treatment from staff that they were familiar with. The service had systems in place to assess and manage risk effectively. All patients had a risk management plans in place, including detailed contingency plans for patients that left treatment early. A doctor and a manager were on call twenty-four hours a day, seven days a week to support staff and patients. The service recorded one serious incident and one accident in the last six months. We observed evidence of an investigation, feedback to staff and patients, and actions taken from the lessons learnt.
- The service had good systems in place to assess the patient prior to their admission to the service, and during their treatment. Staff worked in collaboration with the patient to agree a care plan in a one to one care plan meeting. All patients had a current care plan in place that they had signed and dated. Evidenced

Summary of findings

based psychological therapies, group-based interventions, medications and detox regimes recommended by the National Institute for Health and Care Excellence were used in the service. Staff with the necessary skills, experience, supervision and training administered and delivered this treatment and care. Patients engaging in treatment at Oasis Recovery Community Bradford were highly likely to achieve their detoxification treatment goals at the service. Between 1 September 2015 and 9 February 2016, 87% of patients left Oasis Recovery Community Bradford in a planned way having completed their treatment.

- All the patients we spoke to told us that the staff were caring, approachable and were always available to speak to if they needed further support. Staff were caring and respectful and their interactions were person-centred, friendly, and recovery focused. Relatives and carers were also offered support by the service, as well as in their local area.
- Oasis Recovery Community Bradford was able to admit patients within 14 days from being referred by a community substance misuse team, or from referring themselves. The service was responsive to emergency referrals from hospital or the community and could admit patients within 48 hours in these situations. Patients were seen by a doctor immediately on admission and a full assessment was completed. All patients knew how to complain. The staff we spoke to were clear about the complaints procedure. However, complaints about the service were rare. There had been one formal complaint since 1 September 2015, escalated to the senior management team that was not upheld.
- Oasis Recovery Community Bradford was well led, with local governance arrangements in place to ensure good quality care, including a range of performance indicators, policies and procedures and clinical audit. Staff understood and followed safeguarding, incident reporting, complaints and Mental Capacity Act (2005) procedures. Staff, patients, relatives and carers were able to give feedback on the planning, delivery and development of the service. The directors completed detailed quarterly quality audits, reviewing the service governance structures to ensure that treatment and care was safe, effective, and continued to improve.

However, we also found areas that the service provider could improve:

- Oasis Recovery Community Bradford did not have patient call alarms in the bedroom, or panic alarms for staff in the building in the event of an emergency or an incident of violence or aggression. There were contingency arrangements in place. However, there were no formal risk assessments completed to assess if these systems were required.
- Whilst risk management plans were in place for all patients, these were generic for each patient and lacked person-centred detail. The plans centred fully on the service delivery, rather than including the patient's own strategies to manage the risk, which they had perhaps used prior to attending the service, or ones that they could use when they were discharged.
- The service had systems in place for the clinical staff to audit the patient records weekly. However, the service did not use a standard clinical audit tool and so could not be sure that these record audits were completed consistently to the same standard.
- Formal complaints were recorded. However, most concerns and complaints were resolved locally. These were not recorded. Therefore, recurrent themes may not be identified by the service.
- The documents for supervision, appraisal and training were not held in one central place which made it difficult to ensure the data collected was correct.

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Background to Oasis Recovery Community Bradford

Oasis Recovery Community Bradford is a 17-bed inpatient unit that provides treatment to men and women over 18 years of age who have a drug or alcohol dependency. The service provides detoxification and stabilisation. The majority of people were referred to Oasis Recovery Community Bradford by the community drug and alcohol teams, with their places being funded through their Local Authority. However, people can also refer themselves to the service and self-fund. The service takes referrals from all over the country. It is equipped to accommodate people with limited mobility and wheelchair users who can care for themselves. The service is situated close to the city centre of Bradford and it is easily reached on foot, by car and public transport.

Oasis Recovery Community Bradford is one of three locations registered with the Care Quality Commission by Oasis Recovery Communities Limited. It has been registered since 26 August 2015 to provide accommodation for persons who require treatment for substance misuse as its regulated activity. It has a registered manager appointed to manage the regulated activity on behalf of Oasis Recovery Communities Limited. It also has a nominated individual who is a senior person in the organisation who has overall authority over the regulated activity.

Oasis Recovery Community Bradford had not previously been inspected prior to this inspection visit.

Our inspection team

The team leader of the inspection was Kate Gorse-Brightmore.

The inspection team consisted of one inspection manager, one inspector, one inspection assistant, and pharmacist inspector.

Why we carried out this inspection

We inspected this service as part of our ongoing substance misuse inspection programme.

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location, asked a range of other organisations for information and sought feedback from patients at a focus group.

During the inspection visit, the inspection team:

- looked at the quality of the environment and observed how staff were caring for patients
- spoke with ten patients and collected feedback from one patient using comment cards
- spoke with six relatives or carers
- spoke with the registered manager
- spoke with five other staff members, including the deputy manager, a nurse, a support worker, the chef and the administrator
- attended and observed one handover meeting
- attended and observed a house meeting

Summary of this inspection

- attended and observed a one to one care plan meeting
- looked at 10 care and treatment records of current clients
- carried out a specific check of the medication management
- looked at a range of policies, procedures and other documents relating to the running of the service
- received feedback about the service from six care co-ordinators or commissioners.

What people who use the service say

All the patients we spoke with told us that they felt that the service was safe and clean. They told us that the staff were caring, approachable and were always available to speak to if they needed further support. They told us that the staff were friendly and respectful, and that they always felt listened to by staff.

Eight patients we spoke with told us that their treatment and care had been clearly explained to them by the service, as well as the expectations of the service, for example to attend the groups and to become an active member of the inpatient community. Patients also told us that the boundaries of the service had been clearly explained to them, including not talking about medication and not having their mobile phone whilst in treatment. The patients also told us that they had been given the rationale for these requirements.

Carers and relatives echoed the positive comments of patients. They also told us that staff were never too busy to talk to them and that communication with the staff team was generally good. Two out of the six relatives and carers we spoke with said that they would definitely recommend this service to others.

All the stakeholder feedback we received described a safe service, which supported patients and achieved good outcomes. One provider informed us of an issue where a patient did not want to share a room, it had been readily resolved by Oasis Recovery Community Bradford.

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 found the following areas of good practice:

- The environment at Oasis Recovery Community Bradford was clean, safe and well maintained.
- Environmental and ligature risk assessments were in place and there was evidence of a recent infection control audit.
- There was adequate staffing at the unit with low use of agency staff.
- A doctor and a manager were on call twenty-four hours a day, seven days a week.
- Ninety-six per cent of staff had completed their mandatory training.
- All ten patients had a risk management plan in place, including detailed contingency plans for patients that left treatment early.
- Medicines were stored securely in locked cupboards and on a locked trolley, within a locked clinic room. This included the safe storage of controlled drugs. There were processes in place for the safe disposal of medicines.
- Staff had a good understanding of safeguarding adults and children and one hundred percent of staff had completed the mandatory training required.
- There was one serious incident and an accident at the service since 1 September 2015. Where an incident occurred, there was evidence of an investigation, feedback to staff and patients, and lesson learnt being actioned.

However, we also found areas that the service provider could improve:

- The equipment in the accessible bedroom had not been assessed for ligature points.
- There was no service risk assessment in place regarding the use, or requirement of patient call alarms in the bedroom, or panic alarms for staff in the event of an emergency or an incident of violence or aggression.

Summary of this inspection

- The risk management plans were generic for each patient, lacking person-centred detail, and centred fully on the service, rather than drawing on patients' individual strategies.
- There was no evidence in the visiting policy that visits were risk assessed with regard to safeguarding children and vulnerable adults.

Are services effective?

We found the following areas of good practice:

- All patients had current care plan in place that were signed and dated by the patient.
- Confidentiality and information sharing, and the treatment contract was discussed and agreed on admission, and then at each care plan meeting.
- Patients had a full physical examination on the day as admission with the nurse and the doctor.
- Medication was given to service users in a private, person-centred manner and the ten treatment charts in use at the time of the inspection were accurately completed.
- Patients were required to attend a therapeutic recovery programme five days a week, and activities were available seven days per week.
- Psychological therapies, group-based interventions, medications and detox regimes used were evidence based and recommended by the National Institute for Health and Care Excellence.
- The nurses completed weekly clinical audits on patient records to check that care plans, risk assessments and risk management plans were in place for each patient.
- Staff had the necessary skills, experience, supervision and training to fulfil their role.
- Patients were discussed by the multi-disciplinary team twice daily in handover sessions. Patient did not attend but their opinions, thoughts and feelings were fed into the handover through the daily diaries that they completed each evening.

However, we also found areas that the service provider could improve:

Summary of this inspection

- Despite the service completed regular file audits, they did not use a standard clinical audit tool to ensure that the files were audited to the same standard each time.

Are services caring?

We found the following areas of good practice:

- Staff were caring and respectful. Their interactions were person-centred, friendly, and recovery focused.
- Family members and carers were offered one to one support when they attended for visits, and were signposted to a local service for on-going support in their area.
- Patients were able to input into the treatment and care they received through daily diaries, daily house meetings, and monthly community meetings.

Are services responsive?

We found the following areas of good practice:

- There were no waiting times to access the service and the service had accepted emergency referrals from hospital or the community within 48 hours.
- Patients were seen by a doctor immediately on admission and a full assessment was completed.
- Between 1 September 2015 and 9 February 2016, 87% of patients left Oasis Recovery Community Bradford in a planned way, having completed their detoxification treatment goals.
- Oasis Recovery Community Bradford had a full range accessible rooms to support patients' treatment and care, including a fully equipped clinic room. Patients could also access a clean and well-maintained outside space.
- The service met the needs of all the patients who used the service. This included accessibility to the service, their access to religious and spiritual support, ensuring that their spiritual and dietary requirements were addressed, and that treatment information was in a format that they could understand.
- There had been one formal complaint since 1 September 2015. Patients knew how to complain and staff were clear about the complaints procedure.

However, we also found areas that the service provider could improve:

Summary of this inspection

- There was no input from a dietician into the menu choice, and no specific input for patients with cross-addictions including eating disorders.
- Formal complaints were recorded. However, most concerns and complaints were resolved locally. These were not recorded. Therefore, recurrent themes may not be identified by the service.

Are services well-led?

We found the following areas of good practice:

- All staff could explain the service's mission, vision and values. They represented and demonstrated these through their behaviours and interactions with the patients.
- All staff knew the most senior managers by name. They told us that these managers were approachable and attended the service regularly.
- There were local governance arrangements in place to ensure good quality care, including a range of performance indicators, policies and procedures and clinical audit.
- All staff we spoke to were highly motivated and talked positively about their work at the service and said that morale was good.
- Staff followed safeguarding, incident reporting, complaints, and Mental Capacity Act (2005) procedures.
- Staff and patients, families and carers were able to feedback into the planning, delivery and development of the service.
- The company directors completed detailed quarterly quality audits, reviewing the service governance structures to ensure that treatment and care was safe, effective, and continued to improve.

However, we also found areas that the service provider could improve:

- The documents for supervision, appraisal and training were not held in a central place, which made it more difficult to ensure the data collected was correct in the first instance.
- We observed two medicines policies that had been reviewed in January 2015 but these did not reflect current practice in the service.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff had received the mandatory training in the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.
- There were no patients subject to Deprivation of Liberty Safeguards.
- Staff gave were examples where patients did not have capacity to consent to treatment due to intoxication, including one instance where a patient was heavily intoxicated on admission and the service had waited to complete the admission assessment until the patient had regained capacity to make their treatment decisions.

Substance misuse/detoxification

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse/detoxification services safe?

Safe and clean environment

- The environment at Oasis Recovery Community Bradford was clean, safe and well maintained. All rooms, including consultation rooms, the dining room, the lounge and the family room were accessible to staff and patients.
- The patient areas were comfortable and the furniture, fixtures and fitting were generally in good condition. Current environmental risk assessments were completed by an external company in January 2016 including health and safety, fire risk and the control of substances hazardous to health. There were management plans to reduce risk and environmental impact for each of the risk assessments. Health and safety checks were completed by staff on a daily, weekly and monthly basis as directed in the risk management plan. Environmental shortfalls were picked up through these checks, for example there were some scuffs in the paintwork which were picked up on these checks. However, we observed some loose wires around the television in the family room that were a potential hazard. Fire safety, including evacuation procedures and fire alarms were reviewed on the patient treatment contract, which is discussed with the patient on admission.
- The infection control policy for Oasis Recovery Community Bradford included protocols for hand hygiene, disposal of sharps and clinical waste, the use of personal protective equipment, blood borne viruses and general housekeeping to prevent infection. An infection control audit and a clinical waste audit were completed in January 2016, both had detailed actions which were overseen by the centre manager. Cleaning schedules were observed and these had been signed and dated when the action had been completed. Hand hygiene posters were on display.
- The service could accommodate 17 patients at any one time. The bedrooms were single occupancy, except for one triple bedroom available for patients who preferred to share. As this was a mixed sex unit, staff told us that only patients of the same sex would share a bedroom. All bedrooms had en-suite toilets and shower-rooms and all but one bedroom were situated on the second floor. Patients could lock their bedrooms and they had fobs to gain entry to their own room. Staff also had fobs to gain entry to all the bedrooms.
- A current ligature risk assessment had been completed by an external agency in February 2016. This highlighted the ligature risk for the bedrooms and how these would be mitigated, including patient observations, risk assessments and risk management plans. However, this ligature assessment did not includethe equipment in the accessible bedroom.
- The staff office was situated on the first floor. There were restricted lines of sight from this office to a number of the patient areas, including a bathroom with a whirlpool bath and all the upstairs bedrooms, so patients could not be seen at all times. All staff told us that blind-spots were mitigated through the use of staff observations and the use of the downstairs bedroom opposite the staff office where a risk assessment and management plan identified that the patient required increased observations and support.
- Observations were a minimum of hourly throughout the day and night. This was in line with the service's observation policy. Evidence in the patient records demonstrated that observations were taking place and could be increased and decreased in line with the

patient risk assessment and management plan. The centre manager confirmed that the nursing staff and recovery coaches (workers who support the patient with their recovery through the use of psychosocial interventions) could increase patient observations but a decrease in observation had to be agreed by the manager, nurse and doctor as a multi-disciplinary risk assessment. All bedrooms had an observation hatch that could be covered for privacy and dignity. Where the observation hatch was covered, staff would open the door to check the patient. All patients confirmed that they were informed of this in the unit orientation and that the information was also available in the admission handbook which we observed in all the patient bedrooms.

- Bedrooms did not have patient call buttons. The centre manager and the directors of Oasis Recovery Community Bradford informed us that walkie-talkies were used where a risk assessment identified that a patient was at increased risk, for example at risk of seizures. There had been no incidents recorded as a result of patients being unable to contact staff in an emergency since the beginning of September 2015, which all the staff we spoke to confirmed. All patients told us that the staff were available when they needed them. The service had not completed a risk assessment for the requirement of patient call buttons in the service.
- Staff did not carry personal alarms and there was no panic alarm system in use at the time of our visit. This meant that if an aggressive or violent incident occurred, then other staff may not be aware and may not be able to respond. However, all staff confirmed that there had been no violent or aggressive incidents in the service since September 2015, nor were there any recorded incidents by the service. Managing violence and aggression and conflict resolution training were mandatory, and all the staff had completed it. The code of conduct for patients, including violence and aggression, was detailed in the admission handbook and in the treatment agreement. The consequences were also detailed. All patients were fully risk assessed for historic and recent episodes of violence and aggression, which included widening the assessment to include other agencies, like the probation service. One of the directors and the centre mangers confirmed that police may be called and a patient could be asked to leave treatment for the safety of the other patients. However, the service had no formal service risk assessment in place for the requirement of staff personal alarms or a panic alarm system in the service.
- Oasis Recovery Community Bradford confirmed that on admission there is a procedure for new admissions where two members of staff will search suitcases, bags and pockets. There are no invasive searches. Visitors do not take bags into the visits but store them in the lockers provided. This is reflected in the Oasis Recovery Communities search policy and the visitors policy.
- There was a fully equipped clinic room with an examination couch and the necessary equipment to carry out examinations, as well as resuscitation equipment. There were crash grab bags on each floor that were stocked and maintained.

Safe staffing

- Oasis Recovery Community Bradford had 15 staff in total at the time of the inspection, including a centre manager, a deputy manager, a recovery coach (a worker who supports the patients with their recovery through the use of psychosocial interventions), four nurses and five support workers (four whole time equivalent support workers), a chef and an administrator. A cleaner and maintenance worker are additional to these staff members.
- The four band five whole time equivalent nurses cover 14 shifts per week: seven night shifts and seven day shifts. The service requires a nurse to be onsite in order to be operational. Where a nurse cannot attend for a shift due to leave, sickness or vacant posts, the service uses its own bank staff to cover in the first instance and then would contact a regular agency. In instances where they cannot use either of these, the centre manager told us that they have a second agency that they can contact as a back-up but this is rare. Since 1 September 2015, the service has covered 69 shifts with its own bank staff and eight shifts using agency staff. During the inspection, we observed a detailed handover between the staff on the night shift and the staff starting on the morning shift. The handover notes we reviewed reflected the information discussed in the handover session accurately.
- At night and at the weekend, there are two full-time staff members: a nurse and a support worker. This was

observed on the staff rotas. At the weekend there is an additional support worker between 11am and five pm to cover the period where staff are required to prepare meals and cleaning duties as there is no chef or cleaner employed at the weekend. The support workers role includes some cleaning duties and patient laundry throughout the week. An induction checklist was completed with all agency staff, as well as a comprehensive handover.

- The recovery coach, deputy manager, centre manager, chef and administrator work on weekdays only.
- Both the director and the centre manager confirmed that if they require additional staff due to a particular case mix at the inpatient unit, they would increase staff numbers as required, for example if there was a patient with more complex physical health needs who required additional support. The staffing ratios have been based on the previous service that ran successfully on the current compliment of staff without incident, as has Oasis since it registered. Staff and patients told us that there was enough staff to cover the service.
- All staff and patients reported that there were sufficient staff at all times to facilitate one to one appointments and activities in and out of the centre. There was an hour and fifteen minutes allocated each morning for patients to have a one to one with a staff member. Staff told us that they had not known of a time when activities had been cancelled due to the design of the therapeutic programme. However, insufficient time for one to ones or cancelled activities was not recorded by the service.
- The nursing staff were responsible for administering the patient medication and overseeing the patients' treatment and care, after the initial admission assessment by the doctors. Oasis Recovery Community Bradford has two doctors, who work on an on call rota so that a doctor is available at all times. The centre staff can contact them by telephone or email and the doctors will attend the centre if required .There is also management cover twenty-four hours a day.
- At the time of the inspection, the mandatory training completed for all staff was above 96%. However, it was 100% for training that was completed or in progress, including:
- basic life support,
- health and safety awareness,
- information governance,
- fire safety,
- managing challenging behaviour,
- infection control manual handling,
- child and adult safeguarding,
- understanding mental health awareness,
- Mental Capacity Act (2005),
- Deprivation of Liberty Safeguards.
- However there were two systems in use collating this data which made it difficult for the service to provide accurate data initially.
- The service used support workers to assist the nurse in administering medicines to make sure there were two people present when medicines were given. We viewed records which showed that all staff had received training on medicines and checks had been undertaken to ensure they were able to administer medicines safely.
- Staff could access the paper notes which are kept in a filing cabinet in the staff office. When staff left the office the cabinet was locked and a key chain system was in place. Staff required to access the handover information kept on the computer had passwords to access this.

Assessing and managing risk to clients and staff

- Oasis Recovery Community Bradford had a clear admission criteria. It did not accept detained patients and could not accept people that had a high level of physical support needs or who were unable to self-care with a limited level of support, or those who were on level three multi agency public protection arrangements with the police and other partners.
- All patients were risk assessed at the pre-admission assessment by the service, in addition the risk assessment and management plan that referring agencies were required to submit with the referral information. The centre manager gave clear examples of where they had requested further information from the patient or the referrer in order to make a decision as to whether the patient was suitable for admission, for

example information from probation about offences or additional blood work from the GP. Staff had to sign both the risk assessments and risk management plans to confirm that they had seen them.

- Following the pre-admission assessment, risk was reviewed by the doctor and the nurse at the admission assessment which was completed on the day the patient was due to enter the service. Risk information was reviewed twice daily at the morning and evening handovers by the staff, including the nurses. Each patient was discussed in turn using information from staff general observation, nurses' physical observations and patient feedback through daily diaries. This information was forwarded to the doctor to review following each handover.
- All ten files had risk management plans in place. However, in one file we could not locate the risk assessment, despite the risk management plan being in place. The risk assessment tool was comprehensive and covered most risks, for example, self-harm, overdose, poly-drug use (using a combination of different drugs), injecting behaviour, violence, conflict, parental responsibility, forensic history and housing.
- In one other file, risk of seizures, suicide and memory problems were highlighted but not detailed in the risk management plan. This could mean that despite the risk being assessed, the information may not be accessible to staff at the time they need it, for example if they hadn't been present at the handover where each patient and their current risks are discussed.
- The risk management plans were generic for each patient, lacking person-centred detail, and centred fully on the service, for example to attend groups to address the risk. However, for some risks, like self-harm or anxiety, there was no evidence in the risk management plans that patients were empowered to find their own individual solutions to manage their risks, or to draw on solutions or coping mechanisms they had used previously, or could continue to use when they left the service.
- Patient's mental and emotional health was assessed and risk assessed at pre-admission, admission by the doctor, and then on an on-going basis by the nursing staff. The centre manager gave evidence of how they responded promptly to a patient's deterioration. The evening prior to the inspection, there was evidence in the handover of how a patient had tried to self-harm and the staff had responded with increased observation and general talking support. The centre manager gave an example of where they would use 999 in a medical emergency and contact the crisis team or the police if a patient became mentally unwell. All staff had completed the mandatory understanding mental health training. Staff demonstrated how addiction and recovery could affect patients' mental health, including increased depression and anxiety.
- Plan for discharge, including contingency plans for unplanned discharges were observed in all patient files, including who the service would ring if the patient left, where the patient would stay, an explanation around medication and money reconciliation, and harm minimisation information. The service would also contact the local care co-ordinator who referred the patient. If the patient just left, the doctor told us the service would consider raising a welfare check with the police.
- Medicines were stored securely in locked cupboards and a locked trolley within a locked clinic room, this included safe storage of controlled drugs. Controlled drugs are medicines which are more liable to misuse and therefore need close monitoring. We checked a sample of medicines stored in the service and found these were in date and matched stock records. An accurate register was in place to record the handling of controlled drugs. We viewed records that demonstrated the controlled drugs were disposed of appropriately. We checked the availability of emergency medicines at the service, and we found one was missing when compared with their stock list. This was addressed during our inspection. We saw records indicating the recommended maximum and minimum temperatures were not being met for medicines requiring cold storage. This had been recognised prior to our visit and the service had put steps in place to rectify this.
- There were processes in place for the management of waste medicines. Arrangements for ordering and receiving people's medicines from the pharmacy were suitable. There was clear documentation about the

medicines people brought in to the service with them. There were also arrangements to obtain medicines that might be needed in addition to people's usual requirements (such as antibiotics).

- All staff had received mandatory training in managing challenging behaviour and conflict resolution. Patients were admitted on the morning of the weekdays so that more staff were present to support the admission and any more challenging behaviour that could potentially result from a new admission. The centre manager gave examples where he would contact the police in situations of violence or aggression in order to protect the other patients and staff All the patients we spoke to told us that the staff were good at calming patients down and supporting them when they felt unwell and upset.
- Oasis Recovery Community Bradford had detailed policies for safeguarding adults and children. This could be a challenge to the service as patients came from a number of areas. However, the centre manager gave details of how they overcame this by building up a contact list or discussing this with the referring community drugs team. All staff gave examples of safeguarding and the action they may take depending on the level of their delegated authority. This included staff to patient safeguarding concerns, as well as adult and child safeguarding concerns. All staff had completed mandatory child and adult safeguarding training.
- There were procedures in place for children to visit. These were included in the visiting policy, which stated that the child is the responsibility of the parent and that visits would take place in the family room. However, this policy did not refer to risk assessments required prior to any visit, for example considering any risk to a child from a visit, or a vulnerable adult. Despite giving detailed information on when a visit may be terminated this did not link with the child safeguarding policy for example if something occurred, or was observed, during the visit. This was the same with regard to visits and safeguarding vulnerable adults, for example in cases of domestic abuse.
- All staff had been checked by the disclosure and barring service. We observed current disclosure and barring certificates in the four files that we observed.

Track record on safety

- Since 1 September 2015, there has been one serious incident reported. This was a medication error on the 17 January 2016 where a patient was given over double their medication. This was reported to the relevant agencies. We saw documentation that this had been escalated appropriately and a full investigation had been carried out, with learning from this being shared with the team. We saw evidence to confirm that the patient was offered increased support following the incident, and the level of observation was increased.

Reporting incidents and learning from when things go wrong

- All staff were aware of the types of incidents that should be reported, including environmental concerns, accidents, medication errors, aggression and violence, and safeguarding. They confirmed that the incident book was kept in the office and this was completed immediately by the person witnessing the incident. They stated that they were encouraged to report all incidents and felt supported to do so.
- Since September 2015, there have been two incidents: an accident where a patient hit his head and a medication incident. Patients in both incidents had increased physical health checks and observations, and were offered additional support, observed in the incident forms.
- The staff we spoke with stated that there were rarely any incidents. They confirmed that investigations had been conducted into incidents by the centre manager and that the staff involved would meet to discuss the incident and the lessons learnt. Meeting minutes from a review of the medication incident on the 19 January 2016 confirmed that all the staff involved met to discuss the incident. The minutes reflected that following the investigation, the medication incident resulted due to the language difficulties of an agency nurse recruited at short notice for staff sickness on a Sunday from the back up agency. The usual agency was unable to provide a nurse to cover the shift. The medication error occurred despite the agency nurse having an induction and a thorough handover. Actions were agreed and were

overseen by the centre manager included liaising with the agency about the competency of the staff member involved and implementing further training within two months.

- The meeting minutes from the medication incident review held on the 19 January 2016 did not include any details regarding the services response to the patient involved in the medication incident. The centre manager informed us that the patient had received an apology and that this was recorded in the notes, which we confirmed. The centre manager stated that the patient was not written to formally as they remained in treatment with them.
- Senior staff confirmed that they understood the duty of candour but stated that transparency and openness was an ethos of the organisation. The service had a current "being open and duty of candour" policy that reflected the requirements of the regulation.

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

Assessment of needs and planning of care

- All patients had a care plan meeting and a care plan review within 48 hours of admission, and then at least once during their stay; more if required by the patient, or if they were in treatment over seven days. A one to one care plan meeting was observed between a patient and a recovery coach. The meeting discussion covered mental, emotional and physical health, including how the patient was feeling and sleeping during the detox. Participation in the therapeutic programme was reviewed, as well as discharge and aftercare plans. The previous care plan was also reviewed. The patient and worker worked in collaboration to agree goals. This information was then transferred to the care plan review form.
- Ten care records were reviewed during the inspection. Care plans were in place and up to date and the patient had signed the care plan. Staff and patients told us that copies of the care plans were offered to the patient. Care plan reviews were holistic and fully orientated towards recovery. However, some of the information from the care plan meeting narrative did not always get written-up into the care plan review document. The care plan review document demonstrated the patients' outcomes with what goals had been achieved and what hadn't. However, the care plan review did not always reflect the goals and hopes discussed in the care plan meeting.
- All patient care records had a detailed plan if the patient left treatment early, including who should be contacted and the address they would return to. Harm minimisation information and mutual aid meetings information were given on discharge.
- Confidentiality and information sharing, and the treatment contract was discussed and agreed on admission, and then at each care plan meeting.
- A pre-admission assessment was completed with patients, which included a detailed history of the patient, including physical and mental health, relationships, offending behaviour and social circumstances, including housing, employment and education. A risk assessment and risk management plan was completed. This information was forwarded to the consultant who triages this information and may request further information. Routine blood tests are completed but the consultant may request additional blood work prior to admission where there are other physical health concerns.
- Patients had a full physical examination on the day of admission with the nurse and the doctor. This included physical observations such as blood pressure, pulse and a breath and urine screen for alcohol and drugs respectively. The centre manager told us that the doctor discusses the medication options for the detox with the patient, and provides them with information around these medications. The doctor prescribes the agreed medication and regime and this was then monitored by the nurse and overseen by the doctor remotely.
- Blood borne virus testing and vaccination was offered on admission to the service and then referrals made to the patient's local GP to complete the treatment. Evidence of blood borne virus discussions were observed in the patients' care records.
- We observed medicines being given to service users in a private, person-centred manner. A nurse and support worked were present and the service user was given as much time as they needed to discuss their current

presentation. The nurse took time to explain what each medicine was for, and assessed each person for withdrawal symptoms against nationally recognised scales in a caring and respectful way. The nurse stayed with people to ensure they had swallowed the medicines safely. Medicines administration time was used as an opportunity to support the service user with their overall health and wellbeing, for example by discussing the service user's physical health problems. We saw a service user who had high blood pressure was encouraged to see their GP and a service user who had diabetes had a discussion with the nurse about their feet.

- We viewed ten treatment charts in use at the time of the inspection and found that these were accurately completed. They included the use of patients own medicines and administration instructions for medicines taken on an "as required" basis. Where service users needed medicines after food, they were asked to come back after lunch to take these.
- The nationally recognised withdrawal scales used by Oasis Recovery Community Bradford including the clinical institute withdrawal assessment revised scale for alcohol, the clinical institute withdrawal assessment scale for benzodiazepines, and the clinical opiate withdrawal scale.
- Oasis Recovery Community Bradford had a therapeutic programme five days a week. There was a four-week rolling group programme with two therapeutic groups per day. This included a process group facilitated by staff to support patients to understand their immediate issues, explore them with input of their peers and then come up with actions to help them to resolve the issue. Other groups included relapse prevention, the effects of detox, exploring emotions and relationships, mind mapping, life skills and an educational group. The third and final group of the day was a recreational activity designed to end the day on a positive with the recovery community in the unit, for example a quiz or a walk. Evenings and weekends were more relaxed with patients having more free time to build relationships with each other. Mutual aid meetings and family visits took place at the weekend. Patients were also empowered to complete daily chores to learn daily living skills.

Best practice in treatment and care

- The psychological therapies delivered in one to one sessions and in a group setting were evidence based and recommended by the National Institute for Health and Care Excellence, including motivational interviewing and cognitive behavioural techniques, and also used the 12 step philosophy.
- The process groups had been designed in line with the Egan Skilled Helper Model, which is a three-stage framework used to help people manage their problems more effectively and develop opportunities. This is recognised and used nationally and internationally in rehabilitation treatment centres.
- The therapeutic group sessions were based on the Public Health England resources and toolkits, including the international treatment effectiveness project link node mapping, which is the simple technique for presenting verbal information in a diagram
- Detox medication and reduction plans were based on the National Institute for Health and Care Excellence guidelines but were also tailored to individual need, for example with the use of other medication used for the side-effects of a patient's withdrawal, or the speed of the detox if someone was struggling with the regime, or conversely wanted to detox faster. This was demonstrated in the patient's care records.
- The patients completed daily diaries so staff were aware on a daily basis how they were feeling mentally, emotionally and physically, and how well they were engaging with the therapeutic programme. These were used as guide for additional support, like a one to one, increased observations, or to contact the doctor regarding a change of medication.
- The care plan review was outcome focussed so staff and patients knew if their objectives had been achieved. The service asked patients to complete an exit questionnaire and collated the data to review patient outcomes, satisfaction and how to improve the service they offer.
- The nursing staff completed weekly audits of patients' records and the treatment and care they are receiving. We observed evidence of theses audits and a weekly audit schedule. However, a standard audit tool was not used so the service could not be sure that these records were audited consistently. The directors completed internal quality audits quarterly. We observed both audits completed which covered a comprehensive

review of the service and all aspects of governance, including medication, patient files, supervision, training, monitoring requirements, contract and business continuity, health and safety, kitchen hygiene and fire safety.

Skilled staff to deliver care

- Oasis Recovery Community Bradford had a training matrix mapped against the specific roles for all staff, and all mandatory training and specialist training was either in progress or completed. We observed a training plan for 2016 which ensured that staff maintained their competence. This included training on understanding mental health, the Care Act (2014) and the Equality Act (2010) to ensure that staff understood how to work with patients from specific groups in the context of these Acts.
- Oasis Recovery Communities employed two consultants to cover their three services, including Oasis Recovery Community Bradford. Both consultants had completed the Royal College of General Practitioners certificate in substance misuse, parts one and two. This was a requirement for working in the service. The evidence based course gives doctors the knowledge and skills to match the competency framework in delivering quality care for drug and alcohol users. Both consultants had been revalidated.
- All qualified nurses, and workers in other roles, had been trained in the last 12 months in administering medication. We saw evidence in the staff files that nurses were qualified and registered.
- The recovery coaches competencies were mapped against the drug and alcohol national occupational standards, and the training that they had all completed matched the competencies required to fulfil their role, for example group facilitation, person-centred care, care planning, record keeping and report writing, and a counselling qualification or equivalent. Both the support workers and those in a recovery coach role had either completed, or were working towards level three national vocational qualifications, or equivalent, in Health and Social Care.
- The deputy manager and the centre manager had either completed, or were working towards, a level five national vocational qualification in leadership and management.
- All staff received monthly management supervisions from the centre manager. The nursing staff also received quarterly clinical supervision from the lead nurse. The lead nurse received clinical supervision with the consultant. Supervision ensured that staff were competent to fulfil their role, that they were adequately supported and that any underperformance could be identified. For nursing staff, clinical supervision was also a requirement of their registration. The appraisal information provided by Oasis Recovery Community Bradford evidenced that 40% of all staff, and 22% of non-medical staff had been appraised. However, this figure reflected the number of staff appraised since the service became Oasis Recovery Communities on the 1 September 2016. During the inspection, we confirmed that all staff had a current appraisal in the last 12 months but this had been completed by the same centre manager under the previous provider.
- During the inspection, we observed four files and saw evidence that supervision had been completed monthly and that appraisals were present. We also observed a comprehensive induction completed by staff and signed off by managers, and training certificates. Personnel files included recruitment packs, including job descriptions and interview questions and answers, current disclosure and barring certificates, health assessments and risk assessments and management plans for employees with previous criminal convictions. All files except one had two reference checks, a member of staff who had previously worked for the service had just once reference. Some information was in the paper files, some had been archived, and some was on the computer system so the management of this information was inconsistent and not easily accessible.
- The service identified and addressed poor performance promptly and we observed increased supervision and action plans to address this with a staff member.

Multi-disciplinary and inter-agency team work

- There was multi-disciplinary input into the comprehensive pre-admission assessment appropriate to the individual patient, including from community substance misuse teams, the patient's GP, criminal justice services, hospitals and social workers prior to the patient being admitted. This was to ensure the patient could be supported adequately and any risk managed appropriately whilst they were in the inpatient unit.

Substance misuse/detoxification

Likewise, on discharge in the aftercare plan, Oasis Recovery Community Bradford worked collaboratively with a wide range of agencies that could support their patient's individual needs in a number of geographical areas, for example housing, employment and education, residential rehabilitation services, and health and well-being services. The local Narcotics Anonymous mutual aid group attended the service and the staff told us that they ensure that patients were provided with mutual aid information for their local area on discharge.

- Each patient had a clearly identified named nurse whose role was to liaise with the GP regarding any health concerns and any medication. They also had a named recovery coach whose primary role is to take ownership of the relationships with those involved in the patients care, including the referring agency and community care co-ordinators if it is a statutory referral.
- There were two handovers each day: one in the morning and one in the evening. We observed a morning handover. A nurse, a recovery coach, a support worker, a social work student, the deputy manager, a director and an administrator attended. Staff told us that it was usual for all staff to attend. Each patient was discussed in turn by the nurse, including the patient's physical observations, blood pressure, sleep disturbance and any mental and emotional concerns. Each patient was then discussed by the deputy manager which included the patient's motivation and engagement in the programme, and the patients overall presentation from the recovery coaches point of view. The centre manager or deputy manager viewed the daily diaries each morning so the patients' thoughts and feelings were fed into the morning handover in this way. The handovers were recorded onto the computer system and a copy emailed to the doctor for review.
- Team meetings took place monthly, led by the centre manager. All staff attended. The minutes we observed demonstrated the multidisciplinary team attendance and the services commitment to patient treatment and care, safety and quality, through discussions around audit, ensuring the kitchen hygiene and making improvements to the therapeutic programme.

Adherence to the MHA and the MHA Code of Practice

- Oasis Recovery Community Bradford did not admit patients detained under the Mental Health Act.

Good practice in applying the MCA

- Care records we observed and treatment agreements showed that patients had signed and consented to treatment, sharing of information and confidentiality agreements. Discussions with patients demonstrated that they were all aware of, and agreed with, their treatment and care.
- All staff had received the mandatory training in the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.
- There were no patients subject to Deprivation of Liberty Safeguards.
- Examples were given where patients did not have capacity to consent to treatment, for example on admission due to intoxication, and the service had waited to complete the admission assessment until the patient had regained capacity to make their treatment decisions.
- Patients could leave the service if they wished as they were assessed as having capacity to make decisions, even if it was an unwise one. However, they were encouraged not to leave, but to complete their treatment.

Are substance misuse/detoxification services caring?

Kindness, dignity, respect and support

- All patients were extremely positive about the care, compassion and commitment of staff. Staff were observed engaging with patients in a range of activities, for example groups, one to ones and medication rounds, in a person-centred, respectful and supportive manner. Interactions were positive and recovery focussed. Staff were relaxed and friendly and boundaries continued to be maintained.
- Patients, family and carers we spoke to said that all the staff were professional, approachable and accessible, and always made time to talk to them. They were never too busy. They told us they felt comfortable to raise any concerns they may have about their treatment or people in their recovery community. Relationships and a sense of community appeared strong, with patients sitting together and supporting one another.

Substance misuse/detoxification

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

The involvement of people in the care they receive

- Patients were fully informed through a robust admission process, which included a pre-admission assessment, a full admissions assessment and a full orientation to the inpatient unit, so that they understood the ethos and restrictions of the service. We observed a patient who had been recently admitted being shown around the ward by a staff member. The admission handbook is in all patient bedrooms throughout their stay, and is available on line prior to admission.
- Each patient was allocated a named recovery coach who was responsible for working with the patient through their treatment journey, including completing the care plan and one to one therapeutic interventions for continuity. Patients were fully involved with their care and treatment; care plan review meetings were completed in collaboration with the patient and then this information was transferred to a care plan that was signed by the patient. All patients had current, signed care plans and agreed discharge plans should they leave the service unexpectedly.
- Patients and families were supported to access advocacy from Bradford Citizens' Advice Bureaux or Bradford and Airedale Mental Health Advocacy Group. However, staff and patients told us that they had not needed to use this.
- The staff we spoke with told us that patients were actively encouraged to contact their family members. We observed that keeping in contact was part of the care plan meeting and review. Family members and carers told us that they were able to contact the service to speak to staff about their family member and their treatment. Oasis Recovery Community has a service level agreement with a local service that would offer telephone support and help families and carers find support in their local area. Relatives and carers were offered one to one support when they attended for visits. The centre manager informed us that they had previously facilitated a family and carers group but as people did not attend, they had moved to delivering one to one interventions.
- Patients were able to input into the treatment and care they received through daily diaries, daily house meetings, and monthly community meetings. The daily diaries were reviewed and the information was fed into the handover. During the inspection, we attended a house meeting. Patients were informed which staff members were working that day and what was happening in the service, including a new patient admission. A short motivational story was read to the group. The staff members present offered the patients the opportunity to read this story to the rest of the group. Patients appeared comfortable in raising issues personal to them, for example one patient had difficulty sleeping and they were advised to bring the issue to the therapeutic process group later that day. We also observed minutes of three community meetings, which evidenced patients offering feedback into their treatment and the service. The centre manager told us that in response to patient feedback, individual mirrors were bought for patients to style their hair and put their make-up on. Quarterly quality improvement forums were due to start in March 2016 so that patients could input into wider service changes.

Are substance misuse/detoxification services responsive to people's needs? (for example, to feedback?)

Access and discharge

- At the time of the inspection, there were ten patients in treatment at Oasis Recovery Communities, though the capacity of the service was 17 patients. The centre manager told us that the average number of patients was 12 and so the average bed occupancy since September was 71%.
- The majority of referrals into Oasis Recovery Community Bradford came via the community substance misuse teams and were funded by the commissioners in those areas. This accounted for 85% of their referrals. Some commissioners would block purchase beds and others paid for each admission. Patients could also self-refer.

Substance misuse/detoxification

Referrals came from a number of areas in Yorkshire, Lancashire and Greater Manchester. This was representative of the patient mix at the time of our inspection. However, the service takes referrals from across the country.

- The service had a clear admission criteria, which included the patient having a willingness to engage in the service and to agree to the treatment contract, that they were not sectioned under the Mental Health Act, and that they had a detailed discharge and aftercare plan in place. Since 1 September 2015, there had been 125 admissions to Oasis Recovery Community Bradford, including 84 admissions for alcohol dependence, 31 admissions for drug dependence and 14 admissions for both alcohol and drugs.
- The average length of stay for patients detoxing from alcohol only was 10 days, 17 days for patients detoxing off drugs only, and 14 days for patients detoxing of both alcohol and drugs.
- The National Drug Treatment Monitoring Data demonstrated four waits over three weeks to access opiate detoxifications between 1 October 2015 and the end of December 2015. However, the centre manager and directors told us that there were no waiting times to access treatment, and this was likely to be a recording error. Waiting times were being recorded where the patient was delaying access to treatment rather than the service delaying admission. The service target from referral to admission is 14 days. At the time of the inspection, there were patients who had been emergency referrals from hospital or who had been in crisis in the community and had been admitted immediately. A family member confirmed that he had contacted the service and his partner had been admitted the following day.
- For urgent or self-referrals, the service worked with the patient to agree the discharge and aftercare plan, and to find appropriate support services in their area to support their recovery and well-being, for example the local community drug team, the GP, mutual aid, sports centres and activities like arts and crafts. We observed a staff member contacting agencies in a patient's local area during our visit.
- A doctor saw all patients on admission and completed a full assessment. The treatment and care was then handed over to the nurse. The doctor was accessible by telephone and received the email handovers twice daily. All the staff told us that the doctor would attend the service if it was felt necessary or the service would support the patient to attend the walk in centre, or for more urgent care, the acute hospital.
- Between 1 September 2015 and 9 February 2016 there were 126 discharges: 111 (87%) planned and 15 (13%) unplanned. Unplanned discharges are reviewed, and action was taken where areas of improvement were identified, for example working with a referrer to ensure that they work through the admissions handbook with the patient prior to admission.

The facilities promote recovery, comfort, dignity and confidentiality

- Confidentiality, policies and procedures were discussed with patients on admission and in the weekly community groups. The treatment contract and community group minutes we observed confirmed this.
- Oasis Recovery Community Bradford has an accessible clinic room, including a couch and space to examine patients. It also had a full range of rooms to support patients' treatment and care. This included rooms available for one to one appointments, a lounge for group activities, a family room, a dining room including facilities to allow patients to get involved in community chores like washing up, laundry rooms for patients and staff, and a whirl-pool bath to help with the detox symptoms like sweats and to support relaxation.
- A good sized outside area that was clean and well maintained was available for patients, including an area for patients to smoke. Patients could access the outside area at all times throughout the day. However, this was locked in the evening for security but patients could ask to go outside at all times.
- All staff and patients told us that they were able to personalise their bedrooms. We observed bedrooms that were personalised even where the length of stay for the patient was seven days.
- Patients were not allowed to keep their mobile phones during their stay at the service but could use a payphone in the evenings between six and 11pm. Staff told us that patients were encouraged to contact their families. However, the payphone was situated in the

corridor so had limited privacy. One patient told us that they had requested to use a phone for work purposes and the staff had let him use a phone in private and another patient told us that cordless phones could be used for private phone calls. All patients told us that family could ring at all times and staff would pass messages on. They also told us that they were aware prior to admission that they could not have their mobile phones whilst in treatment at the service and that this information was in the admission handbook. Mobile phones were not permitted during treatment at the inpatient unit as patients were expected to engage in the groups and become part of the inpatient recovery community. Plus, there was a risk that patients could contact dealers and put themselves, and the recovery community at risk.

- The service had two televisions in the lounge and in the family room respectively. There were board games and computer consoles for patients to use in the evenings and at weekends. There was no internet access for patients at the service. The centre manager told us that the priority was establishing a community where patients interacted and built relationships with each other. Other organised recreational activities included quizzes, walks in the park and relaxation groups and these were at a set time during each day and at the weekend and were in addition to the therapeutic activities and groups. Patients were not able to leave the unit unescorted, which they were all aware of prior to entering treatment.
- Patients could lock belongings in their room to keep them safe. There was a list of items detailed in the admissions handbook that patients could not keep in their rooms, like perfume or mouthwash for example that contain alcohol. Each patient had a storage box in the locked staff office and items were checked in and out by staff. Patients' money was kept in the safe and logged. Staff gave patients access to their money in small amounts when they needed it, for example for the phone or the shop. This was to prevent any theft, bullying or a patient leaving the unit with all their money when they may be vulnerable to using substances. Patients told us that they were aware of this prior to entering treatment at Oasis Recovery Community Bradford.

Meeting the needs of all people who use the service

- The service was accessible, with lifts and an adapted accessible bedroom including the necessary equipment.
- We observed a choice of meals, with healthy options. All patients spoke highly of the food served at all mealtimes. Patients could have snacks and hot drinks twenty-four hours a day. Dietary requirements were discussed in the pre-admission assessment and we were told that all special dietary requirements could be catered for including halal meat, vegan and diabetic. There was no input from a dietician and no specific input for example for patients with cross-addictions including eating disorders who were in treatment at the time of the inspection.
- Narcotics Anonymous attended the service on a weekly basis. However, as most of the patients were not from the local area staff told us that on discharge they gave patients the information on their local mutual aid meetings to support them in their recovery, including Narcotics Anonymous and Alcoholics Anonymous.
- Visits took place weekly, each Sunday 3pm until 5pm. A family room was available for patients with children which had comfortable sofas, TV, games consoles and age appropriate toys and board games clearly identified.
- The centre manager told us that Bibles and Korans were available for patients to use, as well as prayer mats. We were told that phone calls could be arranged with faith leaders. We observed a notice saying that the family room could be made available as a prayer room but this may not have been available when required for example where prayer times or visiting times clashed and the space evidently for families and children.
- Leaflets about detoxification treatments were available and actively given to patients at admission and when they may be struggling with a specific treatment regime or considering a change to their treatment. The centre manager gave us an example where as well as accessing interpreters, he had used a translation service to ensure these leaflets were appropriate for those who first language was not English We also observed a daily diary where a support worker had written this with the patient as they were unable to read and write very well.
- We observed posters with details of two local advocacy services: Bradford Citizens' Advice Bureaux and Bradford

and Airedale Mental Health Advocacy Group. Staff told us that they would support patients to access advocacy if they requested this or if they felt the patient would benefit from their support.

Listening to and learning from concerns and complaints

- Information on how to complain was observed in the patient treatment contract and the admission handbook which all patients had a copy of. All patients told us that they were aware of how to complain but that they would generally just approach a member of staff and their concern would get resolved. Staff told us that if someone wanted to complain they would try to resolve it and would inform the centre manager. If the complaint could not be resolved, staff told us they would support patients to make a formal complaint.
- Complaints were also collated through the patient exit surveys and on a daily basis through the patient daily diaries. A complaint by a patient regarding the menu choices had been picked up and rectified through the daily diaries.
- Evidence was provided of one complaint in the last six months where a patient had stated there had not been adequate choice around the detox regime. Discussions with the centre manager and evidence observed demonstrated that this complaint was investigated formally and was not upheld. The patient was written to by one of the directors of the organisation. This was in line with complaints policy we observed.
- The service also collected compliments in the patient exit survey. Fifty positive comments were collected between the 1 September 2016 and end of December 2016.
- Oasis Recovery Communities had the mechanism in place to discuss all compliments and complaints from all three of their locations at their senior management meeting. We were told that the staff involved in the complaint would receive a debrief and the lessons learnt would then be cascaded to the centre managers to all the locations. This was reflected in the complaints policy and the clinical governance framework. However, the inspection team could not observe evidence of this due to the lack of formal complaints that were upheld and the fact the locally resolved concerns were not recorded. Also, as locally resolved concerns were not recorded, recurrent themes may not be monitored by the service.

Are substance misuse/detoxification services well-led?

Vision and values

- The chief executive and directors told us that Oasis Recovery Communities' mission, vision and values had been adopted from the previous provider whilst the organisation constructed the necessary governance structures to consult with staff and review these. The organisation's mission was to "provide high quality, outcome focused drug and alcohol addiction recovery services nationwide. The values were as follows:
- We act with integrity and show respect
- We are all accountable
- We are passionate about our business, our service and our clients
- We have the humility and hunger to learn
- We love success
- We strive for simplicity
- The organisation had a clear definition of recovery explained in its vision, that "every person and family suffering from drug and alcohol addiction has a free choice to fully recover from their addiction and achieve their potential.
- Whilst staff could not state the mission, vision and values, all staff could explain a service culture that these represented. Staff demonstrated this through the interactions we observed with the patients, their commitment to improving the service for people during their treatment, as well as improving service outcomes, like the numbers of planned completions.
- All staff knew most senior managers by name. They told us that these managers were approachable and attended the service regularly.

Good governance

Substance misuse/detoxification

- Oasis Recovery Community used a variety of key performance indicators to monitor how well the service was performing. For example completing 80% of all exit questionnaires and 100% of admission questionnaires to gather patient feedback on the service, a 14 day admission date from the date of referral and a care plan to be in place within 48 hours of admission. They were also required to meet the National Data Treatment Monitoring System targets. An issue was identified that the data submitted did not always reflect the service delivery. They were actually meeting these targets, which would indicate the service was providing a good service for the patients.
- There were local governance arrangements in place to ensure good quality care, including quarterly quality audits. We observed two audits and action plans. All mandatory training was up to date and matched the current job descriptions of staff. Staff had regular management and clinical supervision and documents were in place to confirm this. Despite the low appraisal figures, all staff had had an appraisal and they were present in all four files that we observed. However, the documents for supervision, appraisal and training were not held in one central place, which made it difficult to ensure the data collected was correct in the first instance.
- Local governance structures linked into the Oasis Recovery Communities clinical governance framework. The centre manager from Oasis Recovery Community Bradford attended the performance and governance committee and all staff attended the centre meeting. A quality improvement forum was due to start, which would include both staff and patient feedback. There was no local risk register. However, we were told by one of the directors that Oasis Recovery Community were currently in the process of addressing this.
- The policies for Oasis Recovery Communities had been recently reviewed. However, we observed two medicines policies that had been reviewed in January 2015 but did not match current practice in the service. Safeguarding, incident reporting and Mental Capacity Act (2005) procedures were all followed, as were complaints procedures. We saw evidence that there was learning implemented following a medication incident.
- There were sufficient staff in the service and patients told us there was always a member of staff available if they need additional support. An additional support worker was employed at the weekend between 11am and 5pm to ensure that a staff member was available to support patients whilst the other staff were covering kitchen and cleaning duties. On weekdays, nursing staff and support workers were engaged in a full programme of therapeutic duties unlike at the weekends but were still required to cover cleaning duties whilst the current cleaner was off on extended sick-leave. This meant that there was less time for these staff on direct care activities.

Leadership, morale and staff engagement

- The directors for Oasis Recovery Communities, as well as the centre manager and deputy manager for Oasis Recovery Community Bradford were knowledgeable, with experience of leading and managing in the changing environment of the substance misuse field. According to all the staff, the managers and directors were approachable and supported an open, supportive and honest culture, with staff being able to access support from colleagues, managers or clinicians any time they required it. They felt confident in being able to approach the registered manager with concerns without fear of victimisation and were aware of the whistleblowing policy, though thought it was unlikely they would need to use it.
- All staff we spoke to were highly motivated and talked positively about their work at the service and said that morale was good, despite the potentially stressful environment they worked in. They told us that all members of the multi-disciplinary team listened to each other and valued each other's opinion. They also told us that they were proud of the service that they deliver. During the inspection, we observed a real team ethos towards service delivery, for example staff supporting the cover of the cleaning rota.
- The sickness rate at Oasis Recovery Community Bradford was 7.6% between 1 September 2015 and 21 December 2015, which is higher than the national average. The sickness absence was 23 days in total and was attributed to different staff, for different reasons. However, one employee accounted for a third of those sickness absence days. The vacancy rate was 6.7% for this same time-frame. One staff member had left and this vacancy was filled.

Substance misuse/detoxification

- Staff and patients, families and carers were able to feedback into the planning, delivery and development of the service. Oasis Recovery Communities had recently conducted a staff survey. At the time of inspection, the data was still being collated. A quality meeting was scheduled for March 2016, which included patient input from each location, including Bradford.

Commitment to quality improvement and innovation

- Oasis Recovery Community Bradford ensured that patients' views were sought via entry and exit questionnaires in order to improve their service delivery and the experience of the patients during their treatment.
- The company directors completed detailed quarterly quality audits, reviewing the service governance structures to ensure that treatment and care was safe, effective, and continued to improve.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that there are risk assessments in place for the requirement of patient call alarms and staff panic alarms for emergencies or incidents of violence and aggression.
- The provider should review the visits policy to ensure that visits are risk assessed to safeguard children and vulnerable adults.
- The provider should ensure that there is consistent filing and recording of training, supervision and appraisal.
- The provider should ensure that risk management plans contain all the information in the patient record and that they are individually tailored to patient need and include strategies that were used successful prior to treatment, and ones that can be used when the patient leaves treatment.
- The provider should continue to monitor and review fridge temperatures and take action if showing outside the normal range of 2-8°C.
- The provider should initiate a documentation process for the recording of self-administered “when required” medication, for example Salbutamol inhalers that remain in the service users possession.
- The provider should document the risk assessment carried out on admission where a decision is made that medication can remain in a service user’s possession.
- The provider should review their approach to care planning to ensure that there is no duplication of information and that information is not lost between the meeting and the review.
- The provider should consider the additional training on eating disorders and diet for those staff members involving in preparing the menus and food for the patients.
- The provider should consider whether the dual use of the family room as a prayer room is necessary, and if so, how it can meet the needs of those wishing to use it.
- The provider should consider a mechanism to record locally resolved concerns in order to assist them in identifying themes that may require additional action.
- The provider should ensure there is consistent cover arrangement for the cleaner during the week to ensure that staff are not removed from direct patient activities.
- The provider should ensure that staff have adequate training to understand the definitions of the national data treatment monitoring service.
- The provider should ensure that they have a local risk register in place.