Care Quality Commission

Ocean Recovery and Wellness Centre

Quality Report

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Date of inspection visit: 26 October 2016
Date of publication: 05/05/2017

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

This was an unannounced focused inspection relating to issues identified at a previous inspection in August 2016 following which we served warning notices. We do not currently rate independent standalone substance misuse services.

Following a comprehensive inspection in August 2016 we issued a warning notice under regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we assessed whether the service provider had put right issues identified in the warning notice. We found some improvements had been made. However not all areas had been addressed.

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

- The service was not administering medication safely. Medication administration records were not always completed properly. There were gaps in signatures

to confirm administration. Prescription charts were not always signed by a doctor. We found some prescription charts were duplicated. Staff administering medication had not been signed off as competent to do so.

- Physical health and withdrawal symptoms were not being monitored effectively. Physical health observations requested by the doctor were not always being completed. Staff completed Clinical Institute Withdrawal Assessment for alcohol scales on admission. However these were not repeated consistently.
- Staff had not completed medication management training at the time of the inspection. However evidence was provided to show that staff had been booked onto training.
- Staff were monitoring fridge temperatures. However the thermometer did not allow them to record minimum and maximum temperatures.
- There were gaps in medication management. There was a system for auditing medication stock levels. However clients' own medication was being recorded on a separate sheet. This meant that the provider's policy was not being followed. Controlled drugs were being managed in accordance with legislation. A new medicines policy had been developed. However there was no date of issue on the policy.

However, we also found the following areas of good practice:

- Staff we spoke with had either received basic life support training or had been booked to attend training.
- There were two adrenaline pens on site. Staff had undergone training in their use.

Following the comprehensive inspection in August 2016 we issued a warning notice under regulation 17 of the Health and Social Care Act 2008 (regulated activities).

At this inspection we assessed whether the service provider had put right issues identified in the warning notice. We found some improvements had been made. However not all areas had been addressed.

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

- Robust systems There was a lack of audits in place. Staff told us that a care record audit was completed monthly. However, the provider shared results verbally with staff and there was no documentation to evidence this. The provider's quality assurance programme requires the service to complete at least two different audits each year.
- Risk assessments were completed. We found some evidence of risk management plans. However there were risks that had been identified that were not addressed in risk management or care plans.
- There was a ligature audit. This identified the level of access clients had to rooms with ligature points. There was no additional assessment or mitigation in place. However mental health was part of the pre-admission assessment for clients. The service did not admit individuals at risk of suicide.
- Not all policies and procedures had been reviewed. Several policies were overdue for review. There was a box on the front page to evidence that review had taken place.

However, we also found the following areas of good practice:

- Care plans were complete and up to date. Clients' goals and objectives were captured using the wheel of life tool.

Following the comprehensive inspection in August 2016 we issued a warning notice under regulation 18 of the Health and Social Care Act 2008 (regulated activities).

At this inspection we assessed whether the service provider had put right issues identified in the warning notice. We found some improvements had been made. However not all areas had been addressed.

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

- Data on compliance with mandatory training was not available during the inspection. Staff we spoke with told us that training had been discussed in team meetings and that they had training dates booked in.

Summary of findings

- Staff appraisal rates remained low. However staff we spoke with were able to tell us the dates of their planned appraisal. They had been given a pre-appraisal assessment to complete as part of the process.

However, we also found the following areas of good practice:

- Staff informed referral agencies if they were unable to accept referrals due to the consultant psychiatrist being unable to attend. Staff knew how to contact GPs and emergency services in the event of a medical emergency.

Following the inspection we held a management review meeting to discuss the findings. We issued a letter of intent to the provider, requesting further information and assurance. It also laid out the regulatory and enforcement actions available to the CQC if regulations were not met.

Summary of findings

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Care Quality Commission

Ocean Recovery and Wellness Centre

Services we looked at
Substance misuse/detoxification;

Summary of this inspection

Background to Ocean Recovery and Wellness Centre

Ocean Recovery and Wellness Centre provides 24 hour care for clients who are undergoing detoxification from alcohol or substance misuse. The service is based in Blackpool. It has 18 beds over three floors but there are only ever a maximum of 12 clients admitted to the service at any one time. There were nine clients admitted to the service at the time of our inspection. The service accepted nationwide referrals from males and females aged 18 years or older. The service accepted referrals for clients who were privately funded.

As well as detoxification, the service provided individual and group work sessions which included family work, neuro-linguistic programming and recovery. Sessional staff attended the service to deliver activities and treatments including acupuncture, reiki, yoga and meditation.

The service was registered with CQC in December 2014. It is registered to provide accommodation for persons who require treatment for substance misuse and treatment of disease disorder or injury. The service had a registered manager.

There have been three previous inspections carried out at the service. The service was inspected in June 2015 following whistleblowing concerns. The service was issued with warning notices under regulation 15 (premises and equipment) and regulation 17 (good governance).

We carried out a follow up inspection in September 2015. The service had met the requirements of the warning notices. However we issued a requirement notice under regulation 12 (safe care and treatment).

The service was inspected again in August 2016. The service was issued with three warning notices under regulation 12 (safe care and treatment), regulation 17 (good governance) and regulation 18 (staffing). The service was also issued with two requirement notices under regulation 15 (premises and equipment) and regulation 19 (fit and proper persons employed).

At this inspection we only followed up on the warning notices that had been served.

Our inspection team

The team that inspected the service comprised CQC inspector Paul O'Higgins (inspection lead), one other CQC inspector and a CQC pharmacist specialist.

Why we carried out this inspection

We undertook this unannounced inspection to find out if Ocean Recovery and Wellbeing Centre had made improvements since our last comprehensive inspection in August 2016. Following that inspection we issued the provider with three warning notices. Warning notices were served under regulation 12 (safe care and treatment), regulation 17 (good governance) and regulation 18 (safe staffing) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Summary of this inspection

How we carried out this inspection

On this inspection, we assessed whether the service had made improvements in response to the specific concerns we identified during our last inspection. We inspected elements of the following three domains:

- Is it safe?
- Is it effective?
- Is it well led?

Before the inspection visit we reviewed information that we held about the service.

- During the inspection visit, the inspection team: spoke with two staff members
- reviewed five care and treatment records
- reviewed six prescription charts and medication administration records
- reviewed medication management
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

We did not interview people who use the service during this visit.

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 issues that the service provider needs to improve:

- Medication administration record sheets were not always completed properly. There were gaps in signatures to confirm administration. Patient allergies were not always recorded.
- Prescription charts were not always completed properly. Some charts were not signed by a doctor. We found some prescription charts were duplicated.
- Staff had not completed medication management training at the time of the inspection.
- Staff were monitoring fridge temperatures. However the thermometer did not allow them to record minimum and maximum temperatures.
- There was a system for auditing medication stock levels. However clients own medication was being recorded on a separate sheet. This meant that the provider's policy was not being followed.

However, we also found the following areas of good practice:

- Staff had either received basic life support training or had been booked to attend training.
- There were two adrenaline pens on site. Staff had been trained in their use.
- A new medicines policy had been developed. However there was no date of issue on the policy.
- Controlled drugs were being managed in accordance with legislation.

Are services effective?

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

- Physical health observations were not being carried out in line with care plans.
- There was inconsistent use of the Clinical Institute Withdrawal Assessment for Alcohol scales on admission. They were completed on admission but not repeated consistently.
- Compliance with annual appraisals was low. However staff had been given dates for their appraisal and preparatory work to complete.

- There was a limited programme of audit. There was a lack of audits in place. Staff told us that a care record audit was completed monthly. However results were fed back verbally and there was no documentation to evidence this.

However, we also found the following areas of good practice:

- Clients completed a wheel of life to identify their goals and objectives. The document was discussed with staff in one to one sessions and updated regularly.

Are services caring?

We did not review the caring domain at this inspection.

Are services responsive?

We did not review the responsive domain at this inspection.

Are services well-led?

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

- The service was not compliant with its quality improvement system. The quality improvement system states that there should be a minimum of two audits per year. Staff told us that there was a monthly care record audit. However these were not recorded and there was no evidence to support this.
- Policies and procedures were overdue for review. Twenty three policies were overdue for review.

Detailed findings from this inspection

Mental Health Act responsibilities

We did not review the use of the Mental Health Act at this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

We did not review the use of the Mental Capacity Act at this inspection

Substance misuse/detoxification

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse/detoxification services safe?

Safe and clean environment

Following our inspection in August 2016, we served a warning notice relating to environmental risks. In August 2016 we found that ligature risks were identified but that there was no supporting plan around how staff were to reduce or manage those risks. A ligature point is a place to which clients intent on self-harm might ties something to strangle themselves. At this inspection we found that the ligature risk assessment identified the level of access clients had to ligature points. For example if the ligature point was in a room which was kept locked and whether clients had supervised or unsupervised access. Clients were risk assessed prior to admission. The assessment included mental health, self-harm and suicidal ideation. The service did not accept clients who were at the risk of suicide. This meant that the part of the warning notice relating to safety of the environment had been met.

Safe staffing

Following our inspection in August 2016, we served a warning notice relating to low compliance with mandatory training. At this inspection we were unable to determine training compliance as records were kept by the team manager who was not on shift. However, staff we spoke with told us that training had been discussed in team meetings and that they were being booked onto mandatory training courses. One staff member that we spoke with provided certification to evidence that they had accessed first aid and basic life support training since the comprehensive inspection. Following our inspection the service provided evidence that training was being provided for all staff. This meant that the part of the warning notice relating to compliance with mandatory training had been met.

Following our inspection in August 2016, we served a warning notice relating to the lack of cover arrangements for the consultant psychiatrist. The service employed a consultant psychiatrist on a sessional basis when clients were admitted. The consultant carried out the admission assessment. In August 2016 we identified there was no system in place if the consultant psychiatrist was unable to attend the service. No arrangements were in place to cover absence such as sick leave or holidays. At this inspection we identified that staff were informing referral agencies when the consultant was unavailable. They requested that referrals not be sent to the service on those days. When the consultant was scheduled to be away on leave the service was able to source cover from agency services. Staff were aware of how to access medical support from GPs, accident and emergency and emergency services if required. This meant that the part of the warning notice relating to lack of cover arrangements for the consultant psychiatrist had been met.

Assessing and managing risk to clients and staff

Following our inspection in August 2016, we served a warning notice relating to quality of individual client risk assessments. In August 2016 we identified that risk assessments completed by the service were not detailed and did not include management plans. At this inspection we continued to find issues in this regard. We reviewed five care records and found that risk assessments were in place. Assessments covered all relevant areas and had been fully completed. However risk management plans were not in place for all clients. We saw one risk management plan for a client who had a staphylococcal infection in his arm. However one individual was identified as having a potential choking risk whilst eating. There was no associated plan to manage this. However staff we spoke

with were aware of the client's risk. Staff eat meals with clients and were able to monitor for any issues. The part of the warning notice relating to quality of individual client risk assessments had not been met.

Following our inspection in August 2016, we served a warning notice relating to safe administration of medication. We identified that medication administration record sheets were not always completed properly. At this inspection we found that this continued to be an issue. For example, some records did not contain the patient's allergy status. This increases the risk of a person receiving a medicine they are allergic to. We found gaps in administration signatures in five of the six records we reviewed. This meant that we could not be sure medication had been administered in line with the doctor's prescription. A failure to sign to confirm that the medication had been administered also presents the risk of the medication being administered twice.

We found that prescription charts were not always signed by the doctor. Staff had administered medicines from unsigned prescription charts. In addition, staff had transcribed medicines onto new charts without the doctor's signature or second staff member checking the transcription. Some of these transcriptions were incorrect or did not contain the relevant information. This increases the risk of somebody receiving the wrong medicine or the wrong dose. We found that some prescription charts were duplicated which increases the risk of a person receiving the same medicine twice. We saw one client had received two days' worth of detoxification medicines within the same 24 hour period which was not in accordance with the doctor's instructions. We were informed that the company secretary who is a registered nurse completed a session with staff around the safe handling and administration of medications in February 2016. Following the inspection the service provided evidence that staff had been booked on medication awareness training in November 2016. We were told the registered manager was in discussions with the local pharmacist to hold a training session within the next month. However, at the time of this inspection the part of the warning notice relating to safe administration of medication had not been met.

Following our inspection in August 2016 we served a warning notice relating to safe storage of medication. In August 2016, we identified that staff were not monitoring the temperature of fridges used to store medication. At this inspection we found that a thermometer had been purchased and that staff were recording fridge temperatures daily. However the thermometer was incapable of recording minimum and maximum temperatures. As a result only the current temperature had been recorded which was not in accordance with national guidelines. We reviewed daily checks recorded by staff and found they were all in the correct range for storing medicines. This meant that the part of the warning notice relating to safe storage of medication had been partly met.

Following our inspection in August 2016 we served a warning notice relating to the lack of effective systems in place for auditing medication stock levels. At this inspection we found that a system had been introduced to record stock received into the service. However the service's administration of medicines policy stated the receipt of clients own medication should be recorded in the space provided on the chart. However, we found that this was recorded on a separate sheet. As a result staff were not following the provider's policy. This meant that the part of the warning notice relating to the lack of effective systems in place for auditing medication stock levels had been partly met.

Following our inspection in August 2016 we served a warning notice because records of controlled drugs were not being completed in accordance with the Misuse of Drugs Regulations 2001. At this inspection we found that improvements had been made. All records had been made in accordance with legislation. Staff were recording the time controlled drugs were being administered. This meant that the part of the warning notice relating to records of controlled drugs had been met.

Following our inspection in August 2016 we served a warning notice because the provider's medicines policy had expired. At this inspection we reviewed the administration of medicines policy. Staff we spoke with told us it was a new policy. However there was no date of implementation or review. The policy stated injections, controlled drugs, and any medication that requires skilled observations to be made before, during or after administration should only be administered by staff who had undergone training and been assessed as competent. Staff we spoke with told us that they had not had competency assessments at the time of the inspection. Following the inspection the service provided copies of completed competency assessments. These confirmed

that staff had read and understood the policy but did not evidence that the staff member had been observed administering medication prior to be signed off as competent. This meant that the part of the warning notice relating to the medicines policy had partly been met.

Following our inspection in August 2016 we served a warning notice because staff were not trained to administer rectal diazepam. At this inspection we identified that the service was no longer using rectal diazepam. The service was using buccal midazolam as an alternative medication. A protocol to support the use of buccal midazolam was in place. This meant that the part of the warning notice relating to administration of rectal diazepam had been met.

Following our inspection in August 2016 we served a warning notice because the service did not have adequate arrangements to deal with medical emergencies. They did not hold adequate stocks of adrenaline pens to treat severe allergic reactions. At this inspection, there were adequate stocks of adrenaline pens. Staff had undergone training in their use. This meant that the part of the warning notice relating to dealing with medical emergencies had been met.

Following our inspection in August 2016 we served a warning notice relating to the lack of syringes to administer pabrinex if this was required. Pabrinex is prescribed to individuals whose alcohol intake has caused vitamin B and C levels to drop resulting in a depletion of thiamine levels. If this is untreated it can lead to a brain condition called Wernicke's encephalopathy. At this inspection we identified that syringes were available. This meant that the part of the warning notice relating to lack of syringes had been met.

Track record on safety

We did not review the service's track record of safety at this inspection.

Reporting incidents and learning from when things go wrong

We did not review the reporting of incidents and learning from when things go wrong at this inspection.

Duty of candour

We did not review duty of candour at this inspection.

Are substance misuse/detoxification services effective?

(for example, treatment is effective)

Assessment of needs and planning of care

Following our inspection in August 2016, we served a warning notice because care plans were poorly completed. They did not document client's recovery aspects and goals of treatment. At this inspection we found that care plans were up to date. The service had introduced the wheel of life tool. This was being used by clients to identify their goals and objectives. The document was incorporated into care plans. This meant that the part of the warning notice relating to care plans had been met.

Best practice in treatment and care

Following our inspection in August 2016, we served a warning notice because the monitoring of physical health and withdrawal symptoms was not being carried out. We found that physical observations requested by the consultant had not been carried out. At this inspection we found that this continued to be an issue. The doctor requested staff to monitor the client's blood pressure and pulse for the first 24 hours, but records showed that this did not occur for every client. We reviewed five care and treatment records. Of the five records only one had evidence that physical health observations had been conducted in line with the doctor's request. In addition, staff did not regularly assess client's withdrawal symptoms during the detoxification programme as per national guidance. The Clinical Institute Withdrawal Assessment for Alcohol was completed upon initial assessment. The Clinical Institute Withdrawal Assessment for Alcohol is a tool used to monitor a patients withdrawal symptoms and to help identify the need for PRN medication to manage those symptoms. The assessment tool provides an overall score relating to withdrawal symptoms and should be repeated until the score falls to a level where PRM medication is not required. We found evidence that this was then being repeated but this was not consistent for each client. We reviewed five care records. We found that in three records monitoring using the assessment scale had stopped before the scoring reached an appropriate level. It was not clear why this occurred.

Substance misuse/detoxification

This meant that the part of the warning notice relating to monitoring of physical health and withdrawal symptoms had not been met.

Skilled staff to deliver care

Following our inspection in August 2016, we served a warning notice because staff had not received annual appraisals. At this inspection we found that staff had still not received annual appraisals. However staff we spoke with told us the date their appraisal had been booked in for. Staff also showed us the pre-appraisal assessment form they had been given to complete. This meant that the part of the warning notice relating to staff appraisals had been partly met.

Multidisciplinary and inter-agency team work

We did not review multidisciplinary and inter-agency teamwork at this inspection.

Good practice in applying the MCA

We did not review the application of the Mental Capacity Act at this inspection.

Equality and human rights

We did not review equality and human rights at this inspection.

Management of transition arrangements, referral and discharge

We did not review the management of transition arrangements, referral and discharge at this inspection.

Are substance misuse/detoxification services caring?

We did not review the caring domain at this inspection.

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

We did not review the responsive domain at this inspection.

Are substance misuse/detoxification services well-led?

Vision and values

We did not review vision and values this inspection.

Good governance

Following our inspection in August 2016, we served a warning notice relating to policies and procedures. In August 2016, we identified that there were a range of policies and procedures to support staff. However we found that these policies had not been reviewed and updated. On this inspection we identified that 19 of the 42 policies had been reviewed. The remaining policies were under review and there was a programme to achieve this. This meant that the warning notice had been partially met. During our inspection in August 2016, we found that there were three versions of the complaints policy available. At this inspection there was one version. During our inspection in August 2016, we identified that the service's safeguarding policy did not state that staff should inform the CQC of safeguarding alerts or concerns. The safeguarding policy had been amended to reflect this. This meant that the part of the warning notice relating to policies and procedures had been met.

Following our inspection in August 2016, we served a warning notice because the service did not have a quality improvement system in place and there was a lack of audits to monitor compliance in all aspects of the service. At this inspection a quality improvement system was in place. Staff told us that a monthly audit of client files was occurring. However results were fed back verbally and not recorded. The quality improvement system states there should be at least two audits a year. We requested further information from the provider who confirmed further audits were due to be implemented. These included an audit of Medication administration record sheets. We were provided with the template that would be used for those audits. The service had completed health and safety audits. This meant that the part of the warning notice relating to audits to monitor compliance had been met.

Leadership, morale and staff engagement

We did not review leadership, morale and staff engagement at this inspection.

Substance misuse/detoxification

Commitment to quality improvement and innovation

We did not review commitment to quality improvement and innovation at this inspection.

Outstanding practice and areas for improvement

Outstanding practice

Start here...

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to meet the regulations:

- The provider must ensure that all staff are compliant with mandatory training requirements and maintain a database of compliance to ensure there are sufficient numbers of suitably trained staff.
- The provider must ensure that risk assessments completed by the service have associated risk management plans in place.
- The provider must ensure that medicines administration records are completed properly and in accordance with legislation.
- The provider must ensure that prescription charts are completed properly and in accordance with legislation.
- The provider must ensure that staff are competent to dispense medication before they are signed off as competent to do so.
- The provider must ensure that physical health observations are being completed as directed by the consultant.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- The provider should ensure that all staff receive an annual appraisal.
- The provider shouldensure that policies and procedures are reviewed regularly and reflect current practice.
- The provider should ensure that the quality improvement system is adhered too. Audits should be completed in line with the quality improvement system. The provider should ensure that the maximum and minimum temperatures of fridges used to store medication are recorded.
- The provider should ensure that it records medication in line with its administration of medicines policy. Clients' own medication should be recorded on the same form as medication prescribed by the service.

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 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff were not complaint with mandatory training requirements. There was no training database available to show the level of staff compliance and when training was due. This was a breach of Regulation 18 (2) (a)

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Risk assessments did not have associated risk management plans. Physical health observations were not being completed as directed by the clinician. The Clinical Institute Withdrawal Assessment for Alcohol had not been completed in line with guidance for all clients. This was a breach of Regulation 12 (1) (2) (a)(b)

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Medication administration records were not fully completed in accordance with best practice and relevant legislation.

This section is primarily information for the provider

Requirement notices

Prescription charts were not fully completed in accordance with best practice and relevant legislation.

Staff dispensing medication had not been assessed as being competent to do so.

This was a breach of Regulation 12 (1) (2) (g)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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