St Anne's Community Services-Alcohol Services

Quality Report

186 Woodhouse Lane
Leeds
West Yorkshire
LS2 9DX
Tel: 0113 243 44863 113 243 4486
Website: www.st-annes.org.uk

Date of inspection visit: 3 September 2019
Date of publication: 05/11/2019

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Outstanding
Are services responsive?	Good
Are services well-led?	Good

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.

Summary of findings

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 rated St Anne's Community Services – Alcohol Services as good because:

- The service provided safe care. The clinical premises where clients were seen were safe and clean. The service had enough staff. Staff assessed and managed risk well and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the clients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The teams had access to the full range of specialists required to meet the needs of clients under their care. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multidisciplinary team and relevant services outside the organisation.
- Staff treated clients with compassion and kindness and understood the individual needs of clients. They actively involved clients in decisions and care planning.
- The service was easy to access. Staff planned and managed discharge well and had alternative pathways for people whose needs it could not meet.
- The service was well led, and the governance processes ensured that its procedures ran smoothly.

However:

- Staff had not disposed of some clinical waste in line with the provider's policy.
- Clients and visitors did not have access to alarms to alert staff to their urgent need for support.
- One bank nursing member of staff did not have access to the same levels of supervision as substantive staff.

Summary of findings

Contents

Good

St Anne's Community Services-Alcohol Services

Services we looked at:
Substance misuse services.

Summary of this inspection

Background to St Anne's Community Services-Alcohol Services

St Anne's Community Services – Alcohol Services is a detoxification service and a residential rehabilitation service. It is located in the independent sector and belongs to a larger charity called St Anne's which provides services for people with mental health issues, leaning disabilities, substance misuse and homelessness. The alcohol service, based in Leeds, provides treatment to men and women over 18 years of age.

The service is separated into:

- A five-bed detoxification service which provides residential alcohol detoxification to adults who require a safe and supervised place to withdraw from alcohol. This includes clients who are stable on substitute prescriptions for opiate dependency.
- An 18-bed residential rehabilitation service provides adults who have been experiencing alcohol-related problems with an intensive period of support to maintain abstinence from alcohol.

Clients can attend the detoxification service without attending the residential service, and vice versa. Clients can also attend for a detoxification from alcohol and then continue into the residential service. The referral route for both the detoxification and the rehabilitation services is through the community-based substance misuse services in Leeds.

The service had a registered manager in place at the time of inspection. The service registered with the Care Quality Commission on 15 March 2011. The service is registered to provide one regulated activity:

- Accommodation for persons who require treatment for substance misuse.

Six inspections have been undertaken since St Anne's Alcohol Services were first registered. At the last inspection on 24 July 2017 we found that St Anne's Alcohol Services was not meeting all the Health and Social Care Act (Registration) Regulations 2009. We issued the provider with one requirement notice in relation to one regulation:

Regulation 18: Notification of other incidents. The provider had not submitted a notification to the Care Quality Commission following an incident of an allegation of abuse in relation to a service user.

Our inspection team

The team that inspected the service comprised one CQC inspector, one assistant inspector and two specialist advisors. The specialist advisors were a doctor and a nurse with experience of working in substance misuse services.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health 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?

Summary of this inspection

- 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 three focus groups. We also attended three engagement meetings with the service's management team.

During the inspection visit, the inspection team:

- visited the service, looked at the quality of the environment and observed how staff were caring for clients
- spoke with six clients who were using the service
- spoke with three carers of clients who were using the service
- spoke with the deputy manager and the area manager
- spoke with seven other staff members; including doctors, nurses, support workers and volunteers
- received feedback about the service from one commissioner
- attended and observed a hand-over meeting, a client discharge meeting and a client therapy group
- looked at three care and treatment records of patients
- 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

What people who use the service say

We spoke with six clients who were using the service. They told us they had regular support from staff who were approachable, helpful and treated them with respect and compassion. Clients felt staff were knowledgeable about addictions and highly motivated to provide the best care possible. The clients in the rehabilitation part of the service found the therapy programme particularly beneficial and they also had access to support through the partnerships the service had with other community organisations. Clients said the food was good and staff were flexible and accommodating with meals choices. During the inspection, we observed many 'thank you' cards displayed around the building from previous clients. The only negative comment was in relation to mattress covers which some clients said were uncomfortable.

We spoke with three carers who gave highly positive feedback. They said staff went out of their way to provide care which was tailored to the needs of the individual. They could attend review meetings and met with managers and staff to discuss care and treatment. Staff were welcoming and approachable to carers and close friends. They felt involved in the treatment plan and had been provided with information about support services and how to help their relative stay abstinent once discharged. All the carers we spoke with thought staff empowered people to realise their potential and felt their relative had made excellent progress whilst in rehabilitation.

All the clients and carers we spoke with could not praise the staff highly enough for their caring approach.

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?

Good

We rated safe as good because:

- All clinical premises where clients received care were safe, clean, appropriately equipped, well furnished, maintained and fit for purpose.Clients had individual bedrooms.
- The service had enough nursing and medical staff, who knew the clients and received basic training to keep them safe from avoidable harm.
- Staff screened clients before admission and only admitted them if it was safe to do so. They assessed and managed risks to clients and themselves well. They responded promptly to sudden deterioration in clients' physical and mental health.
- Staff understood how to protect clients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Staff had access to clinical information and it was easy for them to maintain high quality paper-based clinical records.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each client's physical health.
- The service had a good track record on safety. The service managed client safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave clients honest information and suitable support.

However:

- There was some clinical waste which staff had not disposed of in line with the provider's policy.
- Clients and visitors did not have access to alarms to alert staff to their urgent need for support.

Are services effective?

Good

We rated effective as good because:

- Staff completed comprehensive assessments with clients on admission to the service. They worked with clients to develop individual care plans and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.

Summary of this inspection

- Staff provided a range of care and treatment interventions suitable for the client group and consistent with national guidance on best practice. They ensured that clients had good access to physical healthcare and supported clients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, bench-marking and service improvement initiatives.
- The teams had access to the full range of specialists required to meet the needs of clients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit clients. They supported each other to make sure clients had no gaps in their care. The team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff supported clients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2015 and knew what to do if a client's capacity to make decisions about their care might be impaired.

However:

- One bank nursing member of staff did not have access to the same levels of supervision as substantive staff.

Are services caring?

Outstanding ☆

We rated caring as outstanding because:

- Clients and carers consistently praised staff for the way they treated clients. People felt respected and valued as individuals. Staff treated people with compassion kindness and empowered them to be partners in their own care. They respected patients' privacy and dignity. They understood the individual needs of clients and supported them to understand and manage their care and treatment. Stakeholders, including clients, carers and commissioners thought staff were highly motivated and the culture very person centred.
- Staff involved clients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that clients had easy access to additional support. They were flexible in delivering care and took people's personal, cultural, social and religious needs into account.

Summary of this inspection

- Staff informed and involved families and carers in all aspects of the treatment. Staff recognised the totality of people's needs and carers felt valued and well supported.

Are services responsive?

Good

We rated responsive as good because:

- The service was easy to access. Staff planned and managed discharge well. The service had alternative care pathways and referral systems for people whose needs it could not meet.
- The design, layout, and furnishings of the ward supported clients' treatment, privacy and dignity. Each client had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy.
- The service met the needs of all clients, including those with a protected characteristic or with communication support needs.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

Are services well-led?

Good

We rated well-led as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for clients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively and that performance and risk were managed well.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff collected and analysed data about outcomes and performance.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

All staff had completed mandatory training in the Mental Capacity Act. We saw in care records documented evidence that staff discussed and checked capacity to consent to treatment with all clients on admission. Staff supported clients to make their own decisions and sought advice from managers where they had concerns that a client lacked capacity. Staff showed a good understanding of the principles of the Mental capacity Act and how it applied to their work.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Substance misuse services	Good	Good	☆ Outstanding	Good	Good	Good
Overall	Good	Good	☆ Outstanding	Good	Good	Good

Good

Substance misuse services

Safe	Good
Effective	Good
Caring	Outstanding
Responsive	Good
Well-led	Good

Are substance misuse services safe?

Good

Safe and clean environment

The service provided mixed-sex accommodation for patients. Clients had individual bedrooms but rooms were not segregated so males and females shared bathroom facilities. There were no separate day spaces for female clients but the provider had carried out a risk assessment identifying existing measures to ensure clients safety, privacy and dignity in this environment. This included ensuring potential clients were aware that they would be staying in a mixed sex facility and ensuring they fully understood and were comfortable with what this entailed. Staff could re-direct clients to other services where they wanted or required a single gender facility.

Areas that clients had access to were clean, comfortable and adequately maintained. Staff adhered to infection control principles such as hand-washing. There was non-alcohol hand gel in communal areas and posters advising people about correct hand-washing techniques. The service had arrangements in place to dispose of clinical waste, however we found in the clinic room several sharps containers that had been filled above the three-quarter fill-line. The containers had not been labelled or signed to indicate the date they were assembled and who assembled them. This practice was not in line with the provider's infection control policy. Immediately following the inspection, staff confirmed they had made arrangements for the waste to be collected from the service without delay.

The service had an up-to-date health and safety policy including a fire risk assessment.

The service had an up-to-date health and safety policy including a fire risk assessment.

There was no patient alarm system present but the provider had identified measures to manage the potential risk to patients, visitors and staff. Clients undergoing detoxification were observed every 15 minutes for the first three days and on the night shift, the support worker and the nurse on duty had radio contact with each other. The five detoxification beds were all located close to the nurses office and staff had easy access to an automated external defibrillator, which they had been trained to use. In addition, behaviour contracts were incorporated into clients' licence agreements and they were there voluntarily. The service had worked with some clients prior to entry into the service, assessing their motivation to change and attitude towards shared living. The service had not had any incidents of violence or aggression.

Staff did not have unimpeded sight lines in the facility but had put measures in place to mitigate this, for example observation and risk assessment. The service had effective policies on the use of observation and had carried out a ligature risk audit. Staff had replaced some fittings, which they identified as higher risk with anti-ligature mechanisms, for example, some door closure mechanisms. Some areas were not accessible to clients unless they were supervised by staff. The service had admission criteria which meant the doctor had to be involved in decisions where clients were at moderate or high risk of suicide. Clients would not be admitted if their risk of suicide was considered too great for staff to manage.

Safe staffing

There were enough skilled staff to meet the needs of the clients. The staff team consisted of a service manager, a deputy service manager, five support workers, three nurses and one clinical nurse manager working on a shift pattern. The medical team were contracted from an external service and one doctor visited the service twice per week. A locum acted in the doctor's absence. The service was staffed 24/7. There were three shifts per day and during the day, each shift had at least one nurse and two support workers. On the night shift, there was one nurse and one support worker. However, staffing levels could be increased on a shift by shift basis if this was necessary to ensure patient safety.

Managers anticipated potential staffing problems and had recruited a pool of staff, including nursing staff from the wider organisation to provider cover in the alcohol service in case of substantive staff absence or vacant posts. These staff were experienced in working with substance users. Managers had also recruited a small number of regular agency workers who knew the service well and were experienced with the client group. Information submitted by the provider confirmed that, in the period May 2018 to April 2019, no shifts were left unfilled by bank or agency staff where cover was required for sickness absence or vacant posts.

Managers had adapted their recruitment procedures to make it easier for nursing staff to apply for jobs at the service. At the time of the inspection, the service had several vacant posts and some sickness absence. However, the service had an interim deputy manager in place from the wider organisation and the substantive deputy manager had stepped up into the manager role. Staff also had support from the area manager who worked from the location when needed. Managers had recruited one new full time and one new part time support worker and were waiting for their pre-employment checks to be finalised. Managers were interviewing for two vacant nursing posts the following week.

The clients we spoke with at the service told us they had regular one-to-one time with their key worker and they had not experienced activities or groups being cancelled due to a shortage of staff.

Staff had access to lone working policies and personal safety protocols and this included working away from the main base in the community. Eighty-nine percent of staff had completed mandatory health and safety training which they refreshed every two years. As part of the health and safety training, staff participated in mandatory fire safety training. All staff working in the service had completed training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Overall compliance with mandatory training was at 91%.

Assessing and managing risk to patients and staff.

As part of the inspection, we reviewed three client care records in-depth. All clients had an up-to-date risk assessment and risk management plan including a plan for unexpected discharge from the service. Clients could be transferred to other providers where they did not wish to or could not stay in the rehabilitation part of the service.

Client risk management plans were comprehensive and contained appropriate actions to manage risk, for example, additional physical health monitoring for clients with long-term health conditions. All clients had been assessed for whether they needed a personal evacuation plan in the event of a fire and clients also had falls risk assessments in place where appropriate. Clients admitted to the detoxification service received a daily physical health check using the 'vital signs' observation record. Staff monitored the effects of alcohol withdrawal using the Clinical Institute Withdrawal Assessment, (CIWA), a recognised assessment tool.

Nurses, the doctor, support workers and managers could be involved at the various stages of the risk assessment process as appropriate to the level of risk involved. Staff gathered comprehensive risk information from referrers and ensured all clients had an up-to-date medical history from the client's GP prior to assessment by the doctor at the service. Staff had an effective handover in place between each of the three shifts per day. As part of our inspection, we observed a handover meeting which involved nursing and support staff from the previous shift and staff due to be on the following shift. The nurse had prepared a summary of each client and any issues since the previous handover. The meeting was documented so other staff could refer to it as needed. Assessing and managing client risk was an integral part of handover meetings.

Risk assessment and risk management plans were carried out in collaboration with clients and reviewed regularly in

line with service policies. Staff encouraged positive risk taking, for example, clients were encouraged to spend time with visiting relatives away from the service base as appropriate to their stage of recovery.

Staff identified and responded to changing risks posed by clients and had access to local emergency help-lines and NHS emergency numbers. Staff monitored early warning signs of mental or physical deterioration during daily contact with clients and we saw examples where clients had been transferred to hospital promptly when they had become acutely unwell. Nursing staff used recognised tools to closely monitor withdrawal symptoms with clients undergoing detoxification. The tools provided staff with guidance on when to escalate any physical or mental health concerns.

Clients were made aware of the risks of continued substance use through regular relapse prevention sessions held throughout the rehabilitation element of the programme. Clients had access to written harm reduction materials including the dangers of sudden withdrawal from alcohol and safety planning was an integral part of each client's recovery plan.

Clients could smoke in designated areas outside the building. They had access to smoking cessation advice and support through their partnership with the local substance misuse service.

The service imposed some restrictions on clients' freedoms and this was part of the recovery approach. For example, clients could not use their mobile phones at certain times during the day as they were expected to participate in the provider's groupwork programme. Clients were subject to random breath testing or drugs screening as they had agreed to be abstinent from all substances whilst on the programme. There were set meal times and clients were expected to get up at a certain time each morning. Staff offered flexibility in the application of these restrictions and clients confirmed this when we spoke with them. Clients knew explicitly what the house rules were when they signed up to the programme and these were contained in licence agreements which they signed upon entry to the service.

The provider had protocols in place concerning searching which staff carried out in response to identified concerns. Client behaviour and code of conduct was contained in license agreements, which clients signed on entry to the service.

Safeguarding.

Staff could give examples of how to protect clients from harassment and discrimination including those with protected characteristics. All staff completed mandatory equality and diversity training which included how to protect clients with protected characteristics under the Equality Act. The training delivered by the provider's equality and diversity officer included 'real life' case studies that reflected diversity of people with protected characteristics and their experiences of substance misuse.

All staff had completed and were up-to-date with mandatory adult and child safeguarding training. We saw safeguarding information visibly displayed around the service for clients and staff to refer to. The information contained local contact numbers and a procedure for raising safeguarding concerns. Staff were aware of where and how to make necessary referrals.

The provider had clear safeguarding policies with named leads that staff could approach for further guidance and support. Staff including volunteers knew how to identify abuse and raise safeguarding concerns. At our previous inspection in July 2017, we found the provider had not submitted a notification to the Care Quality Commission, (CQC), following an incident of an abuse allegation in relation to a client. At this inspection, we found that between May 2018 and April 2019, the provider submitted six notifications to CQC concerning allegations of abuse as required by the regulation. None of the notifications submitted related to allegations concerning staff in the service.

Staff worked effectively with partner agencies to promote safety and information sharing to protect clients. For example, the deputy manager provided leadership for the team on domestic abuse issues and had close links with local domestic abuse services and the Multi-agency Risk Assessment Conference. This is a process involving the participation of all the key statutory and voluntary agencies who might be involved in supporting victims of domestic

abuse. Managers had participated in further safeguarding training including forced marriage and modern- day slavery and they acted to provide advice and guidance to staff on these issues.

Staff access to essential information.

Staff used paper records to record the details about client care and were were not expected to record information in more than one place. Each client had a comprehensive paper file which was consistently structured and followed the client if they went from the detoxification to the rehabilitation part of the service. All staff including agency staff, bank staff and students had access to client records as needed to deliver and record appropriate care. The client care records we looked at were contemporaneous, accurate and up-to-date.

Medicines management

Staff had policies, procedures and training in place in relation to medicines management. Protocols relating to prescribing and detoxification were up-to-date and in line with guidance issued by the National Institute for Health and Care Excellence , and the appropriate UK guidelines on clinical management.

We looked at seven medication cards which were completed to the correct standard. Staff administration, recording, storage and disposal of medication was compliant with the appropriate guidance.

The service had a risk assessment in place covering the use of emergency medication to manage health conditions. Staff had access to epi-pens containing adrenaline available for use when dealing with anaphylaxis. They did not have access to emergency medicine to treat benzodiazepine overdose. However, benzodiazepines were administered under controlled arrangements by nursing staff and all clients undergoing detoxification were observed every 15 minutes for the first 72 hours to minimise the risk of over-sedation following admission. Clients' belongings were searched on admission to the service to lower the risk of misuse of benzodiazepines during treatment. The service was located close to hospital emergency departments and staff had access to guidance about responding to medical emergencies. Staff told us that where clients were admitted with opiate dependence, staff worked in partnership with the local drugs service to ensure they had access to naloxone, an emergency medication to treat the effects of opiate overdose.

The service did not prescribe high doses of medicines and the visiting doctor reviewed all clients' medicines on admission to the service and regularly throughout their stay.

Medicines audits were carried out weekly by the clinical lead nurse for the service. Any medicines errors were recorded and discussed at daily handovers, team meetings and during staff supervision.

Track record on safety

The service had few adverse events but in May 2018, they reported one serious incident where a client died on the premises during their detoxification. Following this, the provider had updated their observation policy specifically to reflect that where a client's physical and/or mental health deteriorated, staff should increase observations. Staff were aware of this requirement.

In the period May 2018 to April 2019, this provider had no reports from the coroner regarding any actions they needed to take to prevent future deaths.

Reporting incidents and learning from when things go wrong

The provider had an incident reporting procedure in place and used an electronic system to record all incidents and near misses. Staff knew what incidents to report and how to report them. The policy provided guidance to staff about their roles and responsibilities and the importance of reporting incidents consistently. This was reinforced by managers at team meetings.

Staff discussed lessons learned from incidents in handovers and team meetings. In the clinic room, we saw a chart on the wall with lessons learned from recent medication errors. We checked team meeting minutes and saw that learning from incidents was a standard agenda item. In the meeting 14 August 2019, staff discussed how to ensure care plans were clearly linked to risk assessments following an incident where a client had self-harmed. Staff who were not present at the meeting received the minutes by email and were asked to send a receipt to the manager to indicate they had read them.

Managers and staff were aware of the duty of candour. Duty of candour is a legal duty to inform and apologise to clients and their families if there have been mistakes in their care that have led to significant harm. The provider had a duty

of candour policy in place which staff were aware of. We saw team meeting minutes where staff had discussed the duty when the provider revised their policy in December 2018.

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

Good

Assessment of needs and planning of care

In addition to comprehensive referral information, all clients had a thorough assessment on entry to the service. The assessment was holistic and also assessed the client's motivation through a validated tool, the readiness to change questionnaire. Clients had input into the assessment process by completing a questionnaire designed to assess their strengths and areas of need and broad recovery goals. The doctor reviewed the assessments for all clients entering the detoxification programme and had access to health information from the client's GP prior to admission. This included relevant blood and liver function test results. All clients had a self-report physical health assessment and the doctor would undertake physical health examinations at admission as required. The team had effective handovers which they held three times per day.

At inspection, we reviewed three client records in-depth. All three clients were in the rehabilitation part of the service but had also been through the detoxification programme. Staff used a care planning template which covered eight areas of need; (1) safety and wellbeing; (2) physical health; (3) mental health; (4) social needs; (5) nutrition and hydration; (6) mobility; (7) personal choice and preference; and (8) discharge planning. Care plans were personalised, met the needs identified in the assessment and were recovery orientated. They included treatment goals and identified the client's named key worker.

Key workers updated care plans regularly but, as a minimum they were reviewed at week six of the 13 - week rehabilitation programme. All clients had a comprehensive risk management plan and this included a plan for unexpected exit from treatment. Staff had access to guidance on managing unexpected exits from either the detoxification or rehabilitation elements of the programme.

At assessment, staff discussed with clients who they would contact in the event of unplanned discharge and this included the client's relatives where appropriate. Staff contacted the police or the crisis team where they thought a client might be at risk of harm including self-harm.

Best practice in treatment and care

Staff provided prescribing and psychosocial interventions in line with guidance provided by the National Institute for Health and Care Excellence and Public Health England. We observed a new patient admission where the doctor implemented appropriate prescribing plans including vitamin supplements. The doctor could also prescribe drugs to help clients remain abstinent from alcohol post detoxification and they recorded their rationale for these interventions on the client's admission assessment.

Staff used Cognitive Behavioural Therapies to teach clients coping strategies and promote behaviour change. Some staff had been trained in Social and Behavioural Network Therapies and techniques. This is where a client's support network (often family and friends) were invited to participate in meetings and activities whilst the client was in rehabilitation. Staff also used evidence based motivational interventions to increase commitment and confidence to complete treatment goals. Clients saw their key worker regularly for one-to-one sessions but most of the therapeutic work took place through a structured group work programme. The types of sessions that formed part of the programme included anxiety management, relapse prevention, anger management and future planning. Staff had access to evidence-based manuals and tools to help them develop appropriate recovery programmes. Both staff and clients had access to on-line self-help tools.

In response to guidelines issued by the National Institute for Health and Care Excellence concerning working with people in adult social care services, staff had formed a task group to begin recruiting a cohort of 'experts by experience' to help embed client involvement and influence a range of activities and service developments. The experts were expected to be operational in the service by autumn 2019.

The service did not routinely offer clients blood borne virus testing as it was not commissioned to provide this.

However, the service was part of a consortium with a local community substance use team who triaged all referrals from the catchment area and offered blood borne virus testing as appropriate.

Staff supported clients to live healthier lives through appropriate health promotion advice. We saw examples where staff provided advice and information on healthy eating and clients were encouraged to participate in an exercise routine of their choice at least twice per week whilst in rehabilitation. Clients had access to meaningful activity and this included at weekends. Staff ran appropriate therapy groups focussed on topics relevant to the needs of substance users. As part of our inspection, we observed a therapy group on managing emotions.

Monitoring and comparing treatment outcomes

When we spoke with clients, they told us staff regularly reviewed their recovery plans with them and they had hard copies to keep.

The provider participated in a number of accreditation schemes to improve the quality of care provided. These included the Investors In People award (until 2019), and the Stonewall diversity champions programme.

The provider participated in the National Drug Treatment Monitoring System and routinely provided outcome data about unplanned exits from treatment, waiting times and discharge outcomes. In the year ending March 2019, 94% of clients completed the detoxification programme and 99% of them were alcohol free at the point of discharge. Staff used a tool called the 'alcohol spiders tool' to measure individual client progress against treatment goals across a number of relevant domains. They reported on these to local commissioners quarterly.

Skilled staff to deliver care

All staff were provided with a comprehensive induction prior to starting work at the service and managers ensured they had access to mandatory and other training programmes. The provider submitted data to show that 91% of staff had completed their mandatory training. The doctor had completed specialist training in working with substance users and all staff had access to specialist addictions training through the provider's partnership with the local community substance use service. Nursing staff had received appropriate training in medicines management and the use of tools to monitor withdrawal from alcohol. Staff supported clients to prepare their own meals at weekend when the catering coordinator did not work. They had all completed recognised training in food hygiene.

Managers identified learning needs through annual appraisals which they revisited in supervision each quarter. Staff had access to level 2 mental health training, counselling skills training and motivational interventions. Some staff had undertaken training in domestic abuse and the service had a domestic abuse quality mark issued by Leeds City Council. Staff cascaded learning through team meetings and supervision.

The service had robust recruitment procedures in place which included pre-employment checks for all staff including volunteers. The service had recently introduced values-based recruitment and planned to have the experts by experience involved in developing the process.

Substantive staff had access to regular supervision from the manager and deputy manager at the service. Nurses employed by the service had access to clinical supervision delivered by the lead nurse or by the manager of the service. The minimum supervision requirement was at least four times per year but substantive staff confirmed they could ask for supervision when they needed it. Supervision was documented and followed a structured agenda.

The provider did not have a supervision policy in place for bank staff because they ordinarily only used bank staff to cover ad-hoc shifts. However, in the period April 2019 up to the end of August 2019, one bank nurse had covered 49 shifts for the provider to cover staff shortages caused by illness. During this time, they had one supervision meeting in April but they had not received any more by the time we carried out our inspection in September 2019. Following our visit, the provider confirmed they had booked a supervision session in for the bank nurse later the same month.

All staff who had been with the service for more than12 months had an up-to-date appraisal which was linked to the values of the organisation. Where mangers identified poor staff performance, they addressed this effectively with support from the area manager and the corporate organisation.

Managers recruited volunteers and provided them with training and support to undertake their role. During the

inspection, we spoke with a volunteer who co-facilitated groups with the regular support workers. They confirmed they had received mandatory training and had shadowed substantive staff before engaging in any groupwork.

Multi-disciplinary and inter-agency team work

As part of the assessment process, the service gained input from other professionals including the client's GP, probation officer, community substance use key worker and others as appropriate to the client's circumstances. Nurses and support workers met at each handover to discuss each client. Nursing staff met with the doctor to discuss the clients on the detoxification programme. Staff including support workers, nursing staff and managers met for weekly team meetings.

Each client had a named keyworker clearly identified on their care plan and staff worked with other agencies to provide integrated care. For example, the service had strong links with local GP's pharmacists and mutual aid organisations. We saw examples of communication with client's GP's regarding their medication and health needs. The service had an effective partnership with the local substance misuse organisation and this included effective referral and aftercare pathways for clients. In collaboration with the Leeds Teaching Hospital, staff were involved in a review of treatment pathways for clients with acute health needs who might currently be unable to access the detoxification service.

The service discharged clients as soon as their detoxification and rehabilitation was complete although this could be flexible depending on client need. Staff provided relevant organisations with treatment summaries on discharge from the service.

Good practice in applying the MCA

The service had a policy on applying the Mental Capacity Act and all staff had received training in it. The policy was held on an intranet which all staff had access to. We saw in care records documented evidence that staff discussed and checked capacity to consent to treatment with all clients on admission. Staff supported clients to make their own decisions and told us they would seek advice from managers where they had concerns that a client lacked capacity. Staff showed a good understanding of the principles of the Mental capacity Act and how it applied to their work.

Are substance misuse services caring?

Outstanding ☆

Kindness, privacy, dignity, respect, compassion and support

Feedback from clients, carers and other stakeholders was consistently positive about the way staff treated people. There was a strong person-centred culture which was reflected in the values of the organisation and the behaviour of staff. This was confirmed by all the clients, cares and the commissioner we spoke with as part of our inspection. Clients and carers told us staff empowered people to realise their potential and they had made a lot of progress whilst in treatment at the service. Several clients and their carers told us they could not praise the staff and the service highly enough. Most clients and carers told us staff went the extra mile and the care they received exceeded their expectations. During the inspection, we observed that staff spent the majority of their time engaged with clients in groups and one-to-one sessions.

The clients we spoke with told us staff treated them with kindness, compassion, dignity and respect. They said staff were approachable, flexible and listened to their needs. At inspection, we observed interactions which evidenced that staff provided responsive emotional and practical support when clients needed it. Staff showed an understanding of clients' specific needs regarding their gender, ethnicity, religion, sexual orientation, age and disability. They completed mandatory equality and diversity training which included case studies aimed at reflecting the diversity of people with experience of substance misuse. Staff were passionate and highly motivated to provide high quality care. We observed a group therapy session and saw how staff worked in partnership with clients and empowered them to realise their potential. One client told us they had learned so much about themselves and their relationship with substances that they did not know before coming to the service.

Clients interacted with staff and other health professionals to understand and manage their health conditions, for example, diabetes. Staff directed clients to specialist health services where appropriate and clients felt empowered to have a voice in their treatment including healthcare. Clients

were provided with handouts about prescribed medication including any side effects and staff had access to pharmacy advice. Clients could also speak with the visiting doctor about their medication.

The service had clear confidentiality policies which staff explained to clients on admission to the service. We looked at care records which showed evidence of staff explaining the policy to clients and reinforcing this at appropriate intervals. Clients had up-to-date information sharing agreements in place so staff knew who they could share information with Staff could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes to clients without fear of the consequences. The provider had appropriate information displayed in team offices about how staff could raise concerns. The service operated a code of conduct that outlined behaviour expectations within the service and this was explained to and agreed with clients upon admission.and this included carers and other agencies.

Involvement in care

Clients and carers told us they felt involved in their care and that staff worked in partnership with them to take account of their individual requirements. Staff were flexible in delivering care and took people's personal, cultural, social and religious needs into account.

Staff told us the organisation would provide information, for example, in easy-read format for people with communication difficulties. We saw that staff had provided appropriate communication support for a client with dyslexia.

The service had strong links with a local advocacy service and mutual aid organisations that could support clients and their families as required. Clients and cares felt like active partners in their care and staff empowered people to have a voice and realise their potential.

All clients had a recovery plan including a risk management plan that demonstrated the client's strengths and personal goals. In the group sessions we observed staff had an excellent working knowledge of what support and activities were available in the local area to meet the needs of clients. Staff arranged trips to local services, for example the recovery college, for groups of clients to allow them to see what was on offer first hand. Where required, staff would support them to access these services by attending with them for the first time. Clients and carers met frequently with staff and managers to review care and put holistic and robust plans in place for discharge. Staff had excellent partnerships with other organisations including substance misuse teams, recovery organisations and support projects aimed at meeting the needs of clients.

The clients and carers we spoke with told us staff involved them in the care plan and ensured they had the necessary information to make informed decisions about their care and treatment. All the clients we spoke with had received a copy of their care and recovery plan and we could see from care records that clients had signed their individual care and support plans. Clients were strongly encouraged by staff to engage in activities to promote their dignity and independence.

The service had recently introduced a treatment perception questionnaire which all clients had the opportunity to complete. In the last survey available, clients ranked the caring aspects of the service as the most highly valued. Throughout the service, there were many compliment cards displayed from previous clients. The clients we spoke directly with were very complimentary about the staff and how the service had helped them turn their lives around. The carers we spoke with all gave very positive reports about the progress made by their relative whilst in the service.

Involvement of families and carers

Each day, staff facilitated community meetings with clients where they could give feedback about the service. The service carried out regular surveys with carers and sought feedback from clients when they exited the service. Following the inspection, the provider sent us a copy of the carer and client feedback from 2018 which showed a high degree of satisfaction with the service.

Carers could attend information sessions at the service which staff tailored specifically to the needs of carers. They also had access to a comprehensive information pack about the service and the carers we spoke with confirmed they had received this.

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

Good

Substance misuse services

Good

Access, waiting times and discharge

The provider's partnership with the local drugs service provided alternative care pathways for those whose needs could not be met by the service. Whilst on inspection, we saw how one clients had been transferred to another residential detoxification programme in another area because they were not able to comply with specific treatment requirements.

The service had agreed the response times of two working days from referral to making contact with the clients. In 2018/19, the service achieved 96% compliance with this target due in part to having a critical member of staff off on sick leave. The service also had an agreed target from referral to initial assessment which was 10 working days. In 2018/19, the service averaged seven days from referral to assessment which exceeded their target. Once the client had been assessed, the service monitored their waiting time to enter the detoxification programme and the rehabilitation programme. On average, in 2018/19, 74% of clients waited less than three weeks to start treatment, which did not meet the end of year target. This was due, in part, to the service receiving a higher than expected number of referrals in the last quarter of the financial year. The service commissioner we spoke with was fully aware of this.

The service did not see urgent referrals as all clients had to have a certain level of preparedness to enter the programme. Clients requiring detoxification had to have up-to-date blood tests prior to admission. However, staff could prioritise referrals where this was needed and did not compromise waiting times for other clients. The service had admission criteria to exclude inappropriate referrals, for example, those with serious mental health symptoms which were not being effectively managed or those with certain serious medical conditions. All referrals were discussed with the visiting doctor where staff had any concerns regarding their suitability for the service.

Discharge and transfers of care.

Recovery and risk management plans reflected the needs of the client and demonstrated the service had appropriate pathways with other relevant services, for example, community mental health teams and housing organisations. The service had strong links with local recovery organisations which we saw clients had either attended or been signposted towards.

Referral criteria had been agreed with relevant stakeholders including commissioners and the local substance misuse team which generated the majority of referrals. Referral paperwork had been jointly developed and agreed.

We spoke with one of the service commissioners who told us the provider actively engaged with relevant stakeholders to ensure services were developed which met the needs of the local population including those in vulnerable circumstances. We heard how staff were involved with commissioners and other stakeholders in developing treatment pathways for those with complex physical health problems who might otherwise not receive a service.

As part of our inspection, we observed a client discharge planning meeting involving the client, staff from the provider and from the local drugs service. All clients leaving the detoxification and rehabilitation programme had a follow-up appointment made with the local community substance use team to take place within seven days of completing the programme. We saw how staff supported clients when they transferred back to the community team. The provider was able to show us data that in the year ending March 2019, 99% of clients were alcohol free at the point of discharge. The commissioner we spoke with confirmed the provider had made a positive contribution to improved alcohol treatment completion rates across the Leeds treatment system.

In the handover meeting we observed, we saw how staff supported a client that required temporary treatment, for example at the local acute hospital for a chronic health condition.

The facilities promote recovery, comfort, dignity and confidentiality

All clients in both the detoxication and the rehabilitation programme had their own bedrooms and were not expected to sleep in bed bays or dormitories. Interview rooms had adequate sound proofing and privacy. Clients could have privacy if they wanted, for example to use the

phone and clinic areas were accessible to clients with mobility needs. The service had a stair lift and additional handrails had been fitted. Clients had access to a well-maintained courtyard where they could smoke.

Staff regularly reviewed recovery plans with clients and adjustments were made as appropriate. The service had introduced falls assessments which could be completed with clients at any time in their treatment. The provider showed us information which demonstrated how staff had made adaptations to a client's bedroom following discussions with the client and their family prior to admission.

Clients told us the quality of the food was good and the catering coordinator was flexible about meal times and menu choices. Clients could have food prepared to meet their dietary requirements and individual preferences. Staff supported clients to prepare their own meals at weekends and there was a comfortable dining area with hot and cold drinks and a variety of snacks on offer at all times of the day and night.

Patients' engagement with the wider community.

Clients and their carers confirmed that staff supported them to maintain contact with their families where appropriate and we saw evidence in client records of family involvement. Staff had an excellent knowledge of local community services and had strong links with recovery communities and colleges. We saw examples of clients engaged in activities and educational opportunities aimed at promoting recovery from substance misuse. Where appropriate, clients in recovery could become volunteers in the service once they had completed the programme and been through the necessary checks.

Meeting the needs of all people who use the service

Staff received specific training in understanding the particular issues which might be faced by vulnerable groups, for example, clients experiencing domestic abuse. All the clients we spoke with told us staff had a non-judgmental attitude towards them and offered appropriate support when they needed it including at times they felt the most vulnerable.

Where clients had to wait for treatment, staff worked in partnership with the local drug team to ensure clients were supported and well prepared for entry to the programme. The provider had staff seconded into the local drugs service specifically to ensure this. Staff worked flexibly with commissioners and other stakeholders to ensure wait times were minimised, for example, by ensuring referrals were appropriate and all the relevant administration had been completed in a timely manner. The service had pathways to ensure that referrers could indicate when clients were a priority and needed to be seen quickly.

When we spoke with clients and commissioners of the service, they did not report any delays or cancellations in treatment. Managers monitored maximum waiting times and reported these to commissioners on a quarterly basis. Commissioners confirmed waiting times were within acceptable levels given the resources available to the provider.

Listening to and learning from concerns and complaints

Both the clients and the carers we spoke with told us they knew how to make a complaint but none had wanted to. The service received very few formal complaints and we could only see one formal complaint in the period May 2018 to April 2019 and this was responded to in line with the provider's complaints policy. Staff had a meeting with clients every morning and responded there and then to any concerns raised by them. The clients we spoke with told us staff listened to feedback and made changes where needed. For example, clients had asked for more time at a local education centre and this was facilitated. Staff discussed improvements to services in weekly team meetings. The service had recently introduced a treatment perception questionnaire which all clients had the opportunity to complete.

Are substance misuse services well-led?

Good

Leadership

The service had a nurse qualified clinical lead who provided supervision to nursing staff. Managers had the experience, skills and knowledge to perform their roles. All managers at the service including the area manager had significant experience in substance use issues and demonstrated a good understanding of the services they managed. They could explain that good team working and working in partnership with other stakeholders helped

them deliver high quality care. Managers including area mangers were visible on the service and approachable for staff and clients. One of the carers we spoke with told us they had attended a review meeting with their relative where the manager and the keyworker were both present. The service worked in partnership with the local drugs service towards an individual definition of recovery. The commissioner we spoke with confirmed the service was very person centred and focussed on the recovery needs of individual clients.

Vision and strategy

All staff had a job description. They knew the provider's vision and the values of the organisation. The organisation had a clear vision and a set of values which were on display throughout the service. Both staff and clients had been involved in developing the values which promoted a person-centred culture with a commitment to quality as a top priority.

Staff explained how team working and working in partnership with clients and external stakeholders had helped then deliver high quality of care within available budgets. The commissioner we spoke with thought the provider managed resources effectively to provide good quality care. Staff had the opportunity through team meetings to contribute to discussions about service developments and there was evidence that the provider's vision, mission and values had been developed in consultation with staff and clients from across the organisation. Staff appraisals were linked to the values of the organisation. During the inspection, we observed staff behaviour to be consistent with the provider's values.

Culture

The staff we spoke with during the inspection felt supported and valued. They felt positive and proud to work in the service. Clients confirmed that staff had a positive attitude and enjoyed their work. Staff said the job was very busy and could be stressful but they had access to a variety of employee assistance programmes. These included access to a confidential help-line and counselling for them and their families. Some staff had been trained in mental health first aid and could offer support to colleagues struggling with mental health at work.

The provider had a specific reward and recognition policy and celebrated staff achievements, for example, through an employee of the month scheme. Staff also received gift vouchers for lengths of service after the first five years.

Staff from across the whole organisation took part in an annual staff satisfaction survey but the results could not be disaggregated to level of each individual project. The provider promoted equality and diversity in its day-to-day work and was registered with Stonewall as a Diversity Champion. We saw examples in the staff news bulletin where managers encouraged staff to think about equality and diversity issues in their everyday work. Staff had opportunities for career progression and we saw examples of where staff had been promoted through the service. Staff discussed career progression and professional development in appraisals.

The staff worked well together with each other and had strong links with their colleagues seconded to the local substance misuse service. Where there were difficulties, managers had access to support from a corporate human resources department to deal with them appropriately.

Governance

Overall, the provider had effective governance systems in place to ensure the service was safe, clean and that staff were trained and that clients were treated well. Managers had a staff development plan in place with an up-to-date training needs analysis appropriate to meet the needs of clients. However, the provider did not have a policy to provide supervision to bank staff because they did not anticipate they would be covering many shifts in the service. As a result one bank member of staff had not been provided with supervision during the four-month period prior to our inspection.

The provider had a quality and safety team that carried out regular audits by visiting the service, speaking with relevant stakeholders and providing a detailed report with recommendations for action. For example, during their visit in April 2018, we saw how the team had escalated an issue for action following a review of the fire safety arrangements. Staff had completed the necessary action.

Staff in the service locally carried out audits about medicines management, case files, inductions and appraisals. We saw the clinical lead had made recommendations for actions following medicines management audits.

Team meetings contained standard agenda items to ensure staff regularly discussed essential information such as learning from incidents and service user feedback. The provider regularly updated their policies and each contained an equality impact assessment. This is a good practice process designed to ensure that a policy does not discriminate against any disadvantaged or vulnerable people.

Staff worked well with external providers and had formal partnership arrangements in place appropriate to client need. Staff understood these arrangements and cooperated fully with other internal and external teams.

Incidents were reported and appropriate notifications made to external bodies where required. The service commissioner we spoke with confirmed staff kept them up-to-date with appropriate information about adverse incidents. Staff made appropriate safeguarding notifications to the Care Quality Commission which was something we told the provider they must do following our last focused inspection in July 2017.

The provider had a comprehensive whistleblowing policy in place, the details of which were posted in team office areas. Information was also contained in a regular staff electronic newsletter sent out by the corporate team.

Management of risk, issues and performance

The service had quality assurance procedures in place and the provider was in the process of reviewing their board assurance framework. They had recently appointed into a new post of head of corporate governance and risk to strengthen the organisation's governance structures and oversee risk management and quality improvement. This person was a member of the senior executive team and provided support and training to the area manager responsible for the alcohol services in Leeds.

Staff had the ability to submit items to the providers risk register though they told us the systems holding the information were cumbersome and difficult to read. However, the provider had recently transferred their risk registers onto their electronic incident report systems which staff confirmed was much more useful. The items on the risk register matched staff concerns which were around staffing and the re-tender of their service. Staff had removed this item from the register following their successful bid for the retendering of their service contract.

The service had plans for emergencies which they had revised following a major power cut at the service. The provider monitored sickness absence rates and had asked staff for any ideas on how to improve to meet a new target figure.

Information management

Staff had access to equipment and information technology in order to carry out their work. They had received training in information governance including the confidentiality of client records. The information staff needed to deliver care was stored securely in paper records and available to staff when they needed it. The organisation was considering implementing an electronic client records system to improve the way the team recorded, stored and managed client records.

We saw evidence in case files that staff clearly explained confidentiality to clients and each client had an information sharing agreement in place. This included explicit consent for the service to process data for national data systems.

Managers had access to quarterly performance reports containing detailed information about service key performance outputs and outcomes. The report for the period ending March 2019, showed where the service met, exceeded or did not meet service targets for client admissions, treatment completions, waiting times and discharge arrangements. When we spoke with a commissioner of the service, they told us they received regular reports and were satisfied with the overall progress made by the service in respect of their key performance indicators.

Engagement

Staff, clients and carers had access to up-to-date information about the work of the provider through the service specific website and information posted in communal areas of the service. Carers received information about the service in the form of a detailed information pack and staff had access to a regular news bulletin.

Clients had daily meetings with staff and could provide feedback at any time through this. The service carried out regular surveys with clients and carers and had recently introduced a treatment perception questionnaire for use with clients on discharge from the service. Clients were involved in helping to recruit new staff.

Good

Substance misuse services

Staff had access to a staff quarterly staff forum through nominated representatives. The forum provide staff with opportunities to meet with the provider's senior leadership team, give feedback and share ideas about service development. The service had begun to recruit some 'experts by experience' to help shape the organisation's future direction and improve in areas such as staff training, client engagement and values-based recruitment.

Managers of the service engaged in quarterly contract performance meetings with commissioners and meetings with other external stakeholders, for example, the local community substance use treatment service.

Learning, continuous improvement and innovation

The organisation encouraged innovation in line with evidence-based practice. For example, in response to guidelines issued by the National Institute for Health and Care Excellence, the service had begun to recruit 'experts by experience' to help shape service improvements. Staff were involved with a project to improve access to the detoxification service for clients with complex health needs. They were also involved in a local practice development forum with other providers identifying and sharing good practice in the treatment of substance users.

The organisation held a number of quality kite marks including the Investors in People, (IIP) award and, locally the service had a domestic abuse quality mark awarded by the local authority.

The service had staff recognition schemes contained in their organisational reward and recognition policy. Individual staff at the service had been nominated for awards.

Outstanding practice and areas for improvement

Outstanding practice

The service had excellent partnership arrangements in place and links with other organisations including substance misuse teams, recovery organisations and support projects aimed at meeting the needs of clients. A full timetable of therapy was available to clients in the rehabilitation part of the service which included recovery support, practical and emotional help.

Staff were involved in a review of treatment pathways for clients with acute health needs to identify ways to increase access to the detoxification service.

The organisation held a number of quality kite marks including the Investors in People award and, locally the service had a domestic abuse quality mark awarded by the local authority.

The provider promoted equality and diversity and was registered with Stonewall as a Diversity Champion. We saw examples in the staff news bulletin where managers encouraged staff to think about equality and diversity issues and apply them in their everyday work.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure staff dispose of all clinical waste in line with provider's policy.
- The provider should ensure bank staff have access to supervision as appropriate to the number of shifts they are undertaking.
- The provider should ensure there is an appropriate alarm system to enable clients and visitors to alert staff to their urgent need for support.