Broadreach

Quality Report

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

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

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

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

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

Overall summary

We do not currently rate independent standalone substance misuse services.

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

- Clients did not have comprehensive risk management plans. We raised this with the provider during the inspection who confirmed that they would take action to address this. Risk assessments were not completed by the nurses on any of the records we looked at. Risk assessments were completed by the counselling team but these did not include risk management plans. Care plans were not always individualised and did not appear to take into account service users' views or preferences.
- Some physical healthcare provision was required improvement. For example records for one client who had insulin dependent diabetes did not contain enough information for staff to administer additional insulin doses in response to high blood sugar levels and there was no evidence of specialist diabetic input into their care. We raised this with the registered manager, and saw that the provider had started to address this by the end of our inspection.

Summary of findings

- Portable appliance testing for the electrocardiogram (ECG) machine was two months overdue. Staff walkie-talkies were not checked to ensure they were working and staff told us they did not work and that they did not have access to other forms of alarm to access help in an emergency.
- Clients' asthma inhalers were taken out of their original packaging whilst stored in the medicines cupboard. This meant the prescribing information, including dose, was not available.
- Validated dependence tools recommended by the National Institute for health and Care Excellence (NICE) such as the severity of alcohol dependence questionnaire or alcohol problem questionnaire were not used. These tools are recommended by NICE for clients being admitted for alcohol detoxification. However, nurses were using Clinical Institute Withdrawal Assessment from alcohol (CIWA) and the Clinical Opiate Withdrawal Scale (COWS) throughout the detox process.

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

- Clients accessed a range of therapeutic groups as part of their treatment. Clients told us that they thought the therapies were helpful and the food was of good quality.
- Staff completed detailed assessments of client's drug use, injecting history, previous treatment interventions and physical health. Staff demonstrated good practice in following National Institute for health and Care Excellence (NICE) guidelines for detoxification and "drug misuse and dependence: UK guidelines on clinical management (2007)' guidelines".
- Clients who were at risk of self harm could be assigned one of three rooms with reduced ligature points. Clients who left detoxification before the end of treatment were discharged safely.
- The clinic room was clean, tidy and had all necessary equipment. Controlled drugs were ordered, stored and recorded correctly. Environmental risk assessments were undertaken and identified risks were managed. A risk management plan showed what action was to be taken by what date.
- At the time of inspection, there were no nursing staff vacancies. There was always a nurse on duty. The provider only used agency nurses as a last resort.
- All staff were up-to-date for all mandatory training and all staff received supervision and appraisal.

Summary of findings

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Background to Broadreach

Broadreach House is a provider and registered charity, offering treatment and support services for men and women with experience of substance abuse. It consists of three residential services called Broadreach, Longreach and Closereach, and a community day service called Ocean Quay. Broadreach is situated in a large detached house in a residential area in the city of Plymouth.

Broadreach provides residential detoxification from substances for men and women. The service can accommodate 31 clients in a mixture of single and twin rooms. At the start of the inspection Broadreach had 17 clients. During the inspection two clients were discharged and four were admitted.

The majority of clients are funded by community drug and alcohol services and local authorities.

There was a registered manager.

The provider is registered to provide the following regulated activities:

- Accommodation for persons who require treatment for substance misuse
- Diagnostic and screening procedures
- Treatment of disease, disorder or injury

The provider has been inspected four times since registration. The most recent inspection was in 2013 and the provider was found to be compliant in all areas inspected.

Our inspection team

The team that inspected the service was led by CQC inspectors Julia Winstanley and Sarah Lyle, and comprised a specialist CQC pharmacist inspector, a CQC assistant inspector, and a consultant psychiatrist who had experience of substance misuse services.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme to make sure health and care services in England meet the Health and Social Care Act 2008 (regulated activities) regulations 2014.

How we carried out this inspection

To understand the experience of people who use services, we ask the following five questions about every service:

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

Before the inspection visit, we reviewed information that we held about the location and asked other organisations for information.

During the inspection visit, the inspection team:

Summary of this inspection

- visited the location, looked at the quality of the physical environment, and observed how staff were caring for clients
- spoke with 18 clients
- spoke with the registered manager, the lead nurse who was a non-medical prescriber, and the medical officer
- spoke with 12 other staff members employed by the service provider, including the deputy manager, nurses and counsellors
- spoke with the medical officer who was a GP who was contracted to work for the service for six hours per week
- attended and observed a handover meeting
- observed a treatment group and check out group
- collected feedback using comment cards from five clients
- looked at 13 care and treatment records
- looked at medicine management including nine prescription and medication administration charts, observed medicine administration
- observed a client's admission
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

Clients at Broadreach told us they felt safe and that staff were supportive, friendly and helpful. Staff were described as respectful, clients felt that the therapies were helpful and the food was of good quality. Most clients had been involved in their care planning, but the majority did not have a copy of their care plan. Clients told us that they knew how to complain if they needed to. However, clients felt that there were not always enough staff, particularly in the evenings and at weekends, and that the range of activities could be improved. We heard consistently negative comments about the lack of pressure in the showers and lack of choice about having to share a bedroom. We were told that sometimes clients had to share bedrooms even when single bedrooms were available, and some clients were unhappy about not having a lockable space in their rooms where they could secure their personal belongings.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We do not currently rate standalone substance misuse services.

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

- Risk assessments were not completed by the nurses on any of the records we looked at. Risk assessments were completed by the counselling team but these did not include risk management plans. We raised this with the provider during the inspection who confirmed that they would take action to address this
- There was no evidence of weekly checks on defibrillator and portable appliance testing.
- Clients' asthma inhalers were taken out of their original packaging whilst stored in the medicines cupboard. This meant the prescribing information, including dose, was not available.
- There were no formal checks to ensure that staff walkie-talkies were working. Some staff told us that they did not work and they did not have access to other types of alarm.

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

- Three rooms had reduced ligature points and were used for clients who were at risk of self harm.
- The clinic room was clean, tidy and had all necessary equipment including blood pressure monitors, a defibrillator and weighing scales.
- Environmental risk assessments were undertaken. Identified risks were rated and a risk management plan showed what action was to be taken and provided target dates for completion.
- Day shifts were covered to ensure that either the non-medical prescriber or registered manager were always available.
- Clients who left detoxification before the end of treatment were discharged safely.
- Controlled drugs were ordered, stored and recorded correctly.
- Staff at Broadreach were up-to-date in mandatory training.

Are services effective?

We do not currently rate standalone substance misuse services.

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

Summary of this inspection

- Validated tools recommended by the National Institute for health and Care Excellence (NICE) such as the severity of alcohol dependence questionnaire or alcohol problem questionnaire, were not used. However, nurses were using the Clinical Institute Withdrawal Assessment from alcohol (CIWA) and the Clinical Opiate Withdrawal Scale (COWS) throughout the detox process.
- Detoxification treatment plans were generic and pre-printed. They did not contain personalised, holistic or recovery orientated plans. There were no individualised management plans for action to take if a client's mental health or physical health deteriorated.
- Care plans were not always individualised and did not appear to take into account clients' views or preferences. There was not always sufficient focus on long term goal planning and discharge planning.
- We had concerns about some examples physical healthcare provision that required improvement.

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

- Detailed assessments were carried out by the non-medical prescriber and admitting nurse at Broadreach.
- Staff were following National Institute for health and Care Excellence (NICE) guidelines for detoxification and "drug misuse and dependence: UK guidelines on clinical management (2007)" guidelines.
- Clients accessed a range of therapeutic groups as part of their treatment.
- All staff had team supervision and reflective practice sessions, and individual supervision. Appraisals were detailed, thorough and contained goals and objectives.
- New counsellors at Broadreach undertook an orientation programme to ensure they were familiar with all necessary aspects of the service. Counsellors had a range of training opportunities available for their role.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Clients told us they felt safe and well looked after and that staff went the extra mile to meet their needs.
- A buddy system operated so that new clients could be supported by peers who had progressed further through treatment.

Summary of this inspection

- Clients had opportunities to provide comments and suggestions about the service.
- Clients were involved in recruiting new staff.

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

- Some clients told us that some staff had a negative attitude and we witnessed offensive use of language on one occasion to describe a client by one member of staff. We reported this to the registered manager who confirmed that they would address this with staff.

Are services responsive?

We do not currently rate standalone substance misuse services.

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

- There was no defined exclusion criteria but this was managed on a case by case basis.
- There was no secure storage in bedrooms and none of the bedroom doors had locks.
- Some clients told us that that they had not been given a choice about sharing a room, even when there were single rooms available.
- A twin bedroom was used for clients who needed observation because they were at an early stage of their detoxification. This meant that two clients who may be feeling very physically unwell might be sharing a room.
- Clients told us that they sometimes felt bored at weekends and evening and wanted more activities at these times.

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

- An alternative therapies building had recently been built in the grounds.
- The provider could facilitate urgent admissions within three days of referral.
- Discharge arrangements, including unplanned discharges, were agreed before admission.
- Clients who had completed detoxification could move on to the provider's rehabilitation services and community day services, dependent on funding being available.
- Complaints were audited and lessons were learnt. Changes had been made as a result of complaints.

Are services well-led?

We do not currently rate standalone substance misuse services.

Summary of this inspection

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

- Audits were not always effectively identifying areas for improvement.
- There was no effective process in place to ensure that equipment issued to staff to access help in an emergency was working.

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

- There was a clear organisational structure with defined responsibilities for governance and for accountability. The senior leadership team were actively involved in the service.
- There was an effective system for supervision and appraisal.
- The registered manager monitored mandatory training and all staff were up to date.
- The registered manager, deputy manager and non-medical prescriber were undertaking appropriate leadership training.

Detailed findings from this inspection

Mental Health Act responsibilities

We include our assessment of the service provider's compliance with the Mental Capacity Act 2005 and, where relevant, the Mental Health Act 1983 in our overall inspection of the service.

The Mental Health Act was not relevant at this provider.

Further information about findings in relation to the Mental Capacity Act appear later in this report.

Mental Capacity Act and Deprivation of Liberty Safeguards

The provider did not have any clients under the Mental Capacity Act (MCA) Deprivation of Liberty Safeguards (DoLS) and had not made any DoLS applications in the previous 12 months. Mental Capacity Act training and Deprivation of Liberty Safeguards training were mandatory for staff and all staff were up to date. Staff had a good understanding of the Mental Capacity Act.

Mental capacity was assumed for clients, and clients had to have capacity to consent to admission. Consent to treatment and the sharing of information was recorded in client's care records.If clients lacked capacity to consent to some decisions temporarily when first admitted due to intoxication, staff delayed decisions until the person had regained capacity.

Substance misuse/detoxification

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse/detoxification services safe?

Safe and clean environment

- Broadreach was a two storey house with a large garden area. The building provided spacious accommodation and all areas were clean, had good furnishings and were well-maintained.
- The clinic room was clean, tidy and had all necessary equipment including blood pressure monitors, a defibrillator and weighing scales. All nurses were trained to use the defibrillator. However, there was no evidence of the defibrillator being included in the service's weekly checks.
- Portable appliance testing for the electrocardiogram (ECG) machine was two months overdue; however, we saw that the provider had contacted the company in July 2016 to ask them to undertake this. We were advised that the appliance testing had been completed after our inspection. There were appropriate hand washing facilities and equipment was available for phlebotomy and taking blood samples.
- Environmental risk assessments were undertaken. Identified risks were rated and a risk management plan showed what action was to be taken and provided target dates for completion.
- We saw good practice of controlled drugs being stored in a locked cabinet and those that became out of date were denatured before disposal. Denaturing is the process of mixing the controlled drug with another substance to make it unusable.
- Staff told us that if they found illicit drugs on a client, these would be stored and recorded appropriately before being taken to the police station for destruction that date. This was in accordance with the provider's policy.
- Broadreach had a contract with a local waste management company for clinical waste collection.
- The service had a walkie-talkie system which allowed staff to contact each other whilst they were working on site. We were told they also had access to a portable alarm system which was connected to all the managers which could be used in case of emergency. However, staff told us that the walkie-talkie system did not work and that they did not have access to other forms of alarm.

Safe staffing

- Broadreach's staffing establishment consisted of 12 full time staff. The registered manager and six members of staff were registered nurses. Four staff had left in the previous year (33%), of which three had remained within the organisation but moved to work at a different service. Nights were staffed by one nurse and one support worker. Day shifts were arranged to ensure that either the non-medical prescriber or registered manager was always available. The medical officer, who was a local GP, provided cover for the non-medical prescriber's annual leave. There was an on-call system for out of hours support.
- At the time of inspection, there were no vacancies for nursing staff and the only part-time support worker vacancy had recently been filled.
- Unfilled shifts were covered by offering existing staff additional hours or using bank support workers. The

provider only used agency nurses as a last resort. They used a regular agency that had a number of nursing staff who were competent to work in detoxification and who were familiar with the service.

- Staff undertook a range of mandatory training, including adult safeguarding, child protection, fire awareness, and conflict resolution. The registered manager kept electronic and paper records to ensure they were aware of staff compliance with required training. All staff were up-to-date for all mandatory training at the time of our inspection.

Assessing and managing risk to clients and staff

- We looked at 13 client records. Staff had not completed comprehensive risk management plans, this was fed back to the provider during the inspection who confirmed that they would take action. The nursing team and counselling team kept separate client records. Counsellors completed a generic risk assessment form on admission and discharge and completed additional risk assessments during counselling sessions when required. These focused on social and emotional health and did not include risk management plans. A client with asthma did not have a risk assessment or management plan that showed the possible triggers for an asthma attack or what to do when an asthma attack occurred. For a client with diabetes there was no additional information available describing what actions to take in the event that the client's blood glucose levels became too low, or how to monitor the effects of detox treatment on diabetic management. There was no evidence of specialist consultation about diabetes control, and the provider confirmed that changes to treatment had been made by the medical officer, without any specialist input. We raised our concerns about the risk assessments and risk management plans with the registered manager and when we returned two days later this had started to be addressed. For example, the non-medical prescriber had started a risk management plan for the client with diabetes which was detailed, informative and person centred.
- Clients who left detoxification before the end of treatment were discharged safely. We reviewed the documentation for two clients who were discharged early due to testing positive for using substances, which was a breach of the unit's rules. Both unplanned discharges had appropriate information shared with the GP, care manager and next of kin and the clients were given adequate medication to manage their physical and mental health needs. Staff gave advice on the risk of overdose, although naloxone was not provided. Naloxone is a medication used to reverse the effects of opiate overdose. Both clients were given a letter that encouraged them to consider re-trying treatment in the future.
- Restrictions were explained to clients before admission. Restricted items were limited and appropriate for the type of service provided. Clients were asked to hand in phones during the day, but were permitted to use them in the evenings. This was to enable clients to better concentrate on group work.
- A bedroom was used for observation of patients who were higher risk. These rooms had also been adapted to ensure ligature points were minimised.
- Staff demonstrated a good understanding of safeguarding. There was a safeguarding lead for adults and for children and a safeguarding policy which was written in line with the local authorities guidelines. The local authority provided adult safeguarding training. Children's safeguarding training was an e-learning programme. The registered manager kept an electronic record of safeguarding referrals and they were discussed at senior board meetings.
- Fridge and room temperatures in the clinic room were recorded daily, and any breaches of fringe temperature were dealt with appropriately. Medication was stored in a locked cupboard in the treatment room.Adrenaline auto injectors and naloxone were kept in the clinic room for use in an emergency. However, there was no risk assessment of emergency medicines that might be needed for different client groups. Controlled drugs were ordered, stored and recorded correctly, these were checked at staff handovers.
- Nurses administered medicines at Broadreach. Health care assistants provided the second check for controlled drug processes and had undertaken safe administration of medicines training. Allergy information was available on all prescription charts.
- Medicines to be given 'when required' to clients to help with symptoms of withdrawal were prescribed on a separate chart. These charts showed the dose and

frequency of the medicine, including the maximum number of doses where appropriate and the reason for giving the medicine. Medicines prescribed to be given when required that were not for withdrawal were prescribed on the prescription chart. We reviewed nine prescription charts. However, on one prescription chart the prescriber had not written the reason for prescribing the medicine, although the nurse knew the medicine was to be given for hay fever.

- Clients' asthma inhalers were taken out of their original packaging whilst stored in the medicines cupboard. This meant the prescribing information, including dose, was not available. Staff attached name stickers to the inhalers but we saw that one inhaler was not named.
- Medicines given to clients from the homely remedy list were recorded and monitored.
- Visits from children were accommodated. The provider had links with other services locally to offer alternative spaces for children to visit if needed. A 'pod' specifically designed for children's visits was being built at the provider's rehab service Longreach. When complete, we were told that Broadreach clients could use this space when their children visited.

Track record on safety

- The provider reported five serious incidents to the CQC which required further investigation between 11 May 2015 and 11 May 2016. The majority of serious incidents reported involved safeguarding.

Reporting incidents and learning from when things go wrong

- There was an incident reporting policy and staff were encouraged to report incidents. Incidents were recorded and overseen by the manager to identify any themes and learning points.
- Incident reports included a graded risk matrix and were discussed at multi disciplinary team meetings so that any lessons could be learnt. The provider was able to demonstrate learning from incidents, for example, changes had been made to staff supervision following a serious incident.
- Unplanned discharges were recorded as incidents.

Duty of candour

- Staff we spoke to understood the principles of duty of candour and clients gave us examples of when staff had acted candidly. One client told us that staff members had apologised after they had come across as abrupt in a conversation.
- Duty of candour principles were included in the provider's complaints policy.

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

Assessment of needs and planning of care

- We looked at 13 care records for clients at Broadreach.
- The provider kept paper care records and also used an electronic records system which was used by the local drug and alcohol action team and other substance misuse providers in the area. The provider was reviewing its use and hoping to move to another electronic care records in future, but did not have a date for when this would happen. The nursing team and counselling team at Broadreach kept separate sets of client records. This meant that there was not a single, comprehensive care record held for each client and created a potential risk that important information was not available to all staff when needed. However, the provider recognised this risk and was taking action to address this by planning to move onto a web based case management system.
- New admissions to Broadreach were seen by the non-medical prescriber or by the medical officer if the non-medical prescriber was not on duty. If the client had complex health needs, they were seen by both the non-medical prescriber and doctor. Assessments by the non-medical prescriber and admitting nurse contained detailed assessment of client's drug use, injecting history and previous treatment interventions. Physical assessments were completed on admission and urine samples were taken for physical screening and for testing of illicit substances. Electrocardiograms, a test that checks for problems with the electrical activity of the heart, were taken for any client with a pre-existing cardiovascular condition or those using methadone. We looked at the admission paperwork for four clients who had been admitted during our inspection. All four had

seen the medical officer on the day of admission, full physical examinations were completed and treatment plans initiated. Nurses were using Clinical Institute Withdrawal Assessment from alcohol (CIWA) and the Clinical Opiate Withdrawal Scale (COWS) throughout the detox process.The service used the Clinical Opiate Withdrawal Scale (COWS) and the Clinical institute of Withdrawal Assessment (CIWA) to inform the patient's treatment plan. However, validated dependence tools recommended by the National Institute for health and Care Excellence (NICE) such as the severity of alcohol dependence questionnaire or alcohol problem questionnaire were not used. These tools are recommended by NICE for clients being admitted for alcohol detoxification.

- All clients had detoxification treatment plans. However, these were generic and pre-printed. They did not contain personalised, holistic or recovery orientated plans. There were no individualised management plans in place to indicate what action to take if a client's mental health or physical health began to deteriorate. For example, a client who had a diagnosis of asthma and utilised inhalers did not have a care plan to indicate how to manage this if they were to have an asthma attack and a client with liver disease did not have a clear management plan for monitoring symptoms and deterioration. We raised this with the provider during the inspection who confirmed that they would take action to address this
- Care plans were not always individualised and did not appear to take into account service users' views or preferences. There was not always sufficient focus on long term goal planning and discharge planning.
- Client's paper care records were stored securely.

Best practice in treatment and care

- Staff were following National Institute for health and Care Excellence (NICE) guidelines for prescribing detox medication and "drug misuse and dependence: UK guidelines on clinical management (2007)". When off-license prescribing took place there was usually a clear rationale. Very occasionally dihydrocodeine was used for clients undergoing opioid detoxification. This does not follow NICE guidance and the service had only anecdotal evidence of its effectiveness.
- Information about blood borne viruses was either obtained at referral or on admission.
- Counselling staff facilitated groups and one to one sessions. Two counsellors worked during the weekends at Broadreach. Clients accessed a range of therapeutic groups as part of their treatment. Broadreach had a timetable of activities and sessions which included individual one to one sessions, recovery maintenance sessions such as coping with stress and anxiety, cravings and craving busting, stages of change and planning for unexpected a high risk situations. Acupuncture, zimbata and Indian head massage were available. However, clients told us that these therapies were not available as often as they would like. All clients were expected to attend groups as part of their treatment plan.
- A member of staff was trained in eye movement desensitization and reprocessing therapy (EMDR), which is used to help with the symptoms of post-traumatic stress disorder. There was a clear policy and flow chart for EMDR, with referrals discussed at MDT and with the psychiatrist to decide suitability.
- Clients at each service were registered with a local GP practice to ensure their health needs were met. This was the same GP practice which the medical officer worked for. Clients could be treated for minor ailments because a list of homely remedies (medicines that people might purchase for treatment of minor ailments) was available and agreed by the medical officer.
- Staff told us they had links with a range of specialists at the local acute hospital, including the hepatic team for patients with liver damage. However, we had concerns about some examples physical healthcare provision that required improvement. For example records for one client who had insulin dependent diabetes did not contain enough information for staff to adjust the insulin dose in response to blood sugar levels and symptoms and there was no evidence of specialist diabetic input into their care. This client had been experiencing fluctuating blood sugar levels during their admission which warranted a risk assessment and an individualised risk management plan highlighting what action to take if they suffered from hypoglycaemia or hyperglycaemia. We raised this with the registered manager, and saw that the provider had started to address this by the end of our inspection.

Substance misuse/detoxification

- Broadreach's weekly timetable of sessions included physical healthcare workshops such as sexual health, looking after your liver and mental wellbeing.
- Clients completed a, client evaluation of self in treatment, and treatment outcomes measures which monitored change and progress of clients in treatment at regular intervals. Individual session rating tools were not used.
- Audits were carried out using the local commissioners' audit tool. The non-medical prescriber carried out the monthly audits and these included medicines storage, medication administration records, controlled drugs and medicines management checklist. Issues identified in the audits had been acted upon and practice had been changed to improve safety around record keeping. However, not all audits were effective in identifying areas of improvement. For example, audits of care records had not identified that risk assessments were not in place.
- The service provided information including retention and completion rates to the National Drug Treatment Monitoring System.

Skilled staff to deliver care

- Staff at Broadreach included nurses, counsellors and support workers. The registered manager was a nurse and there was a non-medical prescriber (NMP), who was an experienced nurse and had been in post for two years. Nurses worked 13 hour shifts and covered days and nights. Members of the counselling team were available seven days a week. A consultant psychiatrist in addictions worked one afternoon per week and saw individual clients, attended multi-disciplinary team meetings and provided mental health training to staff. The medical officer was a GP from a local surgery who was contracted for six hours a week at Broadreach and supervised the non-medical prescriber (NMP). The medical officer covered the NMP's annual leave and as they were not on site for as many hours as the NMP the provider reduced the numbers of admissions during these times.
- There was access to a prescriber at all times, with out of hours detoxification related issues covered by the medical office and non-medical prescriber on an on-call rota basis. The region's out-of-hours GP service provided care for clients' general health issues. Counsellors took part in an out-of-hours duty rota and could be contacted to provide support and advice if clients wanted to leave the service unplanned.
- Counsellors had a minimum of level three counselling qualification or equivalent.
- The registered manager, deputy manager and non-medical prescriber were all undertaking level five higher apprenticeships in care leadership and management in health and social care.
- Broadreach did not have any peer volunteer workers.
- New staff received induction, and staff undertook training that was useful for their role, for example, all staff took level two mental health awareness training. New counsellors at Broadreach undertook an orientation programme to ensure they were familiar with all necessary aspects of the service. Counsellors had a range of training opportunities available for their role such as a level four diploma in therapeutic counselling, level three motivational interviewing and drug and alcohol awareness training.
- All staff had team supervision, reflective practice sessions, and individual supervision. Staff appraisals took place during a set three month period for all staff from September to December. The appraisals that we saw were detailed, thorough, and contained goals and objectives
- Poor staff performance was addressed promptly and effectively by the registered manager and deputy manager.

Multidisciplinary and inter-agency team work

- Weekly multidisciplinary team (MDT) meetings took place at Broadreach for all three services. The consultant psychiatrist and medical officer attended the weekly MDT. New referrals, planned admissions and unplanned discharges and safeguarding were discussed in the meetings, which were minuted. Daily handovers took place at 8.30 am and 4.00 pm. We observed a handover at Broadreach and saw that client risk was discussed and staff were made aware of clients who might need extra support.

Good practice in applying the MCA

Substance misuse/detoxification

- Mental capacity was assumed for all clients and was assessed before and on admission. If clients lacked capacity to consent to some decisions temporarily when first admitted, due to intoxication staff delayed decisions until the person had regained capacity. Consent to treatment and the sharing of information was recorded in client care records.
- Mental Capacity Act training and Deprivation of Liberty Safeguards training was mandatory for staff and all staff were up to date. Staff had a good understanding of the Mental Capacity Act.
- The provider had not made any Deprivation of Liberty Safeguards (DoLS) and had not made any DoLS applications in the previous 12 months.

Equality and human rights

- The provider had an equality, diversity and inclusion policy. Equality and diversity level two training was mandatory for all staff and all staff were up to date. New staff were required to undertake a training module in relation to equality and diversity during their probationary period and training was refreshed periodically.

Management of transition arrangements, referral and discharge

- Referrals were accepted from community drug and alcohol teams. New referrals were discussed at the multi-disciplinary team meeting. An admissions officer coordinated the admission process and ensured all relevant documentation was in place. Discharge was planned prior to admission. For planned discharges formal reports were sent to the referrer, and a member of the counselling team made contact with the referrer within 24 hours of discharge. When clients left early information was shared with the GP, care manager and next of kin. We looked at the records of two clients who had been discharged early due to breaching the provider's rules and saw that this process was managed safely and consideration was given to encouraging clients to reconsider treatment in future. Clients were discharged to the care of their local community drug and alcohol teams.

Are substance misuse/detoxification services caring?

Kindness, dignity, respect and support

- The vast majority of interactions between staff and clients were kind, respectful, supportive. Staff were patient and care was client focused. Staff had a good understanding of clients' needs, interacted with clients in a friendly manner and there were thankyou cards on display. Staff encouraged clients to let them know if they needed help or support. However, we witnessed inappropriate and offensive use of language on one occasion to describe a client by one member of staff. We reported this to the registered manager who confirmed that they would address this with staff.
- Clients told us they felt safe and well looked after and that staff went the extra mile to meet their needs. One service user explained how they were actively encouraged to go downstairs for a hot drink with the night staff if unable to sleep and felt disturbed at night. Clients were aware ofwho their counsellor was and when their individual sessions took place, they had been made aware of all rules and restrictions before admission, and knew how to complain. However, some clients told us there were too few staff on duty at weekends and that some staff had a negative attitude.

The involvement of clients in the care they receive

- Most clients we spoke to said they had been involved in their care planning, but the majority said they did not have a copy of their care plan
- Clients received a welcome pack and signed a service user agreement which clearly stated rules and responsibilities. A buddy system operated so that new clients could be supported by peers who had progressed further through treatment.
- Clients were involved in recruiting new staff. Prospective new staff were expected to spend a day at the service before an offer of employment was made; after which, clients were asked for their feedback to contribute to the decision making.

Substance misuse/detoxification

- Clients had opportunities to provide comments and suggestions about the service by writing in their daily journals, and were asked to complete an evaluation of treatment form when leaving the service.

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

Access and discharge

- Referrals were considered for a range of complex needs. The service aimed to carry out face-to-face assessment before admission if it was unclear if they had the specific skills required to meet the needs of the client. There was no defined exclusion criteria and this was managed on a case by case basis. Not all staff we spoke to were aware of on what grounds a client would be excluded.
- Admissions took place on Mondays, Tuesdays and Wednesdays. If urgent, the provider could facilitate admission within three days of referral. If not urgent, the average waiting time from referral to admission was three weeks. Length of stay varied depending on the funding authority. The average stay was five to 12 days for alcohol detoxification and two to three weeks for opiate detoxification.
- There were 17 clients in treatment when we inspected, which equated to 54% bed occupancy. Two clients were discharged and four were admitted while we were there. The provider attributed low occupancy rates to reductions in funding available for clients to attend residential detox.
- Discharge arrangements were planned before admission. Unplanned discharge arrangements were agreed before admission and these included the out of hours contact of the referring service, details of who should be contacted if the client left early, and authorisation for assistance with travel or accommodation if the referrer felt the client would be at risk.
- Clients who had completed detoxification could move on to the provider's rehabilitation services at Longreach (for women) and Closereach (for men) and community day services at Ocean Quay, dependent on funding being available.

The facilities promote recovery, comfort, dignity and confidentiality

- Broadreach had a clinic room and a range of rooms that could be used for treatment and care. An alternative therapies building had recently been built in the grounds and there was a shed containing some exercise equipment. Clients could access the garden, which had covered areas for smoking and there were quiet areas that clients could use to meet visitors. There were two large, comfortably furnished living rooms that could be used for group work. One of the lounges could be used as a games area and had a pool table and dart board.
- There was a mixture of single and twin bedrooms. Some rooms were used for observation of patients who were higher risk and had been adapted to ensure ligature points were minimised. One room that was used for observation of higher risk clients, particularly those who were in the early stages of detoxification was a twin room. This meant that two clients who may be feeling very physically unwell might be sharing a room. The provider's printed information about the service said it may be necessary to share a room and clients agreed to this on admission. However, some clients told us that that they had not been given a choice about sharing, even when there were single rooms available.
- Clients could bring a small number of personal items to Broadreach. Clients were discouraged from bringing valuable items but items such as bank cards could be stored securely by staff. However, there was no secure storage in bedrooms and none of the bedroom doors had locks. This meant that clients could not be sure that there personal possessions were safe or be sure that other clients were not able to access their room. This was a breach of clients' privacy and dignity.
- Clients were able to access snacks and drinks and told us that the food was of good quality
- Activities took place at weekends but feedback from staff, including feedback gathered by the provider in treatment evaluation forms, showed that clients sometimes felt bored at weekends and evening and wanted more activities at these times.

Meeting the needs of all clients

- There were temporary ramps available for use by clients with limited mobility. These could be fitted throughout

the building to allow access to all areas, although the corridors were too narrow for large wheelchairs. There were ground floor bedrooms, a stair lift and an adapted shower room and toilets.

- The cook at Broadreach catered for a range of diets such as vegan, halal and gluten free and provided healthy options.

Listening to and learning from concerns and complaints

- Clients knew how to provide feedback and complain. Treatment evaluation forms were completed at the end of treatment. A report was written every three months to collate feedback that had been provided by clients in end-of –treatment evaluation forms. The report for April 2016 to July 2016 showed that the vast majority of clients were very happy with the treatment they received. Feedback about the counsellors was extremely positive.
- The provider had received four formal complaints in 2016 of which one was referred to the service commissioner. Complaints were investigated by the registered manager and copies of the investigation were sent to the client's care manager. Clients received a written letter after the complaint had been investigated and we saw that the provider adhered to duty of candour when writing to complainants. Complaints were audited and lessons were learnt. Changes had been made as a result of complaints, for example, restrictions had been changed to allow clients to use laptops.

Are substance misuse/detoxification services well-led?

Vision and values

- Broadreach had a philosophy with clear aims and objectives that were recovery focused and individual. All staff were aware of the philosophy and values. These were set out in welcome packs to clients. However the provider had not clearly defined their visions and values.

Good governance

- There was a clear organisational structure with defined responsibilities for governance and accountability. The senior leadership team were actively involved in the service. Organisational risks were identified on a corporate risk register. This was graded and had control measures and was reviewed by the board of trustees.
- At the time of inspection all staff had up to date mandatory training. This was monitored by the registered manager. There was an effective system for supervision and appraisal. All staff had disclosure and barring service checks.
- There were a range of staff and daytime staffing levels met the needs of clients. There were no vacancies for nursing staff. A qualified nurse was available at all times, and either the non-medical prescriber or medical officer were available to assess all new admissions.
- The non-medical prescriber carried out monthly audits, these included medicines storage and controlled drugs. The registered manager undertook a range of monthly audits including incidents, safeguarding and complaints, clinical records. Environmental audits took place and resulted in improvements being made to the building, such as reducing ligature risks in three rooms. However some audits were not effective in identifying areas for improvement. For example, audits of care records had not identified that risk assessments were not in place on nursing records or that physical healthcare needs were not always being addressed.
- The service reported to national drug treatment monitoring system and was part of the clinical governance forum for Plymouth.
- There was no effective process in place to ensure that staff had access help in an emergency. Staff told us that walkie talkies did not work and they did not have portable alarms. The provider was either unaware or had not acted to rectify this.

Leadership, morale and staff engagement

- We were not made aware of any bullying or harassment and staff told us they knew how to whistle blow.
- Most staff told us that they enjoyed their work and were supportive of each other.
- Staff turnover was high but many staff that left transferred to other parts of the provider's services. Long term sickness and performance issues were managed by the registered manager.

Substance misuse/detoxification

- There were opportunities for staff development. For example, the provider had assisted the non-medical prescriber to undertake training for their current role.
- The registered manager, deputy manager and non-medical prescriber were undertaking appropriate leadership training.

Commitment to quality improvement and innovation

- Quality improvement was undertaken by using audit data.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that ensure that all medicines given to clients to self-administer have the legally required prescribing and dispensing information, including dose instructions and patient name.
- The provider must ensure that all clients have a comprehensive risk assessment and risk management plan which indicates what action to take if a client's mental health or physical health deteriorates and that is available to all relevant staff.
- The provider must ensure that all clients have a comprehensive individualised treatment care plan that is personalised, holistic and recovery orientated.
- The provider must ensure that equipment, such as the electrocardiogram (ECG) machine, personal alarms and walkie-talkies, is checked and maintained to make sure it is working and that action is taken to repair or replace faulty equipment.

Action the provider SHOULD take to improve

- The provider should ensure that the physical health needs of clients are met, that specialist advice is sought when appropriate, and that staff have access to relevant information relating to clients physical health.
- The provider should ensure that risk assessments for clients' medicines are personalised and contain information relating to that person's condition.
- The provider should ensure that the reason for medicines prescribed to be given when required is recorded on the prescription chart.
- The provider should ensure prescribing is evidence-based, or document clinical justification when deciding to deviate from recognised prescribing guidelines.
- The provider should ensure that audits effectively identify areas for service improvement.
- The provider should ensure that clients are able to lock their rooms, have privacy whilst in double rooms and to have a choice about sharing a room if single rooms are available.
- The provider should ensure that staff continue to talk to staff and clients in a supportive and respectful manner.
- The provider should ensure that there is a detail exclusion and admission criteria for the service.
- The provider should ensure there is a clearly defined visions and values statement for this service, and that this is shared with clients and staff.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for service users. Not all medicines given to clients to self-administer were given with the legally required prescribing and dispensing information, including dose instructions and patient name. Not all clients had a comprehensive risk management plan which indicated what action to take if a client's mental health or physical health deteriorated and that this was available to all relevant staff. The provider had not ensured that equipment was checked and maintained to make sure it was working and that action was taken to repair or replace faulty equipment and that staff were able to access help in an emergency.

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The care and treatment of service users must be a) appropriate, b) meet their needs, and c) reflect their preferences. Clients did not have comprehensive and individualised treatment care plans that were personalised, holistic and recovery orientated.