ASANA Healthcare Ltd

Asana Lodge

Inspection report

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Yardley Gobion
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires Improvement
Are services caring?	Requires Improvement
Are services responsive to people's needs?	Good
Are services well-led?	Inadequate

Summary of findings

Overall summary

Asana Lodge opened in June 2020 and is a 22 bedded residential drug and/or alcohol medically monitored, detoxification and rehabilitation facility based in Yardley Gobion, Towcester. The service provides care and treatment for male and female clients

We rated it as inadequate because:

- Staff did not make a comprehensive assessment of client's physical and mental healthcare needs before treatment started. The prescriber did not conduct a face-to-face assessment of clients before issuing the first prescription and before making any changes to prescriptions.
- The admissions assessment and process was not thorough and did not take into account clients medical history, medical conditions and prescribed medications. This led to inappropriate admissions and allergies not being recorded. The service did not have clients full medical history before starting treatment.
- Medicine were not always managed safely and in line with legislation. Staff administered a prescription only medicines without an individualised prescription. The service did not complete reviews or log why clients were having regular homely remedies for multiple days.
- Not all medicines were prescribed with a clear prescribing rationale or a clear discussion with the client around possible side effects.
- Staff did not complete appropriate protocols for clients prescribed 'as required' medicines
- Staff did not always complete post incident checks. Injuries sustained after an incident were not always recorded clearly and staff did not always complete and record thorough checks after an incident.
- Staff had not completed comprehensive client risk assessments and risk management plans or updated them to reflect clients changing risks. Managers at the service did not have the knowledge and skills to be able to identify for themselves that the service was not keeping clients safe in terms of assessing and prescribing.
- Governance processes in place did not identify areas where compliance with the requirements of the regulations was not being met. Auditing systems did not identify where staff were not following medication management and administration within legal parameters. Auditing systems did not identify gaps in post incident checks and logs.

However:

- The service offered a range of therapies including yoga, walks, sound therapy and regular one to one sessions, with something available 7 days a week.
- The clinical premises where clients were seen were safe and clean. The service had enough staff.
- The service provided a range of treatments suitable to the needs of the clients and in line with national guidance about best practice. The provider made training, supervision and appraisal opportunities available to staff. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation.
- Staff treated clients with compassion and kindness. Staff understood the individual needs of clients and supported them to understand and manage their treatment and condition.
- The service offered a well-established, weekly family and carer group.
- Staff felt respected, supported and valued. They felt positive about their work and proud about working for the provider and delivering the service.
- Following the inspection and enforcement action taken the service told us they had implemented new auditing systems, governance processes and medication management policies and procedures.

Summary of findings

Immediately following this inspection, we issued an urgent letter of intent to ask the provider to take immediate action to improve safety at this location. We did not receive immediate assurance that safety was addressed and so issued further urgent enforcement action to impose conditions on registration.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Substance misuse services	Inadequate 	Asana Lodge opened in June 2020 and is a 22 bedded residential drug and/or alcohol medically monitored, detoxification and rehabilitation facility based in Yardley Gobion, Towcester. The service provides care and treatment for male and female clients We rated it as inadequate because: • Staff did not make a comprehensive assessment of client's physical and mental healthcare needs before treatment started. The prescriber did not conduct a face-to-face assessment of clients before issuing the first prescription and before making any changes to prescriptions. • The admissions assessment and process was not thorough and did not take into account client's medical history, medical conditions and prescribed medications. This led to inappropriate admissions and allergies not being recorded. The service did not have client's full medical history before starting treatment. • Medicines were not always managed safely and in line with legislation. Staff administered a prescription only medicine without an individualised prescription. The service did not complete reviews or log why clients were having regular homely remedies for multiple days. • Not all medicines were prescribed with a clear prescribing rationale or a clear discussion with the client around possible side effects. • Staff did not complete appropriate protocols for clients prescribed 'as required' medicines • Staff did not always complete post incident checks. Injuries sustained after an incident were not always recorded clearly and staff did not always complete and record thorough checks after an incident. • Staff had not completed comprehensive client risk assessments and risk management plans or updated them to reflect clients changing risks. Managers at the service did not have the knowledge and skills to be able to identify for themselves that the service was not keeping clients safe in terms of assessing and prescribing.

Summary of findings

- Governance processes in place did not identify areas where compliance with the requirements of the regulations was not being met. Auditing systems did not identify where staff were not following medication management and administration in line with good practice. Auditing systems did not identify gaps in post incident checks and logs.

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Summary of findings

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Summary of this inspection

Background to Asana Lodge

Asana Lodge opened in June 2020 and is a 22 bedded residential drug and/or alcohol medically monitored, detoxification and rehabilitation facility based in Yardley Gobion, Towcester. The service provides care and treatment for male and female clients.

Asana Lodge provides ongoing abstinence-based treatment, which integrates cognitive behavioural therapy and dialectical behaviour therapy alongside 12-step treatment.

Asana Lodge is registered to provide:

- Accommodation for persons who require treatment for substance misuse.
- Treatment for disease, disorder or injury

At the time of inspection there was a registered manager in post, and 20 people were accessing the service for treatment. The average length of stay for treatment was approximately 28 days. Asana Lodge takes self-referrals from privately funded individuals.

The Care Quality Commission had carried out a focused inspection in May 2021 due to concerns about the quality of risk assessments, the safety of clients, the quality and outcome of investigations and the overall management of governance systems but had not rated the service. We took urgent action and imposed conditions on their registration and asked the provider to make significant improvements to the service. The provider submitted an action plan and based on evidence submitted by the provider that the conditions had been met in full, the conditions were subsequently removed in August 2021.

At this inspection, we undertook an unannounced routine inspection of the service of the following key questions:

- Are services safe?
- Are the services effective?
- Are services caring?
- Are the services responsive?
- Are services well-led?

We visited the location on the 6 and 7 February 2023 during the day shift. Following the onsite inspection visits, we carried out remote interviews with staff members further evidence gathering until 27 February 2023.

What people who use the service say

We spoke with three clients who used the service and four family members and carers.

Clients who used the service told us they felt the staff were kind and approachable, were kept up to date and involved in their treatment and were able to raise concerns if they had any. All three clients stated they liked the food at the service and the number of activities and therapies available. One client stated staff were very supportive and there was always someone available to talk to. However, one client felt even though the onsite initial assessment took their individuality into account the remote assessment did not consider their individual concerns.

Summary of this inspection

All four family members and carers we spoke with felt they were kept informed with their loved one's treatment plan. All family members stated they received regular updates on their loved one's treatment. One family member said they felt fully included in their loved one's care and treatment and actively took part in the family therapy sessions offered by the service. However, one family member stated that the doctor was only available via video call and not face-to-face which in their opinion was not sufficient for a thorough assessment/consultation.

How we carried out this inspection

This was an unannounced inspection, completed to make sure health and care services in England meet the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

The inspection team comprised of 2 inspectors, a medicines inspector, and an expert by experience.

During the inspection, the inspection team:

- visited the location and reviewed the quality of the environments;
- spoke with 3 patients who were using the service;
- spoke with 4 family members and/or carers of the patients using the service;
- spoke with the registered manager, deputy manager, a doctor and clinical lead
- spoke with 6 other staff members including; a nurse, recovery workers and therapists.
- reviewed 7 patient care and treatment records;
- reviewed 6 prescription cards;
- reviewed a range of policies, procedures and other documents relating to the running of the service.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The service MUST ensure all injuries post incidents are recorded using a body map (Regulation 12)
- The service MUST ensure that clients risk assessments, risk management plans are completed in full, kept up to date to reflect client risks (Regulation 12).
- The service MUST ensure they complete face to face assessments prior to prescribing (Regulation 12)
- The service MUST ensure room searches are completed after incident of self-harm in a client's bedroom (Regulation 12).
- The service MUST ensure prescription only medicines are only given in accordance with a valid prescription (Regulation 12).
- The service MUST ensure homely remedies are individually authorised and given in accordance with a policy (Regulation 12).

Summary of this inspection

- The service MUST ensure adequate patient centred information are made available to staff to ensure they can safely support people with their when required medicines administration (Regulation 12).
- The service MUST ensure prescribed medicines are tailored to individuals including a rational for prescribing medicines used to aid sleep (Regulation 12).
- The service MUST ensure the admissions process and assessments process is thorough and takes into account a client's medical history, medical conditions and prescribed medications (Regulation 12).
- The service MUST ensure clients are sufficiently involved in their care and receive care in their chosen style (Regulation 9).
- The service MUST operate effective systems or processes to ensure compliance with the requirements of the regulations (Regulation 17).
- The service MUST ensure medication audits identify where staff are not following medication management within good practice (Regulation 17).
- The service MUST ensure accident / incidents are reviewed and audited effectively to identify where there are gaps in post incident checks (Regulation 17).

Action the service SHOULD take to improve:

- The service should ensure they are able to provide a service for those with different communication needs such as a different language or British Sign Language.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Substance misuse services	Inadequate	Requires Improvement	Requires Improvement	Good	Inadequate	Inadequate
Overall	Inadequate	Requires Improvement	Requires Improvement	Good	Inadequate	Inadequate

Inadequate

Substance misuse services

Safe	Inadequate
Effective	Requires Improvement
Caring	Requires Improvement
Responsive	Good
Well-led	Inadequate

Is the service safe?

Inadequate

We rated it as inadequate.

Safe and clean care environments

All clinical premises where clients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Safety of the facility layout

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. The service health and safety lead carried out weekly walk arounds of the service to identify any environmental risks.

Staff could observe clients in all areas of the service. The service had closed circuit television cameras (CCTV) in place within all communal areas and client observation levels were reviewed in line with client needs. The service had cameras present at entrances, stairs, corridors, communal areas and external areas. Staff offices where the therapy team were based had screens with live images from the CCTV cameras.

The service managed risk and client safety where there was mixed sex accommodation, all bedrooms were en-suite bedrooms. All bedrooms were accessed using a code to maintain privacy but still enabled staff to conduct observational checks when required.

Staff knew about any potential ligature anchor points and mitigated the risks to keep clients safe. This was an area of improvement identified at the previous inspection. The service now had a robust process in place where all patients were risk assessed before items such as cables and sharps were authorised to be kept in their rooms. The service was in the process of refitting bathrooms with anti-ligature showers. (A ligature is something that is used to tie or bind objects to each other tightly. This means that anti-ligature is the prevention of such tying or binding. Anti-ligature devices are meant to prevent vulnerable people from accidentally or intentionally self-harming). All patients had increased observation levels when they first came into the service and this was only reduced following clinical reviews. The service had separate ligature risk assessments in place for different areas which were reviewed regularly.

Staff had easy access to alarms and clients had easy access to call systems. All client rooms had a call system in place and all staff carried a personal alarm.

Maintenance, cleanliness and infection control

All areas were clean, well maintained, well furnished and fit for purpose. The areas were clean and included a well maintained outdoor garden area. The service had several communal areas including a dining room, group room, gym, sauna and library.

Staff made sure cleaning records were up-to-date and the premises were clean. The service employed a dedicated housekeeping team. The head housekeeper completed cleaning records and laundry audits to ensure records were accurate and up to date.

Staff followed infection control policy, including handwashing. Staff had access to sufficient supplies of personal protective equipment (PPE), hand sanitiser and waste bins for the disposal of used items. The service displayed information about using PPE correctly and during the inspection we saw staff doing so.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Clinic rooms were clean, spacious and equipped with handwashing facilities. The service had resuscitation equipment on all floors of the service.

Staff checked, maintained, and cleaned equipment. Cleaning records for medical equipment were completed daily and were up to date.

Safe staffing

The service had enough nursing and medical staff, who knew the clients and received basic training to keep people safe from avoidable harm.

Nursing staff

The service had enough nursing and support staff to keep clients safe. The service always had 2 to 3 recovery workers on shift, 3 therapy workers and a qualified nurse during the day. At night, the service was staffed with 2 healthcare assistants.

The service had low vacancy rates. The service had 1 vacancy for a night-time healthcare worker and 0 vacancies for nurses and therapy workers.

The service regularly used bank and agency nursing assistants. These were mainly for the third recovery worker on shift, due to the vacancy held, which ensured the service was always fully staffed.

Managers limited their use of bank and agency staff and requested staff familiar with the service. The manager had access to 2 regular agency nurses who knew the service and clients and 1 bank recovery worker who they used if staff were off sick.

Inadequate

Substance misuse services

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. This was an area of improvement identified at the previous inspection. The service now ensured all staff including bank and agency staff received a thorough service induction prior to working any shifts. All staff also attended a thorough handover prior to shifts to prepare them for the role and understand individual client needs.

The service had reducing turnover rates. The service had an increased turnover rate of 7.7% in October 2022 as the new manager and change in structure came into place. This had now reduced to 0% in December 2022 and January 2023.

Levels of sickness were low. Six staff had 20 days off sick in the 3 months prior to the inspection that were all COVID-19 related.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The service operated at full staffing levels as the number of clients fluctuated due to the type of service. This meant they were generally over staffed but never understaffed.

The manager could adjust staffing levels according to the needs of the clients. The manager had access to bank and agency staff and the autonomy to use these as required.

Clients had regular one to one sessions with their named nurse and therapists. We saw records of clients having a minimum of a weekly one-to-one session. However, staff told us this was a minimum and often clients received more than one session per week.

Clients rarely had their escorted leave or activities cancelled, even when the service was short staffed. Staff told us when they had higher levels of sickness during COVID-19 outbreaks amongst staff, the wider staff team adapted their roles to assist with activities such as walks. Staff were unaware of incidents where leave had not been facilitated on the day due to inadequate staffing levels, although at times it may have been supported at a different time of day.

Staff shared key information to keep clients safe when handing over their care to others. The service had a thorough handover twice a day. This included discussions around, safeguarding, client observation levels, incidents, risk management, accidents and exit surveys. All staff on site attended the handovers and copies were sent to the doctor via email.

Medical staff

The service did not have daytime and night-time medical cover or a doctor available to go to the site quickly in an emergency. The doctors mostly worked remotely, and staff could contact them via email or for immediate advice using the telephone. One doctor attended the site once a week on a Friday afternoon. All medical emergencies were dealt with by the onsite nurse, NHS 111 or 999.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. The mandatory training programme was comprehensive and met the needs of clients and staff. The service had a thorough mandatory training programme in place including service specific training including alcohol misuse and drug misuse training. Mandatory training completion rates were 100%. This was an improvement from the previous inspection, when compliance rates were at 38%.

Although training compliance rates were at 100% for safe administration of medication, staff and managers had not been able to identify basic medication management issues. This included administering prescription only medication without a prescription.

Managers monitored mandatory training and alerted staff when they needed to update their training. The service had a detailed training matrix in place stating when training had last been completed and when it needed to be updated. Manager used this during staff supervisions and team meetings to alert staff of when they needed to complete training.

Assessing and managing risk to clients and staff

Staff did not always effectively screen clients before admission and sometimes admitted them when it was not safe to do so. They did not always assess and manage risks to clients well.

Assessment of client risk

A remote admissions team completed a pre assessment prior to client admission on receipt of the referral. Staff completed risk assessments for each client on admission or arrival, and a remote medical assessment was completed by a doctor, which was reviewed regularly, including after any incident. The assessment process in place did not always recognise medical conditions such as Parkinson's Disease and we found 1 occasion where an allergy had been missed and 1 inappropriate admission. The service admissions policy in did not prompt staff to take medical history into account at the point of admission. Three staff we spoke to felt the service had inappropriate admissions and one felt they could see the benefits of face-to-face medical assessments rather than online. One family member stated that the doctor was only available via video call and not face-to-face which in their opinion was not sufficient for a thorough assessment or consultation. This meant that staff were not fully aware of clients current or past medical conditions and this could lead to conditions being overlooked, or treatment given without considering contraindications.

Management of client risk

Staff did not always know about any risks to each client and did not always act to prevent or reduce risks. The 7 care plans we reviewed consisted of exit plans and risk management plans. The plans in place were personalised and identified risks such as risk of self harm. However, due to the medical assessments not identifying risks appropriately staff did not always have appropriate risk management plans in place. We found allergies had not been identified at assessment and medications that had contraindications (a contraindication is a condition (a situation or factor that serves as a reason not to take a certain medical treatment due to the harm that it would cause the patient) with each other had been administered to clients. The service still did not have risk management plans that were completed in full, kept up to date to reflect client risks, or that were personalised to each individual client. This was an area of improvement identified at the previous inspection that had still not been met.

Staff identified and responded to some changes in risks to, or posed by, clients. Staff updated observation levels in line with client needs and handed these over in a thorough handover.

Staff followed procedures to minimise risks where they could not easily observe clients. All clients were introduced to the service on high observation levels and numerous risk items such as razors being removed for client safety. Risk was then reviewed regularly by staff and the doctor before items were returned and observation levels were reduced.

Staff did not always follow service policies and procedures when they needed to search clients or their bedrooms to keep them safe from harm. Staff did not always complete and log post incident checks. For example, there was an

incident of self harm where the manager stated a room search should have been completed after the incident but there was no log of this, and the incident form did not state if it had been completed. After the client had left the service 2 days later during a deep clean of the room a broken pen was found hidden in the client's mattress which was stained with blood and had been used to self harm.

Safeguarding

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 received training on how to recognise and report abuse, appropriate for their role. Staff were kept up-to-date with their safeguarding training. Safeguarding training compliance was at 100%. This was a significant improvement from the previous inspection when compliance was only 40%.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service had a safeguarding log in place and good relations with the local authority safeguarding team. Staff were able to give examples of when they recognised potential safeguarding risks and made appropriate referrals to the local authority and the police.

Staff followed clear procedures to keep children visiting the service safe. The service had a designated visiting area and clients who had children visiting were encouraged to go outside the service for a walk together.

Managers took part in serious case reviews and made changes based on the outcomes. Staff informed the manager of all safeguarding referrals and investigations. Lessons learnt from incidents were shared with staff through team meetings.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records.

Client daily notes were comprehensive and all staff could access them easily. The service had an electronic client record system in place and all staff had access to this secure system. The service had enough electronic devices in place for all staff to be able to access the system when required. However, as identified above, the initial admission assessment were not comprehensive or included all relevant information.

Records were stored securely. The electronic system was secure and could only be accessed on site by staff who had their individual log ins.

Medicines management

The service did not use systems and processes to safely prescribe, administer, record and store medicines. Staff did not review the effects of medications on each client's mental and physical health.

Staff stored all medicines safely. Medicines were stored safely and access to medicines storage areas was appropriately restricted and keys held securely. Temperatures of medicines storage areas were monitored. Staff knew how to escalate concerns when the temperature readings were out of range.

Inadequate

Substance misuse services

Although the service welcome pack gave information on medications that may be prescribed during treatment, staff did not review each client's medicines or provide all relevant advice to clients and carers about their medicines. All patients undergoing an alcohol detox regime were prescribed and administered a medicine to aid with sleeping. There was no documentation to show any discussions with the patient had taken place, as to why it was prescribed or that it could have addictive properties and if it was needed by the patient. When we requested the service to immediately review this, a standard statement “Insomnia is a known symptom of alcohol withdrawal hence the patient was prescribed” for the sleeping aid was put into the client assessment rather than a full individual assessment and discussion with each client.

Staff did not complete medicines records accurately or keep them up-to-date. We viewed 6 client prescription records. Clients did not have personalised “when required” (PRN) protocols for PRN medicines that stated when they needed and could take their medicines. There was no clear log on clients’ individual medication logs of when these medications had been taken. Due to immediate concerns, we asked the service to review all as required medications, put an appropriate policy in place and ensure all PRN protocols were in line with this policy. However, the service failed to provide us with the necessary assurances. The protocols sent to us for the clients who received PRN medication did not follow the policy the provider had put in place and did not provide staff with the necessary guidance on when to administer this medication. Out of the 8 protocols submitted, 1 did not state a maximum dose; 1 did not state a minimum time between doses; 5 did not record a date for review and all 8 records did not record client’s capacity to consent to the medication.

Staff did not follow national good practice guidance to check clients had the correct medicines when they were admitted. CQC guidance for substance misuse services states the prescriber should conduct a face-to-face assessment of the person before issuing the first prescription and before making any changes to the prescription (or it should be clear how they are assured that it is safe to do so). However, the admitting doctor completed a virtual medical assessment on admission and prescribed the detox medicines. This assessment was used to assess the patients physical and mental health.

Clients were asked for consent to obtain their medical and drug history from their own GP before commencing on prescribed medicines for detox treatment. On occasions when the patient’s consent was not obtained, the course of treatment still commenced. Therefore, there was a risk that medicines prescribed for detox may not be suitable for the patient due to interactions with medicines already prescribed.

On admission, we saw that one patient’s allergy status was not properly noted. The medicine that they were allergic to was subsequently authorised for administration by the doctor. This could have caused the patient a severe allergic reaction. This practice was also outside the General Medical Council (GMC) guidance which states “In providing clinical care you must: a prescribe medicine or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient’s health, and are satisfied that the medicine or treatment serve the patient’s needs b provide effective treatments based on the best available evidence; check that the care or treatment you provide for each patient is compatible with any other treatments the patient is receiving, including where possible self-prescribed over-the-counter medications”. The inspection team requested the service immediately review all medication and possible contraindications between medicines for every client. However, even after this request the service failed to review 4 of the 15 clients at the service. One of these clients was having medication for a condition that could have had contraindications with one of the homely remedies they had been authorised to take.

Staff did not follow systems and processes to prescribe and administer medicines safely.

One of the prescribing doctors told us they had seen the medication policies and protocols but was not overly aware of what they were. Staff told us they administered a prescription only medicine without a prescription when patients were complaining of nausea or vomiting. The inspection team on site requested the service to remove this medication from the homely remedies medicines cupboard as they were administering this outside of legislation. The service had a Home Office stock license in place which authorised them to store controlled drugs.

Staff did not review the effects of each client's medicines on their physical health according to NICE guidance. When administering homely remedies, staff did not check specific details with the patient to make sure the medicines were safe to give. For example, they did not check if food had been eaten before they gave a medicine that can only be given with or after food. Staff did not record why some homely remedy medicines were given and how long they could be given for. Due to concerns the inspection team asked the service to provide immediate assurances around medication management and ensure all medication was given in accordance with a prescription only.

Track record on safety

Staff recognised incidents but did not always and report them appropriately or complete appropriate post incident checks.

Staff knew what incidents to report and how to report them. All staff had access to the services incident reporting system to report and incident and incidents were discussed at every handover. After every incident the manager communicated lessons learnt through the staff handover, this included a reminder to all staff to inform the doctor if a client has a fall and staff to complete thorough rooms checks after incidents.

Staff did raise concerns but did not always report incidents and near misses in line with service policy. Staff did not always complete body maps after incidents. Staff did not complete body maps after injuries had been sustained following an incident. We reviewed incidents over the 4 months prior to the inspection and found 2 incidents where clients had sustained an injury during an incident on both occasions staff failed to record the injury sustained on a body map. This would make it difficult to establish if a wound was healing effectively, if further injuries had been sustained due to other incidents or if the client required further medical attention. The service incident reporting policy in place guided staff to attach photographs or drawing as necessary, asked what risk management was in place, what could be put in place to prevent such incidents reoccurring and must be reported internally and to relevant external bodies. The policy required incidents to be reviewed and thoroughly investigated by competent staff and monitored to make sure that action is taken to remedy the situation, prevent further occurrences and make sure that improvements are made as a result. The policy in place was now thorough and detailed which was an area of improvement identified within the last report. However, managers did not monitor if staff were following this effectively.

Staff had not recognised that medicines administration was not in line with national guidance, and this had not been raised by staff as an issue to leaders, or outside agencies. This meant we were not assured that staff recognised when poor practice was taking place.

Staff understood the duty of candour. The service was open and transparent, and gave clients and families a full explanation if and when things went wrong. We saw examples of apologies offered to clients. Where clients had given consent, families were informed and kept up to date after incidents.

Staff met to discuss the feedback and look at improvements to client care. Each client was discussed at a daily multidisciplinary team meeting handover and the discussions included incidents, treatment plans and feedback from client exit questionnaires.

Inadequate

Substance misuse services

There was evidence that changes had been made as a result of incidents. The service had changed the admission process and items a client can have in their room after a patient death incident and was in the process of fitting all rooms with anti-ligature showers.

Is the service effective?

Requires Improvement

We rated it as requires improvement.

Assessment of needs and planning of care

Staff 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. However, staff did not complete comprehensive physical assessments with clients on admission to the service.

Staff completed a comprehensive mental health assessment of each client either on admission or soon after. Staff assessed client capacity at admission and completed a toxification assessment. A client would only sign up to the service and complete admission once they were sober or drug free and deemed to have capacity to make this decision.

All clients had their physical health assessed soon after admission and regularly reviewed during their time at the service. However, these assessments were not always thorough and did not consider all information which should be available to staff. Staff did not always access medical histories of clients prior to admission even if clients had consented to this. This resulted in physical health conditions such as Parkinson's Disease and allergies being missed within the physical assessment process. For example, we found records where medical staff had access to a client's medical history and conditions but had not considered the impact of these when prescribing medication. This could have led to the client needing additional medical intervention. This was reviewed once the medical team were asked by CQC to review all client medical history and include this as part of the service medical assessment and treatment plan.

Staff regularly reviewed and updated care plans when clients' needs changed. All care plans and risk assessments viewed had been updated after incidents and when there were changes in care needs. When staff were made aware of risks missed within the initial assessment, they immediately updated client care plans and risk assessments.

Care plans were personalised, holistic and recovery-orientated. This was an area of improvement identified within the last inspection that had now been met. All 7 care plans viewed were personalised, included details of the client's past substance misuse and a personalised treatment exit plan.

Best practice in treatment and care

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 provided a range of care and treatment suitable for the clients in the service. The service offered a range of treatments including therapies (one to one and groups such as music therapy and sound therapy), groups (such as yoga and wellbeing), access to a gym, sauna, jacuzzi bath and satori chair.

Inadequate

Substance misuse services

Staff delivered care in line with best practice and national guidance. Access to alternative therapies such as the sauna, jacuzzi bath and satori chair (A satori chair's design allows the user to undergo a zero-gravity experience, thus refreshing the mind and body, while varying sonic frequencies such as alpha, theta, and delta sounds are emitted from the chair and is known to be a relaxation tool for deep relaxation, chakra balancing, and meditation) were only permitted after a client had completed detox and a thorough risk assessment had been completed as per national guidance.

Staff identified clients' physical health needs and recorded them in their care plans. All clients received a physical health check from the clinical lead on arrival. This included checking vitals such as blood pressure, breathalyser check, COVID-19 test and weight, which were then recorded on the client's admission form before the doctor's medical assessment.

Staff met clients' dietary needs and assessed those needing specialist care for nutrition and hydration. The service had a dietician who attended the service regularly to support clients. The service had a menu in place which offered a choice and met dietary requirements, but clients were able to ask the on-site chef for an alternative if they wanted.

Staff used recognised rating scales to assess and record the severity of clients' conditions and care and treatment outcomes. This included tools to assess dependency on a substance, withdrawal symptoms and mental health presentations.

Staff used technology to support clients. Clients had access to innovative technologies and therapies including a satori chair, known to be a relaxation tool for deep relaxation, chakra balancing, and meditation.

Managers completed audits but these were not always used to make improvements. Staff completed medication audits that were basic monthly medicines checklists and did not identify errors in prescribing practices which were outside legal guidance.

Skilled staff to deliver care

The teams included the full range of specialists required to meet the needs of clients under their care, but teams could not readily access a doctor onsite. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the clients at the service. The service had a full range of a multidisciplinary team including nurses, therapists, doctors and recovery workers. However, access to the doctors for medical advice was only via telephone or email as the doctor only attended the service face-to-face on a Friday afternoon. We found examples, where this access issue had raised concern amongst staff due to medical conditions being missed. A client with Parkinson's Disease had been admitted into the service when this was not an appropriate admission for a substance misuse service. This was only identified by staff on site when the client needed to be taken to hospital to the accident and emergency department.

Managers ensured they had the right staff mix on site with the correct qualifications and experience to meet the needs of the clients in their care, including bank and agency staff but failed to identify staff competency to follow General Medical Council (GMC) guidelines and national medication prescribing and administering guidelines. Staff at the service were administering medication outside of national guidance and this was not identified as a concern by anyone in the service.

Managers gave each new member of staff a full induction to the service before they started work. All staff received a through induction including bank and agency staff.

Managers supported staff through regular, constructive appraisals and supervisions of their work. All staff had received regular supervisions and appraisals. The compliance rates for staff working at the service supervisions and appraisals was 100%. This was an area of improvement identified at the previous inspection, which had now been met.

Managers supported medical staff through regular, constructive clinical supervision of their work. Medical staff received their clinical supervisions through their professional registrations and renewals process.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. The service had monthly team meetings which all staff were invited to, those who could not attend had access to the minutes through videoconference.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The deputy manager had recently been appointed to this position and the service was supporting them to complete additional management qualifications.

Managers made sure staff received any specialist training for their role. The mandatory training program included service specific training including alcohol and drug misuse.

Managers recognised poor performance, could identify the reasons and dealt with these. The manager said the service had access to a supportive human resources team. The service had a staff performance appraisal policy in place.

Multi-disciplinary and interagency teamwork

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 had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss clients and improve their care. The service had monthly team meetings attended by all staff and where staff could not attend meeting minutes were available on video conferencing to view. Areas of discussion included the quality of handovers, incidents, lessons learnt and admissions.

Staff made sure they shared clear information about clients and any changes in their care, including during handover meetings. The service had 2 daily handover meetings, and these were attended by all staff leaving and starting the shift. Handovers were detailed and included a discussion on each client including their observation levels, any incidents, complaints and safeguarding incidents.

Service teams had effective working relationships with external teams and organisations. The service team had good links with external bodies including the local authority to enable timely safeguarding referrals. We saw examples, of where staff had worked well with the local authority and the police to ensure client safety.

Good practice in applying the Mental Capacity Act

Inadequate

Substance misuse services

Staff supported clients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for clients who might have impaired mental capacity.

Staff received, and were consistently up-to-date, with training in the Mental Capacity Act and had a good understanding of at least the five principles. All staff we spoke with knew the basic principles of the Mental Capacity Act and applied this to client care including during admission. Staff ensured clients had capacity and were not intoxicated when they signed admission papers and treatment plans. Where clients were intoxicated on arrival staff supported them to become sober before admitting them to the service.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access. All staff had access to the service shared area which consisted of all service policies including a policy on the Mental Capacity Act.

Staff gave clients all possible support to make specific decisions for themselves before deciding a client did not have the capacity to do so. All clients at the service had capacity to be at the service and admission documentation was only admitted once they were sober.

Staff assessed and recorded capacity to consent clearly at the initial assessment stage, but this was not reflected throughout treatment. Staff were prompted on the admission form to assess capacity before completing admission. However, staff did not record consent with as required medication protocols.

When staff assessed clients as not having capacity, they made decisions in the best interest of clients and considered the client's wishes, feelings, culture and history. If a client was not sober or did not have capacity to make decisions upon admission due to being intoxicated, staff supported them to a room to become sober before completing the admission and assessment process.

The service monitored how well it followed the Mental Capacity Act and made changes to practice when necessary. Every client form logged a client's capacity before an assessment or care plan was completed. The service had a capacity audit in place, stating when they had made referrals to other services.

Is the service caring?

Requires Improvement

We rated it as requires improvement.

Kindness, privacy, dignity, respect, compassion and support

Staff treated clients with compassion and kindness. They respected clients' privacy and dignity. They understood the individual needs of clients and supported them to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for clients. All clients and family members we spoke to felt staff were polite and respectful.

Inadequate

Substance misuse services

Staff gave clients help, emotional support and advice when they needed it. All clients received at least 1 one to one session therapy session and nurse session per week and more if required. All 3 clients stated they liked the food at the service and the number of activities and therapies available. One client stated staff were very supportive and there would always someone available to talk to. One family member said they could not believe the amount of therapy their loved one had access to.

Staff supported clients to understand and manage their own care treatment or condition. All clients we spoke with understood their treatment plan and all family members stated they received regular updates on their loved one's treatment. One family member said they felt fully included in their loved one's care and treatment and actively took part in the family therapy sessions offered by the service.

Staff directed clients to other services and supported them to access those services if they needed help. The service had a client information board on display in the communal area. This consisted of contact details for partner agencies such as Samaritans, the local authority and advocacy services.

Clients said staff treated them well and behaved kindly. All clients and family members we spoke with felt staff were respectful and available.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards clients. All staff we spoke with said they felt comfortable raising concerns if they had any and were aware of the local whistleblowing policies.

Staff followed policy to keep client information confidential. All client information was stored on an electronic system that staff could only access on site. The service had a confidentiality policy, which all staff had access to.

Involvement in care

Not all staff involved clients in care planning and risk assessment.

Staff actively sought client feedback on the quality of care provided. They ensured that clients had easy access to additional support.

Involvement of clients

Staff introduced clients to the location and the services as part of their admission. Staff showed clients around the service and had a buddy system in place to help orient new clients into the service. The buddy system was optional if the client felt comfortable with this.

Not all staff involved clients and gave them access to their care planning and risk assessments. The care planning process was completed by a therapist with a client and the treatment plan would incorporate the client's goals, information discussed at admission and within the medical assessment. However, one client felt even though the on-site initial assessment took their individuality into account the remote assessment did not take into account their individual concerns.

Staff made sure clients understood their care and treatment, through one to one sessions. However, the service itself did not offer a service in different language or to those that may need additional sensory needs.

Inadequate

Substance misuse services

Staff involved clients in decisions about the service, when appropriate. Clients had weekly community group meetings, which gave clients an opportunity to raise any complaints or compliments.

Clients could give feedback on the service and their treatment and staff supported them to do this. The service had a suggestion box where clients could submit suggestions. The service had produced a "you said, we did" list. One of the recommendations from clients was a request for more information and advice on managing personal relationships and as a result the service implemented a fortnightly group, specifically focussed on family relationships and managing conflict.

Staff made sure clients could access advocacy services. The communal area client information board consisted of information on how to access advocacy services.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers once the treatment plan and assessments had been completed. All family members we spoke with felt they received regular updates on their loved one's treatment. However, one family member stated that the doctor was only available via video call and not face-to-face which in their opinion was not sufficient for a thorough assessment/consultation.

Staff helped families to give feedback on the service. The service gave families the opportunity to give feedback on the service through the complaints process, family therapy sessions and feedback forms. All clients received a complaints and compliments form as part of their welcome pack to the service. They actively made changes and updated information and advice after feedback. For example, one of the areas of feedback from families was a request for more information on guidance on accessing external agencies, specifically, continuing personal therapy, mental health support, attention deficit hyperactivity disorder (ADHD) assessment in adults, community drug and alcohol support and accessing fellowship meetings, online and in-person. In response the service updated their discharge paperwork and produced guidance on the practical application of the concepts discussed within the group program and daily planners and made several referrals for attention deficit hyperactivity disorder (ADHD) assessments for adults. This was a new initiative developed by the service since the last inspection.

Is the service responsive?

Good

We rated it as good.

Access and discharge

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.

Bed management

The admissions team offered placements at their alternative service locations if bed occupancy did reach 100%.

Managers regularly reviewed length of stay for clients to ensure they did not stay longer than they needed to. Most clients were at the service for a minimum of 2 weeks and a maximum of 4 weeks.

Managers and staff worked to make sure they did not discharge clients before they were ready. If a client decided to discharge from the service earlier than planned the service always had an unexpected exit plan in place. The service had a policy in place where if a client self-discharged earlier than planned and was at risk they would only be given enough medication for 3 days. Further medication would be posted out securely to the discharge address and where consent had been gained the next of kin would be informed.

Clients were moved between areas only when there were clear clinical reasons or it was in the best interest of the client. All clients were admitted to the ground floor rooms until all risk assessments had been completed and they were deemed clinically suitable to move to another floor if they chose to. All ground floor rooms were fitted with anti-ligature showers and allowed staff to complete more frequent observations.

Discharge and transfers of care

Clients did not have to stay at the location when they were well enough to leave. All clients were privately funded and had the capacity to leave when they chose to.

Staff carefully planned clients' discharge and worked with clients and their family members, where consent was given. Before discharge each client had a one to one session with a therapist and were given an end of treatment pack consisting of contact details of who to contact including the service. Where staff felt a client was at risk, they had access to a driver who was able to drop clients to their discharge address. Where the service was concerned about a client, they were able to raise concerns through services such as the police for welfare checks to be carried out.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the location 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.

Each client had their own bedroom, which they could personalise. All client rooms had an en suite and consisted of storage for the client to keep their personal possessions.

Clients had a secure place to store personal possessions. Each room consisted of a safe where clients could store personal possessions such as bank cards and money.

The service had a full range of rooms and equipment to support treatment and care. This included a communal lounge and dining area, library, gym, sauna and garden area. Staff and clients could access the rooms such as the library and communal lounge and certain rooms such as the gym and sauna were risk assessed before clients could access them.

The service had quiet areas and a room where clients could meet with visitors in private. Clients had access to an admissions room and a library, which were the quieter areas.

Clients could make phone calls in private. Clients had access to their own mobile phones whilst at the service.

The service had an outside space that clients could access easily. The service had a large well-maintained garden that clients could access throughout the day.

Clients could make their own hot drinks and snacks and were not dependent on staff. Clients had access to drinks and snacks throughout the day.

The service offered a variety of good quality food. The service had a set menu offering a choice on a daily basis, but clients were able to make special requests if they did not want to have what was on the menu. The service met dietary requirements such as vegetarian or halal diets if required.

Meeting the needs of all people who use the service

The service met the needs of clients, including those with a protected characteristic but did not offer a service for those with specific communication needs.

The service could support and make adjustments for disabled people. The service was wheelchair accessible and had access to wheelchair accessible rooms. However, they could not meet the needs of those with communication needs or other specific needs such as language needs.

Staff made sure clients could access information on treatment, local service, their rights and how to complain. All clients were given a detailed welcome pack and the service advocated clients accessing local groups such as Alcoholics Anonymous (AA) and cocaine anonymous etc meetings.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Clients, relatives and carers knew how to complain or raise concerns. The service displayed their complaints policy within the communal areas and clients received a copy of this within the welcome pack.

The service clearly displayed information about how to raise a concern in client areas. Where clients did not want to raise a formal complaint, they were able to leave a suggestion in the suggestion box.

Staff understood the policy on complaints and knew how to handle them. All staff knew how to log complaints on the service online shared system and had access to the service policy. This was an area of improvement identified within the last report that had now been met.

Managers investigated complaints and identified themes. All complaints were responded to within the policy 28 day target. Where complaints had been received from family members the service gained consent from the client prior to investigation and sharing confidential information. The manager reviewed complaints and discussed them at team meetings if there were any lessons to be learnt.

Managers shared feedback from complaints with staff and learning was used to improve the service. Changes following complaints included more information within the welcome pack around counselling sessions offered during a client's stay and what they can expect from these.

Inadequate

Substance misuse services

The service used compliments to learn, celebrate success and improve the quality of care. Compliments were noted within the weekly client community meetings and shared with staff through team meetings and community meeting minutes.

Is the service well-led?

Inadequate

We rated it as inadequate.

Leadership

Leaders were visible in the service and approachable for clients and staff.

The service made leadership development opportunities to staff and was supporting a staff member to complete a management qualification at the time of inspection.

However, managers did not always have the skills, knowledge and experience to perform their roles. Despite having detailed policies and procedures for incidents in place, managers and clinical leads had not identified where staff had not followed legislation on medication administration or clinical guidance on assessment processes. Our inspection identified gaps in robust policies and processes for safe management of medication.

Our enforcement action immediately following the inspection asked the provider to undertake a review of policies and procedures for safe management of medicines. Managers failed to identify the documentation submitted, failed to meet the new and revised policies and procedures put in place.

Following the inspection and enforcement action taken the service told us they had implemented new auditing systems, governance processes and medication management policies and procedures.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

All staff told us they aimed to deliver a service which helped clients achieve a lasting recovery. They provided examples of how they applied these to their work and how the range of therapies available supported this. This included making family therapy available to loved ones up 2 years after their loved one had left the service. This was the ethos of the service.

Culture

Staff felt respected, supported and valued. They said the service promoted equality and diversity in daily work and provided opportunities for development and career progression. The service was supporting one staff member to complete management qualifications and actively supported staff diversity and protected characteristics.

Staff felt they could raise any concerns without fear. All staff felt the new management structure since September 2022 was working well and management were approachable and visible. All staff we spoke with felt valued and supported within their role and felt the team worked well together.

Managers dealt with poor staff performance in the circumstances where managers had identified it. The provider supported managers to identify and deal with poor staff performance. This included a dedicated human resources manager and policy guidance.

The service held an equality opportunity and diversity inclusion policy. This had been reviewed regularly in line with the services policy review schedule.

Governance

Our findings from the other key questions demonstrated that governance processes did not operate effectively at team level and that performance and risk were not managed well.

The service now had a staff mobile phone policy in place. Staff were not authorised to use their phones when in patient areas delivering care. This was an area of improvement identified at the last inspection which had now been met.

The provider had an updated risk register that reflected current concerns relating to client risk in place that all staff had access to. Risks identified on the register included staffing and infection prevention control. The register recorded likelihood and seriousness of the risk, along with actions to reduce or manage the risk. Managers submitted risks highlighted by staff to the risk register. This was an area of improvement identified within the last inspection which had now been met.

However, our inspection highlighted a number of significant safety and quality concerns that the provider's existing governance systems had not. Our findings in the safe key question have identified that governance was not robust in medicines management, recording of incidents and the admission assessment process. The services governance processes did not identify the ineffectiveness of the medication audit systems in place. The audit systems did not identify the discrepancies in medication prescribing, administration and management. Even though medication errors were discussed at the clinical governance meetings the processes being outside legislation was not identified or appropriately escalated.

Even though accidents and incidents were discussed at the clinical governance meetings, discrepancies in staff recordings had not been appropriately escalated to senior management. The accident and incident audit systems in place did not identify staff had not completed body maps effectively and in line the accident/ incident policy in place.

Therefore, governance and oversight to highlight issues of non-compliance in all aspects of care and treatment were still not in place. The service did not have effective audit and governance systems in place. These were areas of improvement identified within the last report that had still not been met.

We took urgent action following this inspection and asked the service to provide evidence and assurances that the issues identified would be rectified immediately. Evidence provided by the service did not provide these assurances and key information was missing from documentation in regard to prescription only medication, PRN protocols, and administration of homely remedies. We were not assured that leaders had effective oversight of medicines management and systems in place to keep clients safe.

Inadequate

Substance misuse services

Following the inspection and enforcement action taken the service told us they had implemented new auditing systems, governance processes and medication management policies and procedures.

Management of risk, issues and performance

Teams did not always have access to the information they needed to provide safe and effective care. Medical staff did not always use information regarding medical history when assessing clients. This meant teams did not always have all information needed to provide safe and effective care.

The provider held plans to manage emergencies in the service. This included an extreme weather conditions policy.

Information management

Staff collected analysed data about outcomes and performance, and these were discussed at the clinical governance meetings, such as incidents, complaints, and compliments**.** However, the gaps identified in safe medicines management and incident recording had not been identified by the clinical governance team.

The provider held policies and procedures to manage information governance in the service. This included the confidentiality policy.

The service manager made notifications to external bodies as needed.

Our observation from inspections confirmed information needed to deliver care was stored securely and available to staff, in an accessible form, when they needed it. All staff had personal log ins to the secure electronic care planning system in place.

Records demonstrated that staff completed service confidentiality agreements with clients. We saw the welcome pack for clients included information about confidentiality in the service.

Engagement

Managers encouraged clients to actively engage with local groups such as Alcoholics Anonymous and gave information about local services such as advocacy services available to them. They made referrals where appropriate to local mental health services and local authority.

Staff, clients and carers had access to up-to-date information about the work of the provider and the services they used. The service maintained information online, including an intranet for staff and service website.

Our conversations with clients, family members and carers confirmed they had opportunities to give feedback on the service they received. The service used client exit questionnaires and feedback within these to activity make changes and improvements to service delivery and information available to clients and family members. Questions within the client exit questionnaire included a range of questions from staff approach to treatment information given.

We saw that managers and staff had access to the feedback from clients, family members and carers and used it to make improvements. This included changes in groups they delivered and information within the client discharge pack.

Inadequate

Substance misuse services

Learning, continuous improvement and innovation

The service aimed to use innovative technologies and therapies when delivering their treatment program. This included the satori chair and the range of therapies including sound therapy and the offer of family therapy up to 2 years after a client had left the service.

At the time of the inspection the service was not partaking in any quality improvement projects but the manager stated this was where they wanted the service to be.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The service did not ensure all injuries post incidents were recorded using a body map • The service did not ensure that clients risk assessments, risk management plans were completed in full, kept up to date to reflect client risks • The service did not ensure they completed face to face assessments prior to prescribing • The service did not ensure room searches were completed after incidents of self-harm in a client's bedroom

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The service did not ensure clients were sufficiently involved in their care and receive care in their chosen style.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The service did not ensure prescription only medicines were only given in accordance with a valid prescription. • The service did not ensure homely remedies were individually authorised and given in accordance with a policy. • The service did not ensure adequate patient centred information were made available to staff to ensure they could safely support people with their when required medicines administration. • The service did not ensure prescribed medicines were tailored to individuals including a rational for prescribing medicines used to aid sleep. • The service did not ensure the admissions process and assessments process was thorough and took into account a client's medical history, medical conditions and prescribed medications.

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The service did not operate effective systems or processes to ensure compliance with the requirements of the regulations. • The service did not ensure medicines audits identified where staff were not following medicines management within legal parameters. • The service did not ensure accident / incidents were reviewed and audited effectively to identify where there were gaps in post incident checks.