We Can Recover CIC

We Can Recover CIC

Inspection report

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Date of inspection visit: 23 February 2023
Date of publication: 06/06/2023

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 well-led?	**Inadequate**

Summary of findings

Overall summary

We Can Recover is a Community Interest Company located in West Liverpool. The service was registered to provide inpatient care and detoxification for up to 24 clients with non-opiate addictions such as alcohol or cocaine in their residential rehabilitation facility.

Due to the safety concerns identified on a previous inspection, the Care Quality Commission took immediate enforcement action to prevent this service providing care and treatment to clients until significant improvements had been made. Clients were not safe or at high risk of avoidable harm and the delivery of high quality care was not assured by the leadership, governance, or culture. The service did not have any clients on site due to the suspension of the service. At this inspection, the service could not evidence that all the improvements needed to ensure the safe care and treatment of clients had been made in time for the service to begin operating again on 01 March 2023.

I am placing the service into special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will act in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement, we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

We rated it as inadequate because:

- Clinic rooms were not fully equipped.
- Although the service had contracted a named GP prescriber, their role and cover arrangements remained unclear.
- Although the provider had recruited nursing staff, most lacked previous experience in substance misuse. Arrangements to cover gaps in staffing were not formalised and there was not a clear clinical escalation route for queries out of hours.
- Staff were not provided with the skills needed to safely deliver care to clients in the service. Training records were updated to reflect staff had completed mandatory training, but there were still gaps in the nursing and support staff completion.
- The admission process was unsafe, in that staff who screened client's admission and risks were not trained to do so. The process for reviewing risk prior to admission was unclear.
- Training records provided recorded only two of the four registered nurses had completed medicine administration training. The process around clinical oversight and supervision of registered nurses in medicine management remained unclear.
- Leaders did not have the skills, knowledge, and experience to perform their roles. Managers, including the new clinical lead, did not have experience in delivering a medically managed detoxification service. Managers had acted on some issues identified in the suspension notice, but concerns around the safety of clients if the service began to operate remained.
- Leaders had not implemented safe systems and processes to provide safe and good quality care to clients using the service. Information was not available to us during the inspection and requested information from the previous two inspections remained outstanding. Policies, protocols, and documentation did not accurately reflect how care was to be provided or how the service would operate should the suspension be lifted.

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Summary of findings

However:

- The provider had purchased new equipment for the clinic room and had reviewed their arrangements for emergency medicines. The provider had reviewed their exclusion criteria to include those with complex health problems for whom they would not be able to provide care.
- The service had provided Safeguarding Adults and Children's' training on how to recognise and report abuse, appropriate for their role, however there were still gaps in safeguarding children level two training. The provider had a safeguarding policy that reflected the service's arrangements. Managers had completed all appropriate employment checks for every staff member who had commenced employment.
- The service had revised the medicines administration policy and included additional guidance on as required medicines and a medicines risk assessment form. There were no clients on site due to the suspension of the service so we could not assess the process to safely prescribe, administer, record and store medicines.
- The registered manager was not aware of or understood that the named GP under practicing privileges required a license as defined by the GMC. The named GP had not been vetted under Regulation 18 (schedule 3) fit and proper person employed, to ensure the named GP was a fit and proper person to be employed.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community-based substance misuse services	Inadequate 	

Summary of findings

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Summary of this inspection

Background to We Can Recover CIC

We Can Recover is a Community Interest Company located in West Liverpool. The service is registered to provide inpatient care and detoxification for up to 24 clients with non-opiate addictions such as alcohol or cocaine in their residential rehabilitation facility. The service is not funded through the NHS; all clients pay private fees for treatment.

The service was originally registered with the Care Quality Commission in June 2021 to provide accommodation for persons who require treatment for substance misuse and treatment of disease, disorder or injury. The service was dormant, meaning not in use, until 4 October 2022 when We Can Recover started to admit clients for treatment.

This was the third inspection of the service to follow up on safety issues identified at the previous inspection in November 2022, where we issued a Notice of Decision to suspend the provider's registration. We rated them inadequate overall and in the safe and well led domains. Following the November 2022 inspection, the provider removed treatment of disease, disorder, or injury from their registration.

At the November 2022 inspection we were not assured that staff had the qualifications, competence, skills, and experience to care for clients safely. Support workers, who were caring for people in alcohol withdrawal were not competent, skilled, or experienced in either the assessment and monitoring of withdrawal symptoms or in responding to potentially serious physical health side effects. Staff were not trained in essential skills to recognise and respond to people's health deteriorating due to alcohol withdrawal and had not received other mandatory training.

We were not assured that there were effective medicines management arrangements in place to ensure clients received safe care and treatment, which exposed clients to serious risk of harm. There was no signed service level agreement with a named GP to clarify the process for assessing and prescribing medicines remotely.

The service had a registered manager who was also the nominated individual. Registered managers have a legal responsibility for compliance with the requirements of the Health and Social Care Act 2008 and associated regulations and must be able to influence compliance with the essential standards. A nominated individual supervises the management of a regulated activity across an organisation.

What people who use the service say

There were no clients using the service during this inspection because the provider's registration had been suspended.

How we carried out this inspection

Prior to and following the inspection visit, we reviewed information that we held about the location and asked other organisations, including the local authority, for information.

During the inspection visit, the inspection team:

- spoke with the registered manager and assistant manager and registered nurse.
- toured the building and grounds areas to see if identified improvements had been made.
- reviewed medicine storage facilities.
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this inspection

This was a focused follow up inspection in order to determine if the provider had improved enough to allow the suspension of registration, as recorded in the November 2022 Notice of Decision, to lapse.

The inspection team comprised of two CQC inspectors.

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.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community-based substance misuse services	Inadequate	Not inspected	Not inspected	Not inspected	Inadequate	Inadequate
Overall	Inadequate	Not inspected	Not inspected	Not inspected	Inadequate	Inadequate

Inadequate

Community-based substance misuse services

Safe	Inadequate
Well-led	Inadequate

Is the service safe?

Inadequate

Clinic room and equipment

Clinic rooms were not fully equipped, with emergency drugs that staff checked regularly. The service did not follow best practice standards to purchase and maintain equipment.

The service did not have a couch in the clinic room, weighing scales or a height measure stadiometer. During the tour of the building the registered manager confirmed to the inspectors that equipment would be available on site, once the decision to lift the suspension notice or let it lapse had been confirmed. Handwashing facilities had been installed in the clinic room in keeping with best practice guidance. The service had a defibrillator.

There was no locked cupboard to store medicines in the clinic room, other than a locked filing cabinet, which did not meet medicine storage guidance. The registered manager explained the service planned to buy individual lockable storage for medicines once they had a confirmed a date to reopen, so we were unsure of how medicines would be stored.

Safe staffing

The service did not have enough nursing and medical staff, who had completed basic training to keep people safe from avoidable harm.

Nursing staff

At the last inspection, we identified that the service did not have enough nursing and support staff to keep clients safe. Following the inspection on 26 January, the provider submitted draft duty rosters to provide us with an outline of minimum staffing levels over a 24 hour period. The registered manager and assistant manager confirmed they had offered positions to four registered nurses, only one had commenced to support the assistant manager develop policies, procedures, and practice guidance. Other staff commencing employment depended upon a date of reopening being confirmed. The registered manager also clarified that any shortfalls in shifts for registered nurses would be covered by offering staff additional hours, and the service would not use agency staff. We could not determine the arrangements on how registered nurses would be deployed over a 24 hour basis as the provider could only assure the inspectors, they would admit clients on a risk based phased approach, until they had a service level agreement agreed with the named GP, and the admissions team could accept clients.

Medical staff

Inadequate

Community-based substance misuse services

At the previous inspection, the service did not have access to daytime and night-time medical cover or a doctor available to go to the service quickly in an emergency. There was no doctor providing clinical leadership or guidance to the service.

At this inspection, the provider had contracted the services of a named GP based in Birmingham to manage and oversee medicines. The registered manager could not confirm if the named doctor was acting as an independent doctor or prescribing care and treatment under the regulated activity accommodation for persons who require treatment for substance misuse on behalf of or employed by, We Can Recover CIC. We were provided with a copy of a consulting agreement with a named doctor for providing consultation of their expertise. The consulting agreement did not specify what services the doctor would be providing. For example, the registered manager described the consultation would be via an online platform. This did not include how the doctor had oversight of the information for the referral and assessment process for a client. There was no clearly defined role for the doctor in the referral, assessment and admission process the registered manager described, and the registered manager and assistant manager clarified the policy and process had not yet been defined or completed. The service could not clarify what cover arrangements were in place for the prescribing and monitoring of medication when the named GP was not available. It was unclear who would be responsible for the medical/clinical oversight and personal development of staff at We Can Recover who have not previously worked within a residential substance misuse service.

General Medical Council guidance recommends that practitioners review when remote consultations are appropriate. It recommends that doctors consider face to face consultations when the doctor is not the patient's usual doctor or GP and they have not given consent to share information if the treatment needs following up or monitoring; when the doctor does not have access to the patient's medical records; when the doctor needs to examine the patient; when the doctor is unsure about the patient's capacity to decide about treatment and when the patient has clinical complex needs. The registered manager told us the named doctor would remotely monitor clients and prescribe medicines. We spoke with the doctor following the inspection who confirmed a service level agreement outlining his role was not in place, and that he had not spoken with the service for five weeks.

We saw improvements in the recruitment, training, and development of staff. Policies regarding medicines management had been reviewed and additional risk assessment documents related to medicines administration and use of as required medicines created. The service was also reviewing the policy on the use of emergency medicines for detoxification and where clients had known conditions requiring emergency medicines.

At the last inspection, when staff needed support, they told us they contacted the non-clinical managers for advice. There was still no on call policy and procedure in place on 23 February 2023, with no reference to the named doctor's role, responsibilities, and medical oversight.

Mandatory training

The mandatory training programme was not comprehensive, did not meet the needs of clients and staff, and staff had not completed all the expected areas of mandatory training.

At the last inspection, managers did not monitor mandatory training well or alert staff when they needed to update their training. Training records now included existing and recently appointed staff. We saw there had been improvements in mandatory training around safeguarding, medicines management and basic lifesaving. However, relevant training, indicated on the suspension notice, had not been arranged for ligature risk management, but we were aware the provider was having difficulty in sourcing this training. Role specific training had not been completed by nursing and support staff. Details of training course content was not shared with the Care Quality Commission.

The following policies, procedures and in house training were incomplete:

• Service user pathway admission process

• Risk assessment

• Support plans

• CIWA- Understanding and observation and recording - The Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar) is a scale used in the assessment and management of alcohol withdrawal

• Client exit process

• Client timetable, house rules

In addition, only one of the four registered nurses was recorded as completing basic life support on the provider training matrix version 6. None of the staff on the training matrix had completed managing challenging behaviour, signs of withdrawal, understanding recovery and supporting clients through their treatment. An administrator and support worker were the only two staff who had completed training on the Mental Capacity Act 2005. Having this training and knowledge is essential for staff working in a detoxification and rehabilitation substance misuse service. Following the last inspection, the provider shared details of the induction days' training which included symptoms of alcohol withdrawal, capacity to consent to treatment, the medication policy, updating daily notes, whistleblowing, safeguarding, on call responsibilities, and further detail surrounding the CIWA-Ar content. We were unable to verify the quality of the content of some of the above training because this information was not shared with us in an accessible format before this inspection. Following this inspection, the provider shared the service's training matrix with us. This recorded the assistant manager had completed CIWA training and other staff had not commenced employment so had not completed it.

Assessing client risk

Staff screening client's admission had not completed all the role specific training required to fulfil their role. The service had not developed effective systems and processes to review risk prior to admission. They did not assess and manage risks to clients well.

At the previous inspection we were still unclear on how staff identified risks for each client prior to admission and on arrival. The service provided us with their pre-admission assessment, which now included an exclusion criterion. The risk assessment also included risks associated with clients' addictions, physical and mental health, and risks to self and other clients. There was still no service level agreement with the named GP at this inspection, so we could not determine how risk would be assessed.

However, Staff that screened client's admission and risks had not completed all of the role specific training required to fulfil their role. The service remained unclear on the effective systems and processes to review risk prior to admission, and it was unclear if there was a multidisciplinary approach to admission. The service had not confirmed that the named GP prescriber would have access to client's summary care records or current blood results when assessing admissions.

Safeguarding

Inadequate

Community-based substance misuse services

Not all staff had Safeguarding Adults and Children training on how to recognise and report abuse, appropriate for their role. The provider had a safeguarding policy that reflected the service or best practice.

At the last inspection, staff did not receive training on how to recognise and report abuse appropriate for their role, and they did not keep up to date with their safeguarding training. At this inspection we saw the service had provided Safeguarding Adults and Children's' training on how to recognise and report abuse, appropriate for their role. Registered nurses and support staff had completed level two safeguarding adults training, however there were still gaps in safeguarding children level two training. For example, only one of the three therapy staff had completed level 2 safeguarding adult's training and none of the therapy staff had competed level 2 safeguarding children's training. All the registered nurses had completed safeguarding adults' level 3 training, but not safeguarding children level 2. The lead nurse had completed role specific level three safeguarding children's training as per the national intercollegiate guidance standards.

Medicines management

The service had not implemented a safe system and process to safely prescribe and store medicines.

The registered manager could not provide additional clarity on the prescribing of emergency medicines for alcohol detoxification, until a service level agreement had been discussed with the named GP. Because of the lack of clarity, the inspectors provided the assistant manager with National Institute for Clinical and Health Excellence (NICE) guidance NG QS11 Alcohol-use disorders: diagnosis and management of physical complications, which covered the use of emergency medicines. National Institute for Health and Social Care Excellence guidance recommends that care providers should consider offering a quick acting benzodiazepine (such as lorazepam) to reduce the likelihood of further seizures. In the treatment of alcohol withdrawal, benzodiazepines are primarily used to alleviate potentially dangerous withdrawal symptoms including seizures and delirium and especially in the urgent treatment of delirium tremens, in which cases their administration can be life-saving. Trained staff can only administer these medicines. However, we did not improvements made in the medicines management and pre-admission policies. These had been amended to include the arrangements for emergency medicines, already prescribed to clients for known health conditions. The medicines management policy had also been updated to include the processes in place for the management of Pro Re Nata (take as required) (PRN) medicine including risk assessment and care planning. The policy also addressed arrangements for the safe disposal and collection of medicines.

Managers were unable to provide assurance that suitably qualified staff would be able to review client's medicines regularly and provide advice to clients and carers about their medicines. There were no cover arrangements in place for when the named GP was not available to prescribe or monitor medication.

The service could also not clarify the arrangements for the assessment, planning and delivery of care and treatment of clients being admitted to the service by a medical or clinical practitioner or arrangements to respond appropriately and in good time to client's changing needs, so medicines are administered accurately, in accordance with any prescriber instructions and at suitable times.

The service could not clarify the arrangements for clients storing, accessing, and managing their own prescribed medicines based on risk assessments that balance their needs, safety, rights, and preferences.

On the day of the inspection, the service shared a completed and ratified policy that detailed the service's approach to medicines management. However, we were unable to assess whether this would work in practice as there were no clients on site at the time of inspection.

Inadequate

Community-based substance misuse services

Is the service well-led?

Inadequate

Leadership

Leaders did not have the skills, knowledge, and experience to perform their roles. They did not have a good understanding of what was required to run the service, which was evidenced, when we had to continually explain to the registered manager what was needed to comply with the suspension notice .

At the last inspection we found that leaders did not have the skills, knowledge, and experience to perform their roles. This continued to be the case at this inspection. Although the service now had clinical input to the management team, due to the suspension of the regulated activity, the clinical lead was not working at the service. The clinical lead was identified as someone who had several years' experience working in residential and community substance misuse services.

Leaders did not have the skills, knowledge, and experience to perform their roles. They did not have a good understanding of what was required of them to deliver a safe and well led service. Managers had not acted on all issues identified in the suspension notice. Managers did return information requested by the Care Quality Commission in a timely fashion following this inspection. However, the information did not address the issues related to the service provided by the named GP, including practicing privileges and vetting of that person.

At the last inspection we found that leaders did not have a good understanding of the service they managed. This continued to be the case, for example in discussion with the registered and assistant manager, it was only after a discussion around risk assessment and a red, amber, and green rating to identify risk, that an on-call procedure was created.

However, the governance systems around recording of staff information had improved with all recruitment records being transferred to the provider IT system.

Management of risk, issues and performance

Information that staff needed to provide safe and effective care was unclear, incomplete and at times irrelevant. Managers did not ensure all staff had all the appropriate pre-employment checks in place.

At the previous inspection, the service had not completed all employment checks in line with schedule three of the Health and Social Care Act. We reviewed seven staff records during this inspection and found that it had improved. Managers had completed all necessary employment checks.

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.

Inadequate

Community-based substance misuse services

The service had ensured that clinical premises where clients received care were not well equipped. The clinic room did not have a couch, lockable storage for medicines, weighing scales or a height measure stadiometer. However, the clinic room had handwashing facilities fitted since our last inspection, and new blood pressure monitors were purchased and calibrated in line with manufacturer instructions.

The service kept no emergency medicines and the service had amended the policy on the use of emergency medicines to clarify which emergency medicines clients would have to bring with them as part of the pre-admission assessment The registered and deputy manager told us the named doctor would be responsible for prescribing emergency medicines if and when these were required by clients related to their detoxification from alcohol. Otherwise, emergency medicines would not be kept as a stock item.

Managers did not ensure that staff had access to all the training on the service training matrix, necessary for their role, as there were still identified gaps in training to support clients during their recovery. Supervision could not be delivered yet as the service was not operating. Managers described their approach to the development of a supervision framework, which would be led by an experienced nurse the service had employed, but were unable to provide a supervision policy. Managers stated they would not use an agency staff and would offer overtime to staff to cover shifts. The registered manager described that registered nurses were an additional level of staff employed to ensure clients received safe care and treatment. The registered manager clarified they did not foresee registered nurses would necessarily cover the service over 24 hours a day, as the service treated different addictions, not just addictions to alcohol or substances. In services where clients are being medically monitored, for example by a named doctor. Registered nurses are not a requirement; however, any additional staff must have the knowledge and ability to monitor and recognise signs of deterioration in client's physical and mental health during detoxification or withdrawal and know how to seek or provide help.

Managers explained that the service had created an operations manual that highlighted everything staff would need to know to work in the service. We requested a copy after the inspection, but the file format that was sent was not viewable. We repeatedly asked the provider for a different file type to be sent but this was never returned, so we were unable to assess the effectiveness of this.

The service could not confirm the actual staffing establishment figures for medical, nursing and support staff. We had received draft staff duty rosters to support clients once the service was operational if and when the suspension could be lifted, but could not assess their effectiveness as there were no clients on site as the service was suspended. Managers did not use a safe staffing tool to determine staffing numbers. The registered manager told us they would offer staff additional hours to cover sickness and annual leave. There was still no clinical escalation route out of hours for staff to access a named doctor. The on-call protocol had not been finalised at the time of the inspection.

The latest version of the training matrix we were provided with identified role specific training that was indicated on the suspension notice had either not taken place been completed at the time of this inspection and remained outstanding.

The service was unable to describe effective systems and processes to review risk prior to admission and it was unclear what service the named GP would provide and when it would be provided. We were not confident the named GP prescriber would have access to client's summary records or current blood results when assessing new admissions, without a service level agreement. There was no signed or dated service level agreement that provided the information we required. We were not assured the service recognised the need for medical oversight and assurance.

Gaps remained in safeguarding adults and children's training on how to recognise and report abuse, appropriate for their role. This issue was specified in the suspension notice that was issued following the first inspection.

Inadequate

Community-based substance misuse services

The provider had removed the controlled drugs from the premises held without a home office license. The registered manager told us these had been taken to the local community pharmacist.