Cranstoun - City Road

Quality Report

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

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

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

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

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

Overall summary

We do not currently rate independent standalone substance misuse services.

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

- At the inspection in November 2015, we found that the provider did not have sufficient panic alarms for the staff that were on duty. At the June 2017 inspection, we found that the provider had purchased more alarms and now had six. Staff said that the alarms had been tested but there were no records of how often staff had tested the alarms.
- When the service was inspected in November 2015, we found that staff were not undertaking security checks of the building in line with the provider's policy. During this inspection, we found that the safety and security checks were still not taking place in line with the provider's policy. There were no assurances that the environment and service was safe for both staff and patients at all times due to gaps in the records.
- At the inspection in November 2015, we found there was no written procedure or risk assessment for the security of medicines in transit to and from the service. During this inspection, we found that the provider was in the process of reviewing their policy regarding the secure transportation of medicines. The service manager had issued staff with interim guidance regarding the transportation of medicines. However, staff were not adhering to this guidance. This meant staff were compromising their personal safety when collecting medicines from the pharmacy.

Summary of findings

- Staff had not undertaken fire alarm checks and fire evacuation drills in line with the provider's policy.
- The provider was unable to provide training completion rates for the volunteers at the service. The provider did not offer training to the sessional workers. There was a risk that this group of staff did not have sufficient knowledge and skills to undertake their duties.
- The service was not routinely developing early exit plans with clients. Staff were not giving clients a plan on how to minimise the risk of overdose or physical health complications should they decide to leave treatment early. All clients had a discharge plan, but the plans were brief and lacked detail. The plans did not contain any details for clients on how they could consolidate their progress once they had been discharged.

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

- At our inspection in November 2015, we found that the provider did not train staff in safeguarding children and young people. During this inspection, we found that the provider had trained staff in safeguarding children and young people.
- At our inspection in November 2015, we found that the provider did not have systems in place to monitor staff suitability to work with the client group throughout the period of employment. When we re-inspected the service in June 2017, we found that the provider now had systems in place to ensure that staff remained suitable to work with the client group. The provider requested an updated criminal records check every three years.
- At our inspection of the service in November 2015, we identified that the provider expected staff to undertake capacity assessments but they did not provide staff with training. When we inspected the service in June 2017, we found that the provider had trained staff in the Mental Capacity Act (MCA), although the level of understanding of the MCA varied between staff.
- The service gathered feedback from clients and used it to improve the service.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Substance misuse/ detoxification		

Summary of findings

Contents

Cranstoun, City Road

Services we looked at:
Substance misuse/detoxification;

Summary of this inspection

Background to Cranstoun - City Road

Cranstoun City Road is a residential detoxification, crisis intervention and stabilisation service in North London providing care, treatment and support for up to 21 people with drug and alcohol dependency.

Cranstoun City Road is registered to provide accommodation for persons who require nursing or

personal care; and treatment of disease, disorder or injury.

There was no registered manager at the service. The new manager was applying for registration at the time of the inspection. The service received referrals from various organisations inside and outside of London.

The service was last inspected in November 2015. We found that there were concerns about the quality and safety of the service. We issued the provider with two requirement notices.

Our inspection team

The team that inspected the service comprised of three CQC inspectors.

Why we carried out this inspection

We undertook this inspection to find out whether Cranstoun City Road had made improvements since our inspection in November 2015. Following the November 2015 inspection, we told the provider it must take the following actions to improve the service:

- The provider must ensure staff complete training in safeguarding children
- The provider must ensure they have systems to monitor staff to ensure they meet the fit and proper persons employed requirement throughout the period of employment.

The two requirement notices related to:-

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

How we carried out this inspection

This was an unannounced, focused inspection. We looked at aspects of the service, which had caused concern at the inspection in November 2015. We also looked at other areas that gave us immediate concern during this inspection.

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

· visited the service and looked at the quality of the physical environment

· spoke with one client

· spoke with the manager of the service

· spoke with the psychosocial manager

· spoke with three members of staff

· spoke with one volunteer

· looked at seven care and treatment records

· looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We do not currently rate substance misuse services

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

- At the inspection in November 2015, we found that staff were not undertaking the security checks in line with the provider's policies and procedures. During this inspection, we found that staff were still not undertaking security and safety checks in line with the provider's policies. This meant that the premises might not have been secure and safe for people using the service and staff.
- At the inspection in November 2015, we found that the service did not have an adequate number of panic alarms. When we inspected the service in June 2017, we found that the provider had purchased additional alarms. Staff said that they checked the alarms. However, there were no clear records regarding how frequently they had been checked. The service could not be sure that the alarms were functioning properly without testing them.
- Staff had not undertaken the fire alarm checks and fire evacuation drills in line with the provider's policy. The service had not implemented the remedial actions identified in the service's fire risk assessment action plan.
- The provider did not provide training for the sessional workers who worked at the service. The provider could not provide assurances that volunteers and sessional workers had sufficient skills necessary for their roles.
- At the inspection in November 2015, we found that the provider did not have a policy regarding the transportation of medicines to and from the service. When the service was inspected in June 2017, we found that the provider was in the process of reviewing and drafting a new policy regarding the transportation of medicines from the pharmacy to the service location. In the interim, the service manager had issued guidance to staff regarding the safe transportation of medicines. However, we found that staff were not adhering to the guidance. Staff were compromising their personal safety when collecting medicines from the pharmacy. Staff were collecting the medicines at the same time each day.

However, we found the following areas of good practice:

Summary of this inspection

- At the last inspection in November 2015, we found that the provider did not have up to date Disclosure and Barring Service (criminal records) checks for the staff working at the service. During this inspection, we found that the provider had reviewed their recruitment policy and all staff, volunteers and sessional workers either had up to date criminal records checks or the provider was in the process of requesting up to date criminal records checks. DBS checks are undertaken to ensure that individuals do not have criminal records, which would prevent them from working with vulnerable individuals.
- At the inspection in November 2015, we found that the provider had not trained staff in safeguarding children and young people. During this inspection, we found that the provider had trained permanent staff in safeguarding children and young people. Staff were aware of safeguarding procedures regarding children and young people.
- The service reported incidents and reviewed the learning from these incidents.

Are services effective?

We found the following areas of good practice:

- At the inspection in November 2015, we found that the staff were expected to undertake capacity assessments without the relevant training. During this inspection, we found that all staff had been trained. Although the level of understanding of the MCA varied between staff. There was evidence that staff had requested specialist capacity assessments when required.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- The provider gathered feedback from clients and acted upon the feedback to improve the service. The service had added new therapies to their therapy programme in response to client feedback.

Are services responsive?

We do not currently rate standalone substance misuse services.

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

- None of the clients had an early exit plan. It was not always clear what clients should do if they left treatment early. Clients

Summary of this inspection

who have recently undergone opioid detoxification are at high risk of overdose. Clients who have undergone alcohol detoxification can experience life threatening complications if they leave treatment early.

- The discharge plans for clients were brief and did not have sufficient details regarding the progress the client had made whilst in treatment. There was little information as to how to consolidate their progress once the service discharged the client from treatment.

Are services well-led?

We do not currently rate standalone substance misuse services.

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

- The provider was unable to provide information regarding the training completion rates for the volunteers working at the service.
- The provider had undertaken a range of formal audits to ensure that the quality and safety of the service was monitored. However, at the time of the inspection in June 2017, the remedial actions arising from some of these audits had not been acted upon.
- The service did not have monitoring systems to ensure that the service was safe and secure at all times. For example, fire drills and fire alarm checks were not being undertaken in line with the provider's policy. The service had not identified that there were gaps in the records.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

At the inspection in November 2015, we found that the provider did not offer staff training in the Mental Capacity Act (MCA). However, the provider expected staff to undertake capacity assessments on clients. We asked the provider to take steps to address this. The provider had organised for staff to undertake further MCA training. When we re-inspected the service in June 2017, we found that 93% of staff had undertaken MCA training. However staff members understanding of the MCA varied. Two staff did not understand how the MCA might relate to the clients using the service. There was a risk that they may not respond appropriately to clients. For example, staff may think that client being compliant with treatment meant that they were consenting.

Substance misuse/detoxification

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse/detoxification services safe?

Safe and clean environment

- At the inspection in November 2015, we found that the service did not have an adequate number of panic alarms for staff to wear whilst on duty. During this inspection, we found that the service had sufficient alarms to allow staff to have them whilst undertaking face to face work with clients. Staff also provided alarms to clients who were particularly vulnerable who might need to summon assistance from staff. The manager had identified that two alarms should be permanently placed in rooms where staff undertook one to one meetings with staff. Staff said they checked the alarms. However, there were no clear records to verify this. The staff could not be sure that the alarms were working.
- When we inspected the service in November 2015, we found that staff were not undertaking 12 hour security checks on the building. The provider's policy was not followed. During this inspection, we found that staff were not undertaking the full range of security and safety checks. The checks included ensuring that clients were not smoking in their rooms, or that fire exits were not blocked and the doors were locked and secure. Between the 1 May 2017 and the 19 May 2017, staff missed the full range of checks on 16 occasions. This meant that the provider was not following its own procedures. There were no assurances that the premises were secure and safe for clients and staff at all times.
- The provider had undertaken a fire risk assessment at the service. However, it was undated and the remedial actions that had been identified did not have a date by which they should be completed. The fire risk assessment had identified that there should be weekly alarm tests and monthly fire evacuation drills. Staff undertook fire alarm system checks and fire evacuation drills. However, this was not always in line with the required frequency. Staff had not the monthly fire drill in March 2016. Staff did not always act upon or share the lessons learned from the drills. Lessons learned were not always documented or shared. For example, in December 2016 the alarm was triggered due to a person smoking in their bedroom. Only immediate actions were recorded by staff. There were no further actions, for example, reminding people not to smoke in their bedrooms. Fire alarm system checks were expected to take place each week. We saw that from the period 16 March to 15 June 2017 staff had checked the fire alarm on five occasions to ensure it worked. Staff should have checked the alarms on 15 occasions during this period of time. This meant that service users and staff were placed at potential risk because fire safety checks were not undertaken in line with the agreed frequency.

Safe staffing

- At the inspection in November 2015, we identified that the provider had not requested updated criminal record checks to ensure that employees remained suitable to work with the client group. During this recent inspection, we found that the provider had reviewed their Disclosure and Barring Service (DBS) policy. The provider requested a DBS for all new employees. Staff were required to provide an updated DBS every three years to verify that they had not committed any offence that would have prevented them from working with the client group. We reviewed the DBS checks and noted that the provider had applied for an updated DBS for 100% of the staff and volunteers working at the service.
- The service employed 14 volunteers. The volunteers undertook a range of duties, which included meeting and greeting new clients, escorting clients to appointments and facilitating activities. The provider

had a core training programme for volunteers but was unable to confirm that all volunteers had received sufficient training to ensure that they were able to undertake the range of activities expected of them safely. For example, the provider could not confirm how many volunteers had received training in safeguarding, health and safety or infection control. The service provided staff with opportunities to discuss practice issues for example, maintaining appropriate boundaries and health and safety, during the monthly volunteers meeting.

- The service employed 17 sessional workers. The workers also undertook a range of face-to-face duties with clients. The sessional workers provided cover for annual leave, sickness and vacant posts of nursing and social care staff. The provider did not offer sessional workers any training relevant to the roles they undertook. The provider could not offer assurances that sessional staff were able to safely undertake the range of duties expected of them.

Assessing and managing risk to clients and staff

- At the inspection in November 2015, we noted that the provider did not offer staff training in safeguarding children and young people. This meant staff might not be able to identify when those individuals were at risk of harm. During this inspection, we found that the provider now offered staff training in safeguarding children and young people. The provider had trained all paid staff. All staff we spoke with had an understanding of safeguarding children and young people. The staff were clear regarding the procedures for reporting safeguarding concerns. The provider allowed children to visit the service if an adult accompanied them. Staff liaised with social services prior to children visiting the service. All visits were planned and staff remained in attendance throughout. The service had a designated visitor's room, which was private. Children visiting the service had no contact with other clients and this helped to ensure their safety.

- At the inspection in November 2015, we found that the staff did not prescribe naloxone for clients using the service following opioid detoxification. This medicine is used to reverse overdose if a client relapses and uses drugs. This was not in accordance with national best practice guidance (Drug misuse and dependence: guidelines on clinical management, Department of Health [DH], 2007). During this recent inspection, we found that the service was in the process of drafting a policy for prescribing Naloxone to clients who were being discharged from the service following opioid detoxification. The provider planned to provide training to staff in the use of naloxone and overdose awareness in July 2017.

- At the inspection in November 2015, we found that the service did not have a written procedure for transporting medicines to and from the service. Staff did not have a locked bag to transport medicines from the pharmacy back to the service. When we re-inspected the service in June 2017, the manager informed us that new procedures were in the process of being written. The service manager was in the process of setting up a contract with a pharmacy that could deliver medicines to the service. However, until this arrangement was in place, the service manager had issued staff with interim guidance that two members of staff should collect medicines from the pharmacy and transport them to the service in a locked bag. However, staff collected medicines alone and at a similar time each day. This meant staff placed their personal safety at risk.
- The location of the service was not accessible to wheelchair uses. The service was over four floors. If clients had mobility issues, staff provided them with a shared bedroom on the ground floor and there was a bathroom suitable for people with disabilities. Staff were expected to identify what additional support clients required during assessments and key working sessions. We reviewed the care and treatment records of two clients who had restricted mobility. For one client the service had reviewed the client's needs and put in place additional support. For the other client staff had failed to identify the additional support that was required. The client was reliant on other clients to support them with regards to their restricted mobility. For example, other clients in the service were supporting the client to go up and down the stairs. This put other clients at risk of falls. There was no individualised fire evacuation plan for this client. We brought this to the attention of the manager on the day of the inspection. The staff met with the client to review their needs and put in place additional safeguards.

Track record on safety

Substance misuse/detoxification

- Since the beginning of January 2017, there had been 35 incidents. The provider identified two of these incidents as serious. The themes of the remaining 33 incidents were mainly health concerns, relapse and there had been six medication errors. The service had thoroughly reviewed the circumstances relating to all incidents and had taken appropriate action. For example, the service had a serious incident relating to a medicines error. As a result of this serious incident, the service had reviewed the use of medication charts and had made improvements to recording.

Reporting incidents and learning from when things go wrong

- Staff were aware of the procedures for reporting all incidents. Incident recording was via a paper-based system. Managers reviewed the incidents. They were responsible for reporting the incident to head office and CQC where appropriate.
- Staff discussed incidents during team meetings and the clinical governance meetings. There was evidence that there was learning from incidents and the managers shared this learning with the staff group. However, the service did not record unplanned exits from the service by clients. This meant that they could not easily identify how many unplanned exits had occurred in the service.

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

Good practice in applying the MCA

- When the service was inspected in November 2015, we found that the provider expected staff to undertake capacity assessments on clients. However, the provider did not offer training in the MCA. During this inspection, we found that the provider now offered training to staff and 93% of staff had completed this training. However, staff's understanding of capacity varied. For example, the manager had organised a specialist assessments for a client who had complex health needs, which affected their cognition. However, two staff members were not able relate their learning of MCA to the client group they worked with. These staff told us that issues of capacity were only relevant to clients who had a learning difficulty. This was brought to the attention of the service manager who said that they would provide staff with additional training on the MCA.

Are substance misuse/detoxification services caring?

The involvement of clients in the care they receive

- The service collected feedback in a number of ways. The clients at the service held a community meeting once a week. The meeting allowed the clients to discuss issues that were relevant to them. The service ensured that these meetings were minuted. Minutes of recent meetings showed that clients had raised concerns about various maintenance issues, which the service had addressed.
- The provider gave clients who had used the service the opportunity to provide feedback about the service. Since January 2017, the service had collected 68 feedback questionnaires. The service had collated the feedback and had made changes as a result of suggestions. For example, the service now had a noticeboard, which displayed the suggestions of clients and what the service had done in response to the feedback. In addition, some of the clients had requested a wider range of complimentary therapies. The service had recruited a reflexologist and shiatsu therapist.

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

Access and discharge

- The service was not routinely formulating early exit plans with clients. When clients wanted to leave the service early, staff had an informal discussion with the client. It was not always clear what guidance staff gave to clients should they leave treatment early. Clients who have recently undergone opioid detoxification are at high risk of overdose should they start to use non-prescribed opiate drugs. Clients who are undergoing alcohol detoxification who leave treatment

early can experience life threatening complications. The lack of early exit plans and recorded discussions regarding harm minimisation should clients leave treatment early, increased risks to clients' health.

- The service was formulating discharge plans with clients but these were not sufficiently detailed. We reviewed seven care and treatment records. Five discharge plans did not always clearly outline the ongoing treatment and support the client would receive after they were discharged from City Roads. For example, for one client the discharge plan stated that the client would receive after care support from an organisation that had recently undergone significant changes in staffing and the services they were able to offer. There was no information on the client's care record, which indicated that City Roads had contacted this organisation to clarify what support could still be offered to clients. Another client's discharge plan stated that they would go to "rehab" but there was no other detail on the plan. Effective discharge plans can assist clients in identifying and planning how they can remain drug and alcohol free. The manager of the service had identified that improvements needed to be made regarding discharge planning.

Are substance misuse/detoxification services well-led?

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Good governance

- Since the last inspection in November 2016, the provider had employed a new service manager. The service manager had been in post since February 2017. The service manager was focusing on improving medicines management, staff engagement and reviewing local procedures.
- When we inspected the service in June 2017, we found that the provider had made some improvements since the last inspection. The provider had updated their recruitment policy and had implemented systems to monitor the DBS renewal dates of staff. The provider had trained all permanent staff in safeguarding children and the Mental Capacity Act. The provider had systems to prompt when permanent staff had to renew their training. However, the provider was not able to provide information regarding the training volunteer staff had undertaken and did not offer a programme of training to sessional staff.
- After the last inspection, the provider had updated a number of their policies to ensure that they reflected best practice. For example, the provider was in the process of introducing a policy regarding the prescribing of Naloxone. When the service was inspected in November 2015, we found that the provider's policy regarding the transportation of medicines was not safe. During this inspection, we found that the manager of the service was reviewing the policy to ensure that transportation of medicines was safe.
- The provider had undertaken a range of audits to monitor the quality and safety of the service. However, the provider had not always implemented the remedial actions identified in these audits. For example, the health and safety audit plan undertaken in March 2017, identified that a cleaning schedule plan should be created. The service was still reviewing the cleaning at the service and revising the job description and duties.
- The provider's monitoring systems had not identified that building security checks, fire alarm checks and fire drills were not being undertaken in line with the policy. There were gaps in the records. The provider could not offer assurances that the building, clients and staff were safe at all times.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to meet the regulations:

- The provider must carry out and keep records of the specified environmental, fire alarm and fire safety checks in line with their policies and procedures in order to minimise or mitigate potential risks to clients and staff.
- The provider must ensure that volunteers and sessional staff receive appropriate training to enable them to undertake their duties safely and effectively. The provider must keep training records for volunteers and sessional workers.
- The provider must ensure that clients have early exit plans.

Action the provider SHOULD take to improve

- The provider should ensure that client discharge plans are detailed and identify what progress has been made by the client and sets objectives for future progress.
- The provider should ensure that carry out the remedial actions identified in the health and safety audit action plan.
- The provider should ensure that staff transport medicines safely from the pharmacy to the service location.
- The provider should ensure that clients who have additional physical health needs have clear support and fire evacuation plans.

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 nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Not all volunteers or sessional workers had received appropriate training to enable them to carry out the duties they were required to perform. This was a breach of regulation 18(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not ensured that all clients had an early exit plan. The provider had not ensured that the premises were safe for their intended purpose. Security safety checks and fire alarm checks were not being undertaken in line with the provider's policy. Staff were not recording the checks. This was a breach of Regulation 12 (1) (2) (a) (b) (d)