Verve Health Limited

Verve Health

Inspection report

80 Brandon Road
Watton
Thetford
IP25 6LB
Tel: 01953890012
www.verve-health.co.uk

Date of inspection visit: 12 April to 12 May 2022
Date of publication: 29/07/2022

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?	Inadequate
Are services caring?	Inadequate
Are services responsive to people's needs?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Overall summary

Verve Health is a residential substance misuse service that provides detoxification and rehabilitation treatment for anyone using drugs or alcohol in Watton, Norfolk. This was the first inspection of Verve Health following concerning information brought to the Care Quality Commission. Following the inspection we issued warning notices under Section 29 of the Health and Social Care Act 2008. The warning notice told the provider they were not complying with the requirements of Regulation 12: Safe Care and Treatment, Regulation 17: Good Governance and Regulation 18: Staffing.

Following our initial visit the service voluntarily ceased admissions and put an action plan in place to address some of the safety concerns identified, including contracting agency nurses and a doctor to provide additional support with clients detoxification and physical health needs.

We rated Verve Health as inadequate because:

- The premises where clients received care were not safe, with a number of ligature risk points that were not recognised or mitigated and was visibly dirty in places.
- The service did not have sufficient numbers of suitably qualified, competent, skilled and experienced persons employed in order to meet the requirements of the service. This included medical, nursing and support staff.
- The service did not have a mandatory training programme and most staff had not completed any basic training for their role.
- Staff did not complete robust risk assessments for each client on admission or review the risk assessment regularly. Where risks were identified staff did not complete a risk management plan or take any action to reduce risks.
- Staff did not follow systems and processes to prescribe and administer medicines safely. Staff were not trained adequately to administer medicines and there was minimal oversight of errors and no audits of medicines.
- The service did not manage client safety incidents well. Staff did not recognise incidents or report them appropriately and managers did not investigate incidents or share any lessons learnt following incidents.
- Staff did not complete comprehensive assessments with clients on accessing the service. Staff did not complete individual care plans with clients.
- Staff did not make sure clients had support for their physical health needs and clients were required to contact their home GP for any physical health needs including ongoing detoxification.
- The service did not have access to a full range of specialists to meet the needs of each client. There was no consultant psychiatrist or psychologist in place to work with clients with mental health needs or trauma.
- Managers did not provide staff with appraisals, regular supervision or access to staff meetings.
- The service did not have a policy on the Mental Capacity Act and staff did not have any training in the Mental Capacity Act. Staff completed capacity assessment without any training in how to do so.
- Staff did not make sure clients understood their care and treatment and did not complete care plans or discuss with clients their treatment goals.
- Staff did not provide any harm reduction information such as tolerance and overdose risk to clients leaving treatment and did not put safe exit plans in place for clients who left treatment early.
- The service did not treat concerns and complaints seriously, did not investigate them or learn lessons from the results.
- The service did not have governance systems and processes in place and did not assess, monitor and improve the quality and safety of the service. The service did not hold clinical governance meetings or have any structure for clinical governance and did not have complete audits.
- The service did not have effective HR processes. Staff had worked in the service for seven months without DBS, references, interview details or application forms.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Residential substance misuse services	Inadequate 	

Summary of findings

Contents

Summary of this inspection

Background to Verve Health

Verve Health is a residential substance misuse service that provides detoxification and rehabilitation treatment for anyone using drugs or alcohol.

The service has been registered with the Care Quality Commission since June 2021 to provide accommodation for persons who require treatment for substance misuse.

The service has a registered manager in post since June 2021.

This was our first inspection of the service.

What people who use the service say

We spoke with nine clients currently receiving treatment at the service and one client who had left the service.

Clients told us that they felt the service had misled them about what was offered. The environment was poor, and some treatments advertised, including eye movement desensitisation and reprocessing therapy and yoga weren't offered. There was little medical input with only a virtual GP appointment and no further input and clients told us they had struggled with physical health issues with no support.

Clients told us that once the fees had been paid up front staff didn't appear interested in any complaints or concerns.

How we carried out this inspection

The team that inspected the service comprised one CQC inspection manager, two CQC inspectors, one CQC medicines inspector, one CQC assistant inspector and two specialist advisors with experience of working in substance misuse.

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 environment;
- spoke with nine clients who were using the service and one client who had left the service;
- spoke with the service directors;
- spoke with nine other staff members; including the doctor, nurse, therapist and support workers;
- looked at 10 care and treatment records of patients;
- carried out a specific check of the medication management; and
- looked at 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.

Summary of this inspection

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service 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 staff complete a comprehensive assessment and care plan for all clients. (Regulation 9)
- The service must ensure clients have support for physical health needs (Regulation 9)
- The service must ensure premises are clean, safe and fit for purpose. (Regulation 12)
- The service must ensure staff complete a robust risk assessment for each client on admission, that these are reviewed regularly and that staff complete risk management plans to reduce identified risks. (Regulation 12)
- The service must ensure they use systems and processes to safely prescribe, administer and record medicines. (Regulation 12)
- The service must ensure client safety incidents are managed, staff report incidents appropriately and managers investigate incidents and share lessons learned with the whole team. (Regulation 12)
- The service must ensure staff provide harm reduction advice for all clients leaving the service. (Regulation 12)
- The service must ensure staff understand how to protect clients from abuse, and how and when to make a safeguarding referral (Regulation 13)
- The service must ensure they have a policy on complaints, that they take complaints seriously, investigate them and share learning from outcomes. (Regulation 16)
- The service must ensure leaders have the skills, knowledge and experience to perform their roles, have a good understanding of the services they manage, and are visible in the service and approachable for clients and staff. (Regulation 17)
- The service must ensure governance systems and processes are in place to assess, monitor and improve the quality and safety of the service. (Regulation 17)
- The service must ensure they have enough suitably qualified, competent, skilled and experienced staff. (Regulation 18)
- The service must ensure staff have the right skills, qualifications and experience to meet the needs of the clients in their care. (Regulation 18)
- The service must ensure staff receive a full induction to the service before they start work, ongoing training and that staff receive regular appraisals, supervision and access to team meetings. (Regulation 18)
- The service must ensure they have a policy on the Mental Capacity Act and staff have an understanding of the five principles and how to apply them.

Action the service SHOULD take to improve:

The service should ensure they seek feedback from clients and involved clients in decisions about the service.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Residential substance misuse services	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate

Inadequate

Residential substance misuse services

Safe	Inadequate
Effective	Inadequate
Caring	Inadequate
Responsive	Inadequate
Well-led	Inadequate

Are Residential substance misuse services safe?

Inadequate

We issued warning notices under Section 29 of the Health and Social Care Act 2008. The warning notice told the provider they were not complying with the requirements of Regulation 12: Safe Care and Treatment and Regulation 18: Staffing.

Safe and clean environment

Premises where clients received care were not safe, clean, well equipped, well furnished, well maintained or fit for purpose.

The service had many potential ligature points that someone might use to injure themselves. These included gymnasium equipment, bathroom fittings, cables, and door and window handles that were not included on the environmental risk assessment. Staff had completed a risk assessment but had not taken into account all the potential risks and had not mitigated against any of the risks. For example, staff left clients alone in their bedroom following admission without any staff observation checks.

The service did not have alarms in any rooms for clients or staff to call for assistance if required. Some client bedrooms were located outside of the main building in a courtyard where staff would not be able to hear them if they did require assistance. Staff frequently placed clients who were undergoing detoxification and were more likely to require assistance in the outside bedrooms without any observation checks.

The service was mixed gender and staff did not follow the mixed gender accommodation guidelines. Clients of both genders were placed within bedrooms of close proximity of one another and staff did not adequately assess past forensic history, previous history of abuse or assessment of victims of abuse.

Clients did not have personal emergency evacuation plans in place, leaving clients at risk in the event of an emergency evacuation.

The clinic room had most of the necessary equipment for clients to have thorough physical examinations, although there was no examination couch.

Inadequate

Residential substance misuse services

The service was not clean, well maintained, well-furnished or fit for purpose. Some areas were visibly dirty including the kitchen, and we found several trip hazards throughout the premises. There were some audits of the environment and cleanliness of the service however these had not identified the concerns we found.

Staff did not follow infection control guidelines. Staff continued to admit new clients during a COVID-19 outbreak at the service and did not inform the clients before arriving there were current positive cases. Staff also failed to inform clients they would have to self-isolate for two days following admission.

Safe staffing

The service did not have enough suitably qualified, competent, skilled and experienced staff, who knew the clients and received basic training to keep them safe from avoidable harm.

Managers did not use a recognised tool to calculate safe staffing levels. There was no systematic approach to determine the number of staff and range of skills required in order to meet the needs of the people using the service and keep them safe from harm. This meant there was no assurance that staffing levels and skill mix were reviewed continuously against any initial judgement, nor was there evidence that staffing was adapted to respond to the changing circumstances of people using the service.

Nursing staff

The service did not have enough nursing staff to keep clients safe, the service employed one nurse. Following the concerns we raised after our initial inspection visit about staffing levels, the service employed additional agency nurses to support client's detoxification and physical health needs.

Medical staff

The service did not have enough medical staff. The service employed a GP with special interest in substance misuse to conduct prescribing assessments. The process was for the GP to conduct a telephone assessment prior to admission and then a video assessment on the day of admission. We saw that the telephone assessment rarely took place and that the video assessment was not comprehensive, with only brief discussion of mental and physical health concerns. The GP did not share the notes from the assessment with the service and had not visited the service or clients.

Clients who required medical attention or advice during their stay were required to contact their home GP. In the event of a medical emergency clients attended the local hospital.

The service had no access to a consultant psychiatrist despite some service users having significant mental health needs and access to a consultant psychiatrist being advertised by the service on their website.

Mandatory training

The service did not have a mandatory training programme in place. There were no identified mandatory training requirements and no processes or systems to ensure staff received statutory training.

Support staff completed the Care Certificate but did not have any specific training in substance misuse or in how to support clients.

We found that untrained and unqualified staff were undertaking therapeutic sessions beyond their scope and staff records demonstrated they were not skilled to undertake this therapeutic work.

Inadequate

Residential substance misuse services

Assessing and managing risk to clients and staff

Staff did not assess or manage risks to clients and themselves well. They did not respond promptly to sudden deterioration in clients' physical and mental health. Staff did not make clients aware of harm minimisation and the risks of continued substance misuse.

Assessment of client risk

Staff did not complete robust risk assessments for each client on admission or review the risk assessment regularly. The service had a comprehensive risk assessment tool in place however staff had not been trained in how to complete the assessment. We reviewed 12 client records and saw that in 11 of these the risk assessment had not been fully completed, with scant or no details recorded where a risk had been identified.

Risk assessments were not updated following admission and there were no risk management plans in place for identified risks. We saw examples of where clients had disclosed ongoing mental health needs, trauma and suicidal ideation but no plans were in place to address or mitigate these risks.

Staff did not complete early exit from treatment safety plans or harm reduction work with clients. Staff did not ensure the safety of clients who left treatment earlier than planned or provide any onward referrals to substance misuse or mental health teams.

Management of client risk

Staff did not respond promptly to any sudden deterioration in a client's health. We saw examples in client care records of clients with physical health problems and detoxification side effects who did not receive timely intervention.

The service had naloxone in stock that was used to temporarily reverse the effects of an opioid overdose. However, this was stored in a locked cupboard in the clinic room so was not accessible quickly in the event of an overdose.

The service did not have any personal safety protocols for staff.

Safeguarding

Staff did not understand how to protect clients from abuse. Staff did not have training on how to recognise and report abuse.

Staff had not received training on how to recognise and report abuse, appropriate for their role. The nurse had conducted some informal safeguarding training with some staff but not all staff had attended this, and no staff had completed formal safeguarding training during their employment at the service.

Staff did not know how to make a safeguarding referral and who to inform if they had concerns. The service did not have a safeguarding lead in place and staff did not know what constituted a safeguarding referral. We saw incidents that would have met the threshold for a safeguarding referral, including alleged financial abuse of a client which had not been referred to safeguarding.

Staff access to essential information

Staff did not keep detailed records of clients' care and treatment. Records were not complete or up-to-date

Client notes were not comprehensive. We reviewed 10 records and saw that client notes were not comprehensive, with no record of therapy undertaken recorded. Staff recorded third hand information and personal opinion in client notes and used judgemental and pejorative terms about client's behaviour.

Records were stored securely. The service used paper-based records and these were stored in a locked cupboard in the staff office.

Medicines management

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

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

Staff administering medicines were not adequately trained. The nurse provided medicine administration training to support staff. However, we found not all staff administering medicines had been competency assessed to do so, and we saw in supervision notes that staff had raised not feeling competent to administer.

Medicine recording charts demonstrated unsafe recording practices, such as missed doses of medicines, missed dates of medicines, missing signatures and allergies missing from records. We found minimal oversight of this and some instructions were unclear on medicines charts as to what dose had been administered. There was no pill cutter available for tablets that required halving. In one case the incorrect dose had been given in line with the prescribed detox regime and clients informed us they had their medicine mixed up with a different client, resulting in one client being over prescribed and one client being under prescribed.

Staff were supporting some clients to detox using medicines that had been prescribed by the clients own GP and prescribed not for detoxification purposes.

The medicines chart in use for an anti-sickness medicine was not accurate and did not reflect the dose that could be purchased from a pharmacy. There was no authority in place to administer the dose of anti-sickness medicine associated with detoxification.

Staff did not record medication errors as incidents and there were no audits of medicine administration records in place.

Staff stored and managed all medicines and prescribing documents safely.

Staff did not review the effects of each client's medicines on their physical health according to NICE guidance. The GP did not attend the service or speak with clients following the initial prescribing review. Clients who required additional medical support with detoxification had to contact their home GP. We saw examples in care records where clients had reported physical health side effects from detoxification and had requested to speak to the GP but had been told to wait to speak to their GP which resulted in a delay in medical assistance.

Reporting incidents and learning from when things go wrong

The service did not manage client safety incidents well. Staff did not recognise incidents or report them appropriately. Managers did not investigate incidents or share lessons learned with the whole team and the wider service. When things went wrong, staff did not apologise or give clients honest information and suitable support.

Staff did not know what incidents to report and how to report them. The service had not provided any training for staff on incident reporting.

Inadequate

Residential substance misuse services

Staff did not raise concerns or report incidents and near misses in line with the service's policy.

The service used paper-based incident reports and we reviewed the reports available from the six months prior to inspection. We saw a number of other incidents recorded in client records that were not logged as reported incidents, these included self-harm and injury to clients.

Staff did not understand the duty of candour. They did not give clients and families a full explanation if and when things went wrong. We reviewed a number of incidents that had been reported and staff had not applied duty of candour in any of these cases.

Managers did not investigate incidents thoroughly. We reviewed six incident reports and saw they not been investigated thoroughly and in some cases no actions were recorded to prevent reoccurrence.

Staff did not receive feedback from investigation of incidents. Staff did not discuss incidents or learning from them in team meetings. Some incident feedback was emailed to staff, but this was not done consistently.

The service did not make changes as a result of feedback or incidents. For example, a number of incidents related to medicines but no additional training had been put in place as a result.

Are Residential substance misuse services effective?

Inadequate

Assessment of needs and planning of care

Staff did not complete comprehensive assessments with clients on accessing the service. They did not work with clients to develop individual care plans.

Staff did not complete a comprehensive mental health assessment of each client. Clients who referred themselves to the service had a pre-admission assessment undertaken via telephone by an offsite team who did not have any clinical or substance misuse training. The GP was supposed to complete a further telephone assessment prior to admission but we found this rarely took place. The GP held a brief assessment by videocall with clients on admission, but staff did not complete any in person review of the assessment.

Staff did not ensure that clients had a full physical health assessment or they knew about any physical health problems. The pre-admission assessment completed by the non-clinical offsite team also covered physical health and the GP told us they used this document to assess clients on admission. The service did not request patient health summaries from their home GP prior to admission and did not request blood tests such as liver function tests to be complete prior to starting detoxification. Clients did have physical observations completed on admission by the nurse.

Staff did not develop a comprehensive care plan for each client that met their mental and physical health needs. Staff did not complete care plans with clients. The service used a document they called a care plan but it was a self-assessment of strengths and weaknesses, and did not include needs, goals or how these would be met. We spoke with ten clients who told us that they did not have a care plan or know what their goals were whilst in treatment. Staff did not update the document they referred to as a care plan during clients' treatment.

Inadequate

Residential substance misuse services

Best practice in treatment and care

Staff did not provide a range of care and treatment interventions suitable for the client group and consistent with national guidance on best practice. They did not ensure that clients had good access to physical healthcare or support clients to live healthier lives.

Staff did not provide a range of care and treatment suitable for the clients in the service. The service advertised delivering a range of treatments including dialectical behavioural therapy, eye movement desensitisation reprogramming, trauma therapy, yoga and holistic treatments. However, these were not taking place or in the case of the holistic therapies were offered at additional cost to clients.

Staff did not deliver care in line with best practice and national guidance from relevant bodies such as National Institute for Health and Care Excellence. Support staff delivered group and one to one sessions, including virtual reality therapy, without having the relevant qualifications, training or supervision. One to one sessions were not structured or recovery focused.

Staff did not make sure clients had support for their physical health needs, either from their GP or community services. The service did not have an agreement with a local GP surgery for clients to be temporarily registered. This meant clients had to contact their home GP surgery if they needed any physical health support. We saw examples in client files where they had to contact their home GP for ongoing detoxification, painkillers, and mental health medications.

The nurse completed physical health observations with clients following admission and had trained support staff to complete observations following this including withdrawal scales, blood pressure monitoring and pulse. However, not all staff had been competency assessed by the nurse and we saw some incidents where physical health concerns had not been followed up. These included a patient who self-harmed and did not have their wounds checked by staff, a patient reporting severe stomach pain with constipation and urinary retention who was not taken to hospital for some hours, and patients with ongoing withdrawal symptoms following detoxification who were not assessed by a doctor.

Staff did not support clients to live healthier lives by supporting them to take part in programmes or giving advice. Staff advised clients to seek advice from their home GP.

Staff did not use recognised rating scales to assess and record severity and outcomes. The service did not use any rating scales such as the Alcohol Use Disorders Identification Test or severity of dependence scales to assess clients on admission. Staff did not use any outcome measures to assess clients progress through treatment.

Staff did not take part in clinical audits, benchmarking and quality improvement initiatives. The service had not completed any clinical audits, including any audit of medicines administration charts, and did not have a service improvement plan in place.

Skilled staff to deliver care

The team did not include or have access to the full range of specialists required to meet the needs of clients under their care. Managers did not make sure staff had the range of skills needed to provide high quality care. They did not support staff with appraisals, supervision and opportunities to update and further develop their skills. Managers did not provide an induction programme for new staff.

The service did not have access to a full range of specialists to meet the needs of each client.

Inadequate

Residential substance misuse services

The service advertised having a consultant psychiatrist and a psychologist in post to work with mental health and trauma, however neither of these were in post at the time of the inspection. The service employed one mental health nurse and contracted a GP with special interest in substance misuse who did not work on-site and conducted virtual assessments. The service employed two therapists, project workers and support workers.

Managers did not make sure staff had the right skills, qualifications and experience to meet the needs of the clients in their care. Staff completed the Care Certificate following recruitment but did not complete any substance misuse training or qualifications.

Managers did not give each new member of staff a full induction to the service before they started work. The service did not have a set induction timetable for new staff.

Managers did not support staff through regular, constructive appraisals of their work. Staff did not have annual appraisals completed.

Managers did not support non-medical staff through regular, constructive clinical supervision of their work. The service was unable to provide figures for supervision completion and we saw in staff files supervision did not take place regularly.

Managers did not make sure staff attended regular team meetings or gave information to those who could not attend. We reviewed team meeting minutes and saw these had not taken place between June 2021 and March 2022. However a single staff newsletter had been produced in November 2021 to update staff.

Managers did not make sure staff received any specialist training for their role. Most staff had not received any substance misuse training and any training completed was informal inhouse training without set session plans or competency checks.

Managers did not always recognise poor performance, identify the reasons for this or deal with these. We saw incidents involving staff behaviour that was not raised with the staff involved.

Multidisciplinary and interagency team work

Staff from different disciplines did not work together as a team to benefit clients. The team did not have effective working relationships with relevant services outside the organisation.

Staff did not hold regular multidisciplinary meetings to discuss clients. However, support staff held a daily handover meeting each morning to discuss clients. There was no input from the GP to these.

Staff did not make sure they shared clear information about clients and any changes in their care, including during transfer of care. We reviewed handover meeting minutes and saw that risks noted in handovers which were not acted upon, including a client feeling unsafe and a client expressing thoughts of self-harm. Staff used judgemental language about clients in the meeting minutes, referring to clients as “argumentative” and “aggressive”.

Staff did not have effective working relationships with external teams and organisations. Staff did not refer clients on to support agencies when they left treatment.

Inadequate

Residential substance misuse services

Good practice in applying the Mental Capacity Act

The service did not have a policy on the Mental Capacity Act 2015 and staff did not know what to do if a client's capacity to make decisions about their care might be impaired.

The service did not have a policy on the Mental Capacity Act and staff did not have any training in the Mental Capacity Act.

Staff completed capacity assessments with clients on admission, however they were not provided with sufficient training to do this. Staff completed capacity assessments when clients first arrived at the service and were potentially under the influence of a substance but completed consent to treatment and sharing of information on social media at the same time. Staff did not review capacity assessments after admission.

Are Residential substance misuse services caring?

Inadequate

Kindness, privacy, dignity, respect, compassion and support

Staff did not always treat clients with compassion and kindness. They did not always understand the individual needs of clients or support clients to understand and manage their care and treatment.

Staff did not always support clients to understand and manage their own care treatment or condition. We spoke with 12 clients and seven clients felt that they supported each other rather than the staff supporting them. Clients told us there was no structure to treatment

Clients said staff did not always treat them well or behave kindly. Client feedback on staff was mixed, with clients reporting some staff were supportive and caring. However, clients reported some staff were rude when they asked for help or staff told them they were too busy to help. Clients felt staff did not address their concerns such as intervening when clients were disruptive in groups or when they needed additional support. We saw records of where staff had told clients if they weren't happy with their treatment they should "just leave".

Staff did not always raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards clients and staff. Managers had not addressed incidents of staff behaving disrespectfully towards or about clients.

Involvement in care

Staff did not involve clients in care planning and risk assessment and did not actively seek their feedback on the quality of care provided. They did not ensure that clients had easy access to additional support.

Involvement of clients

Staff did not complete care plans with clients.

Staff did not make sure clients understood their care and treatment. We spoke with 12 clients, none of whom had agreed or discussed their goals for treatment with staff.

Staff did not involve clients in decisions about the service or respond to feedback. Clients had completed a satisfaction survey in November 2021 but actions resulting from this, such as better organised structure for treatment had not been completed.

Inadequate

Residential substance misuse services

Involvement of families and carers

Staff did not inform and involve families and carers appropriately. Staff did not update or engage with families and carers about clients progress in treatment, including when clients had been involved in incidents or were unwell. One client told us their family had contacted staff so they could inform the client about a family bereavement. However, staff had not passed the information to the client and they had been unaware until they were able to speak to their family directly.

Staff did not help families to give feedback on the service. Staff did not respond to family feedback or concerns and complaints.

Are Residential substance misuse services responsive?

Inadequate

Access and waiting times

The service was easy to access but admission procedures were not followed appropriately. Staff did not plan and manage discharge well.

The service had criteria to describe which clients they would offer services to, but this was not specific to the severity of dependence or amount of substances used. The GP told us he oversaw referrals from the admissions team and would not admit anyone he did not feel would be safe to detox remotely. However, we did not see any evidence of clients being declined admission.

Staff did not support clients when they completed treatment and staff did not refer clients on to agencies for support with substance misuse or mental or physical health issues. Staff provided clients with a list of mutual aid meetings in their home area and telephone numbers for national agencies such as Citizens Advice Bureau, Mind, and Age UK.

Staff did not provide any harm reduction information such as tolerance and overdose risk to clients leaving treatment.

The facilities promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms did not fully support clients' treatment, privacy and dignity.

The service had a full range of rooms and equipment to support treatment and care. The service had group room and one to one space rooms.

Interview rooms in the service were not sound proof, so one therapy room had a white noise machine outside to protect privacy and confidentiality.

Clients did not have anywhere to safely store possessions in their bedrooms. Clients' possessions including mobile phones, bank cards and cash, as well as prohibited items such as perfume and hair dye were stored in a designated room. The room was locked with a keypad, but all staff had the code to the room, and we saw the door was left open on occasion. Client possessions were kept in open boxes within the room and there had been incidents of mobile phones being taken by other clients. Staff did not provide clients with receipts for the possessions they had taken into storage.

Inadequate

Residential substance misuse services

Meeting the needs of all people who use the service

The service did not meet the needs of all clients, including those with a protected characteristic or with communication support needs.

The service could not admit any clients who used a wheelchair. Staff told us they could admit clients with reduced mobility, however there were a number of steep stairs to access some of the bedrooms and group room.

Staff did not provide clients with information on treatment, local services, their rights or how to complain.

The service admission criteria stated that they were "unable to cater for the needs of certain faiths as we only have one kitchen, although we are happy to negotiate ways to ensure that spiritual needs are met within the limits of the units".

Listening to and learning from concerns and complaints

The service did not treat concerns and complaints seriously, did not investigate them or learn lessons from the results.

The service did not provide clients, relatives and carers with information on how to complain or raise concerns.

The service did not have a policy or structure on complaints and how to handle them. There was no system or log to record complaints, when they were acknowledged or responded to and no structure of who was responsible for investigating and responding to complaints.

We reviewed a number of complaints and concerns raised by clients and saw they were not acknowledged or responded to in a timely manner with some complaints that had not been responded to at all. Some of the complaints dated back to 2021 but had not been responded to.

Managers did not investigate complaints and we did not see any complaints that had been upheld. Responses to complaints were not always polite or respectful and clients' requests for refunds of money paid were arbitrarily dismissed.

The complaints we reviewed had common themes of clients feeling they had been misled about the service and what it provided, including staffing levels, medical oversight of detoxification and physical and mental health and lack of structured treatment. These themes had not been identified by managers and no action had been taken to address these themes.

Complaint outcomes were not fed back to staff.

Are Residential substance misuse services well-led?

Inadequate

We issued a warning notice under Section 29 of the Health and Social Care Act 2008. The warning notice told the provider they were not complying with the requirements of Regulation 17: Good Governance.

Inadequate

Residential substance misuse services

Leadership

Leaders did not have the skills, knowledge and experience to perform their roles, did not have a good understanding of the services they managed, and were not visible in the service.

The service had a registered manager in post since June 2021, however the manager had not been on site at the service for over a month due to ill health. The service had appointed several deputy managers over the previous year with none remaining in post for a sustained period of time and staff were unclear on who the current deputy manager was.

The nurse was managing the day to day running of the service in the managers absence but was not supported by the service directors to make changes and improvements.

Vision and strategy

The service vision was "to bring a world class and luxury rehabilitation experience at affordable prices to anyone seeking help for alcohol and drug addiction, behavioural addictions and mental health related issues".

Culture

Staff mostly felt supported and valued by other staff. They felt able to raise concerns but did not see any action taken to address concerns.

Support staff told us that generally felt supported by the nurse and they worked well together as a team. Staff told us they felt frustrated they had raised concerns about the safety of the service with the directors but felt their concerns had not been listened to or any action taken.

Governance

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

The service did not have governance systems and processes in place and did not assess, monitor and improve the quality and safety of the service. The service did not hold clinical governance meetings or have any structure for clinical governance.

The service did not have a full audit programme and where audits had taken place, for example a records audit, the findings had not been used to drive improvement.

The service did not have effective HR processes. Staff had worked in the service for seven months without disclosure and barring services checks, references, interview details or application forms. These were completed retrospectively once this was identified by the nurse, however various references were still missing and there was no evidence of HR processes being followed prior to the appointment of the new manager. HR issues were not documented in staff files. One staff member had been employed for six months before their DBS was checked and it was found they had an outstanding conviction which they did not disclose.

Management of risk, issues and performance

Staff did not have access to the information they needed to provide safe and effective care.

The service did not have a clear incident reporting structure or system and did not complete reviews of incidents and so did not share information about learning from incidents or any action taken to prevent reoccurrence.

Inadequate

Residential substance misuse services

The service did not collate key information or use information to drive improvement, such as complaints, incidents, treatment outcomes, training and supervision. We found there were minimal processes to manage risk information or to gauge performance.

The service did not actively encourage feedback about the quality of care and did not ensure that any feedback received would be listened to, recorded and responded to as appropriate. There was no robust complaints procedure to ensure complaints were investigated, responded to and outcomes shared with staff and clients. The service received a number of complaints with common themes that it was not delivering the care and treatment advertised but had not taken any action as a result of this.

The service did not have any audits in place for record keeping. We saw client notes were inconsistent, with varying amounts of information recorded. Staff included third hand information in records which may not have been accurate.

Information management

Staff did not collect analysed data about outcomes and performance.

The service did not collect data or measure outcomes and performance.

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	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The service did not ensure staff understood how to protect clients from abuse, and how and when to make a safeguarding referral

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 18 HSCA (RA) Regulations 2014 Staffing • The service did not ensure they had enough suitably qualified, competent, skilled and experienced staff. • The service did not ensure staff had the right skills, qualifications or experience to meet the needs of the clients in their care. • The service did not ensure staff received a full induction to the service before they started work, ongoing training or that staff receive regular appraisals, supervision and access to team meetings.

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The service did not ensure premises are clean, safe and fit for purpose. • The service did not ensure staff complete a robust risk assessment for each client on admission, that these are reviewed regularly and that staff complete risk management plans to reduce identified risks. • The service did not use systems and processes to safely prescribe, administer and record medicines.

This section is primarily information for the provider

Requirement notices

- The service did not manage client safety incidents, did not ensure staff reported incidents appropriately and managers did not investigate incidents and share lessons learned with the whole team.
- The service did not provide harm reduction advice for all clients leaving the service.

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The service did not ensure leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they manage, or were visible in the service and approachable for clients and staff. • The service did not ensure governance systems and processes were in place to assess, monitor and improve the quality and safety of the service.

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care • Staff did not complete a comprehensive assessment and care plan for all clients. • The service did not ensure clients have support for physical health needs

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The service did not have a policy on complaints, did not take complaints seriously, investigate them or share learning from outcomes.