FOCUS12 - Treatment Centre

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

Overall summary

We do not currently rate independent standalone substance misuse services.

We found that the provider was in breach of regulation and the following issues that the service provider needed to improve:

- The provider had not acted on all areas of concern we had raised following previous inspections. Some of these issues had first been raised with the provider in 2016. The provider had therefore failed to fully act or maintain improvement to meet regulatory requirements.
- There were no environmental and fire risk assessments in place for the premises. Therefore, risks at the premises had not been identified.
- There were insufficient staff to meet the needs of clients. Staff were tired and overstretched and working outside of their contracted hours. The provider had not ensured that pre-employment checks were in place for all people working at the service.
- Policies and procedures for medicines management were not fit for purpose, in date and did not reflect best practice. The provider had not ensured the safe management of medication including controlled drugs.
- There were frequent gaps in client records and these were not updated in a timely manner. We found there were discrepancies in the accuracy of records where an emergency had occurred. Clinical information systems were not robust.
- Client's had been admitted to the service whose clinical needs could not be met. Staff did not have clear instruction regarding how to manage emergencies.
- There was not a robust system for incident reporting, reviewing, learning and feeding this back to staff. Safeguarding concerns had not been reported to the local authority.
- While governance systems were in place meetings had not occurred as scheduled. A draft risk register was put in place but this did not identify all risks to the organisation. There was no programme of audit to ensure that improvements were made to the service when concerns were identified.

We found the following areas of good practice:

- We saw evidence of some involvement in care plans. Staff communicated with clients regarding their treatment.

Summary of findings

- Clients could feedback to the service on the treatment they received.
- Clients were positive about staff at the service.
- The staff files reviewed showed managers had carried out and documented staff appraisals.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Substance misuse/ detoxification		

Summary of findings

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Focus 12 Treatment Centre

Services we looked at
Substance misuse/detoxification

Summary of this inspection

Background to FOCUS12 - Treatment Centre

Focus 12 is an independent charity established in 1997 in Bury St Edmunds. This was a community based treatment centre, which offered detoxification from both drugs and/or alcohol under staff supervision. The primary treatment was offered over a 12-week period. The provider delivered ongoing abstinence based treatment, which included group therapy and individual counselling. In addition to the treatment centre, Focus 12 also had three residential accommodations, where clients who were receiving treatment resided. These were all located in Bury St Edmunds.

When we inspected the service in May 2016 we found the service was not meeting regulations. Enforcement action was taken under Regulation 12 Safe Care and Treatment and Regulation 19 Fit and proper Persons. We also issued a requirement notice under Regulation17 Good governance. When we re-inspected in January 2017 we found that the provider had made some progress and had met the requirements of the warning notice.

We carried out an unannounced inspection on 05 March 2018 following concerns being raised with us about the service. We found the service was not meeting regulations. We began enforcement action and issued a warning notice under Regulation 12 Safe Care and Treatment and Regulation, regulation 17 Good Governance and regulation 19 Fit and Proper Persons. We told the provider that they must comply by 31 May 2018. We issued additional requirement notices under Regulation 12 Safe Care and Treatment, Regulation 17 Good Governance and regulation 11 Need for Consent.

We carried out a further unannounced inspection on 19 and 20 June 2018, to check whether the provider had met the warning notice requirements. We found that the breaches of regulation had not been addressed. Following this the provider gave an undertaking to meet all regulations by 20 July 2018. In addition, the provider voluntarily suspended all detoxification at the service. We returned to the service on 28 June, 16 July and 24 July 2018 to check on progress and ensure that clients were safe. On 24 July 2018 we found that the provider had not fully complied with all regulations.

The Care Quality Commission did not take further action against the provider because following the inspection, the provider told us that they intended to cease treatment and de-register the service.

The service was de-registered by CQC on 8 August 2018.

Our inspection team

The team that inspected the service was led by CQC inspector, Teresa Radcliffe. The team consisted of three inspection managers, three other CQC Inspectors, one CQC specialist pharmacist and two specialist advisors.

Why we carried out this inspection

This was an unannounced follow up inspection for warning notices issued in March 2018 by the Care Quality Commission.

Summary of this inspection

How we carried out this inspection

We specifically looked at three questions as part of following up on the warning notice

• Is it safe?

• Is it caring?

• Is it well led?

During the inspection visit, the inspection team:

• reviewed the quality of the physical environment, and observed how staff cared for clients

• spoke with seven clients

• spoke with two trustees, the manager and the lead counsellor

• met with seven other staff members

• reviewed 13 care and treatment records, including medicines records

• observed medicines administered to clients

• reviewed the systems in place for the management storage and administration of medicines

• examined the incident reports log

• looked at HR files of five staff

• Reviewed the policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with seven clients who used the service.

Clients told us that they were pleased to be in treatment and receiving the help and support they needed. The clients felt staff were respectful and felt they could talk to them. The atmosphere between clients and staff was considered positive. One client stated they never felt healthier. Clients said that staff were supportive when they went out into the community. However, one client said that communication between staff and clients can be hit and miss, and that staffing was an issue due to sickness when there were not so many people around and visible.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We do not currently rate standalone substance misuse services.

We found that the provider was in breach of regulation and the following issues that the service provider needed to improve:

- There were no environmental and fire risk assessments in place for the premises. Therefore, risks at the premises had not been identified.
- There were insufficient staff to meet the needs of clients. Staff were tired and overstretched and working outside of their contracted hours.
- Policies and procedures for medicines management were not fit for purpose, in date and did not reflect best practice. The provider had not ensured the safe management of medication including controlled drugs.
- There were frequent gaps in client records and these were not updated in a timely manner. We found there were discrepancies in the accuracy of records where an emergency had occurred. Clinical information systems were not robust.
- Client's had been admitted the centre whose clinical needs could not be met. Staff did not have clear instruction regarding how to manage emergencies. Client's risk assessments were not always updated following incidents or emergencies.
- There was not a robust system for incident reporting, reviewing, learning and feeding this back to staff. Safeguarding concerns had not been reported to the local authority.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- We saw evidence of some involvement in care plans. Staff communicated with clients regarding their treatment.
- Clients could feedback to the service on the treatment they received.
- Clients were positive about staff at the service.

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

- Clients were given information about the service prior to admission. However, this had factual inaccuracies about services that were provided.

Summary of this inspection

Are services well-led?

We do not currently rate standalone substance misuse services.

We found that the provider was in breach of regulation and the following issues that the service provider needed to improve:

- The provider had not acted on all areas of concern we had raised following previous inspections. Some of these issues had first been raised with the provider in 2016. The provider had therefore failed to fully act or maintain improvement to meet regulatory requirements.
- While governance systems were in place meetings had not occurred as scheduled. A draft risk register was put in place but this did not identify all risks to the organisation. There was no programme of audit to ensure that improvements were made to the service when concerns were identified.
- The provider had not ensured that pre-employment checks were in place for all people working at the service.
- There were some gaps in staff receiving clinical supervision and the recording of management supervision remained inconsistent.
- There had been a high turnover of staff and shortfall was having an impact on the welfare of the team. Staff said they were tired and overstretched and were working on an on-call rota system overnight which they were not contracted to deliver. Staff did not feel they could raise concerns or that they would be supported.

We found the following areas of good practice:

- The staff files reviewed showed managers had carried out and documented staff appraisals.

Substance misuse/detoxification

Safe	
Caring	
Well-led	

Are substance misuse/detoxification services safe?

Safe and clean environment

- Since the inspection of March 2018, the provider had reduced the size of the treatment centre by moving all functions in to one of two original buildings. Work was still in progress to change the internal structure of the building making the premises appear cluttered and dusty.
- The Nominated Individual had not informed the Commission, as required by regulation, that the premises had changed prior to the inspection on 19 June 2018.
- There were no environmental risk assessments in place for the premises. Therefore, risks at the premises had not been identified. This meant staff were not aware of how to effectively manage any risks at the service.
- The provider had not ensured that a fire risk assessment was conducted since the change of premises. This meant there was no assurance the internal structural change to the building was safe and met fire regulations. The smoke and fire alarms had not been moved to accommodate the additional rooms. We raised this immediately with the provider as a concern on 19 June 2018. A fire safety inspection was carried out on 28 June 2018 to ensure the premises met the regulatory reform (fire safety) order 2005. This identified risks needing to be addressed. At our follow up visits these had not all been met.
- During the inspection of March 2018, we advised the provider to move the cleaning equipment out of the disabled toilet area. This action had not been completed by our June inspection.
- There was a cleaning schedule in place, however this was not robust. The schedule lacked detail and did not cover all areas. The admissions manager told us this was under review. Throughout the inspections we found the building to not be sufficiently clean.
- The manager had put into place a system for the disposal of clinical waste and this was appropriate and safe. The contractor providing this completed a risk assessment for the service to ensure this was managed appropriately for the service needs.
- Furnishings were maintained throughout the premises. Staff maintained the garden area, which was clean and tidy for clients to use.
- Staff at the treatment centre did not have access to static alarms. Since the move of premises there was no static alarm in place in reception. In an emergency staff would need to call for help or phone for police to attend the premises.

Safe staffing

- The lead counsellor completed staff rotas and determined staffing levels required for the treatment centre. The required staffing level for the service was 18. Staff employed consisted of a consultant psychiatrist and an addiction nurse, both contracted to the service, counsellors, keyworkers, administration and night staff. At the time of the inspection there were five vacancies.
- The provider had a minimum staffing level of two staff during the day and evening. The evening shift finished at 11pm. We reviewed six weeks of staff rotas. Staff were working double shifts to fill gaps. Staff said they were tired and overstretched. Managers had the option to use agency/bank staff at the service however, they did not do so.
- The manager of the service informed us there were no night staff at the service after 11pm, until 8 am in the morning. Instead staff were working on an on-call rota system overnight. Staff told us that they were not contracted to deliver this role. Staff we spoke with were

not happy to do this and informed us they had raised this with managers. This included non-clinical staff who did not feel they had the skills required to cover in a safe manner. This meant staff's workload had increased significantly and impacted on the care for clients.

- A specialist substance misuse nurse was contracted to attend the service during the week. This was not being delivered safely or appropriately as the nurse at the service was also employed in a full-time role in addition to her contractual commitment to Focus 12. This raised concern for the clinical care and safety of clients at the service.
- The consultant psychiatrist was not available at the time of the inspection.
- The provider did not have an out of hours or on call doctor. In an emergency the staff on duty would call the manager who then contacted the nurse if required. We found evidence that staff were not calling 999 in cases of emergency. This meant that staff were putting clients at risk.

Assessing and managing risk to clients and staff

- We reviewed 13 clients' files and found one client's file had been accessed by a person who was not an employee. This was a breach of the General Data Protection Regulation (the protection of natural persons with regard to the processing of personal data and on the free movement of such data).
- There were frequent gaps in client records. Staff did not always update these in a timely manner. We found that three out of four clients files did not document physical health observation of a client. There were no actions taken to ensure the clients safety. Some of the recorded information was not clear or explained in full. On our third visit, we reviewed further client files, and found there were discrepancies in the accuracy of events leading up to the discharge of a client. Two different accounts were recorded. When we requested this information, we were told that the discharge report still needed to be completed. However, the client had been discharged from the service 20 days earlier.
- The administration manager and staff completed an initial brief risk assessment by telephone as part of the admissions process. Staff completed client's severity of alcohol dependence questionnaire. Staff assessed mental health and self-harm risk. The admissions staff sought additional information from the clients GP, mental health teams, social workers and when appropriate criminal justice teams. However, we found that one clients risk assessment had not been updated following a very serious incident.
- Staff completed recognised screening tools such as objective and subjective opioid withdrawal scales. The service used the clinical institute withdrawal assessment. However, one client had a high clinical institute withdrawal assessment score which meant that staff needed to closely monitor their physical health. We found that no action was taken for this client in line with the recognised screening guidelines. We reviewed the client's record and found that the centre had been aware of their clinical needs prior to admission but had admitted them to the service even though they could not provide the required level of clinical monitoring.
- We were also concerned that a client's physical health could not be monitored during the night. We found evidence of a client who was admitted who required regular clinical monitoring, this did not happen. Therefore, we were not assured clients on detoxification of drugs and alcohol could be managed safely at the service.
- Staff had completed safeguarding training however, there had been no safeguarding referrals made by the service, and managers did not have a log of safeguarding action. We were informed on inspection that clients were encouraged not to tell staff of concerns if they did not wish for them to be reported. We raised this concern immediately with the provider. On our second visit, the nominated individual told us a reporting system would be put in place. This had still not been fully addressed by our final visit.
- Managers and staff told us all staff at the service administered medication to clients. The manager told us staff had received basic medicines administration training. This included the administration of emergency medication. We viewed the mandatory training data and there were gaps in medicines' administration mandatory training. We raised this as a concern and the lead counsellor told us that further training was planned and only trained staff would administer medication.

Substance misuse/detoxification

- When we inspected the service in March 2018 we found that the medicines management policy was not adequate and we were concerned about the safe and proper management of medicines. When we inspected the service in June 2018 the policy had not been updated and our concerns had not all been addressed. Following this, the policy was updated by the nurse advisor. However, when we reviewed the updated policy we found that it contained factual inaccuracies and there remained gaps in the policy which had not been addressed.
- Medicines management areas of concern were found at the inspection of 24 July 2018, relating to medicine storage, controlled drug records, dispensing procedures, medicine administration/stock record charts and audits.
- Medicines were stored outside of the manufacturer's recommended temperatures and appropriate action was not taken regarding the stability of the medicines. There were no audits carried out to include checks on this action.
- The controlled drugs register was not completed in accordance with legislation and included:
  - Medicine administration entries without any staff signatures.
  - Stock quantity changes without a medicine administration entry.
  - Quantity alterations without explanation and including entries over-written.
  - Missing running stock balance counts.
  - Inaccurate final balance stock counts which indicated that some of the medicine was still available.
  - There was no record of the medicine stock checks entered in the CD register, which should include checking the balance of all medicines against stock. The stock check record should include the date and signature of the health professional carrying out the check.
- One patient was self-medicating, staff explained that the medicines were removed from their containers and placed in an envelope labelled with patient's name and name of medicine. We also, found evidence of handwritten labels on two patient's medicines within the clinic room, which did not have the required fully completed details on them. This was not in accordance with legislation which requires that the dispensing of medicines should be in an appropriate labelled container, the dispensing process completed by trained staff and following a standard operating procedure. This could have resulted in the patient not receiving the medicine as prescribed. This was not in accordance with the provider's medicine policy.
- The medicine administration/stock record charts were a record of the medicines administered to the patient. There was no method of recording on the chart if a patient had not received a medicine. This could have been through patient refusal or medicine unavailable. This could have led to patients not receiving a medicine which had been prescribed.
- Allergy status of the patient regarding medicines was not completed on two out of the three patients reviewed.
- There were no medicine management audits completed on medicine storage, medicine administration/stock charts, controlled drug register and medicine incident reports. This meant that there was no oversight of the processes and ongoing issues were continuing without being addressed.
- Nine medicine incident reports were seen. The responses to the incidents varied and included when fully completed recommendations to staff and an action plan. Two out of the nine included actions that we saw during the inspection to have been implemented. Two incident reports did not have any actions listed. These were where the correct prescribed amount of the medicine was not administered to patients. From the other seven, recommendations included reference to a clinical governance meeting for discussion and instructions for staff to be careful. No follow up to the actions was seen, no audits of the procedures, no competency checks of the staff seen after medicine administration errors and no forum available to share learning from the errors was available.
- Naloxone for opioid overdose was placed in the first aid bag of each of the residential properties. Naloxone was available at the treatment centre, this included the night bag carried by staff who worked until 11pm and weekends. There were no measures in place overnight.

Substance misuse/detoxification

- Managers had no safe system for transporting medication to the accommodation in the evening period between 5pm and 11pm, such as a tamper proof container.
- During one follow up visit we found that all staff at the service attended a graduation of a client. There was no one present at the reception area of the building, office doors were open, staff files and draws unlocked and there were personal, company and client laptops situated in the office. We found a new client who had arrived 15 minutes before he was due to be admitted to the service wandering around the downstairs area of the building. As inspectors had discovered this concern we stayed in the reception and office area of the service whilst waiting for a member of Focus 12 staff to return. We informed the staff and the nominated individual. There seemed to be a lack of understanding around why this was a concern.

Track record on safety

- There had been one serious incident since our inspection in March 2018. The management of this incident was poor and raised serious concerns around the systems and processes in place to mitigate risk. The provider did not fully review this incident.

Reporting incidents and learning from when things go wrong

- The provider had a system in place to report and record incidents internally. However, there were still concerns around the learning from incidents. We found evidence of an incident where a client had not received the appropriate care and treatment. There were delays throughout this incident, this included treatment administered by someone not employed by the provider, staff did not call 999 or take the client to hospital. The learning from this incident by the clinical governance meeting was not robust. The response to this client's medical needs was not appropriate.
- When interviewing managers of this service there was a clear lack of understanding of the response to a serious incident and the risks associated with this.
- Incidents were not reported to the Care Quality Commission as required by regulation. It is a requirement to report specific incidents, including when serious harm to a client occurs. This was identified as a concern at the previous inspection of this service in March 2018. The provider had not put a system in place to ensure concerns were reported.

Duty of candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify clients (or other persons) of certain notifiable safety incidents and provide reasonable support to that person. The manager was not able to outline the responsibilities of the duty of candour. However, staff at the service displayed some understanding as there was evidence of openness with clients at a group following the overdose incident. However, there was no evidence of an apology to the client.

Are substance misuse/detoxification services caring?

Kindness, dignity, respect and support

- Clients told us staff interactions were respectful and kind. They said that staff at the service were supportive. Generally, the staff knew their clients and were aware of their needs.
- We spoke with seven clients at the service who spoke highly of the staff.
- The clients we spoke with were happy with their treatment and were positive about their future. Clients stated that senior managers were engaged, friendly and very approachable.

The involvement of clients in the care they receive

- Clients were given information about the service prior to admission. However, on one return visit to the service we found that information supplied to clients had factual inaccuracies about services that were provided. In addition, information on the website was misleading and factually inaccurate. The nominated individual told us that it would be changed to reflect accurate information to clients.
- We saw evidence of some involvement in care plans. Staff communicated with clients regarding their treatment.

Substance misuse/detoxification

- Clients could feedback to the service on the treatment they received.

Are substance misuse/detoxification services well-led?

Good governance

- When we inspected the service in March 2018 we told the provider that they must ensure that systems and processes were put in place to assess, monitor and improve the quality of the service and mitigate risks to the health, safety and welfare of clients. When we re-inspected in June 2018 we found that the provider had not acted on all areas of concern we had raised. These included a failure to ensure appropriate arrangements to manage medication, to manage client risks and to put robust staff checks in place. Some of these issues had first been raised with the provider in 2016. The provider had therefore failed to fully act or maintain improvement to meet regulatory requirements.
- We reviewed the clinical governance meeting minutes for March 2018, lessons learnt and actions from incidents were limited. We saw further incidents of drug errors at the service and management response was to discuss concerns and solutions at the clinical governance meetings. However, there were no other minutes available, as no further meetings had been held.
- The lack of meetings being held at a governance level was a concern as this meant that important issues needing to be resolved were missed. For example, the change of address at the service had not been fully managed and had a negative impact on meeting requirements. This included that prescription pads were printed with the previous address. The provider had also failed to inform the Commission of their change of address as required under regulation. Following the move the provider had failed to risk assess the environment and implement fire risk procedures. The provider's website had not been amended to reflect this change.
- In June 2018 there was still no completed risk register in place. However, in July 2018 the manager could provide a draft register. This was still in a very simple form and needed further work.
- The service still has no key performance indicators in place. However, the provider has produced an action plan to put this in place with agreed completion dates for this.
- The provider had not ensured disclosure barring system check for two members of staff working at this service. The managers did not have an organisational risk assessment in place for those members of staff working with clients.
- On inspection on 19 June 2018 there were no references available or employment checks for two people actively involved with clinical aspects of the organisation. Both were responding to the service as on-call clinicians. Managers had told us that one clinician was not employed by the service. This was raised as an immediate concern. The nominated individual assured us this clinician would not be used until relevant checks were complete and employment offered. However, when we visited on 28 June 2018 we found evidence to show this was not the case as the clinician had made entries within client notes. On 16 July 2018 the relevant paperwork for the employed clinician was in place however the second clinician still had no relevant checks in the staff file. This meant clients were still at risk as there was no mitigation in place.
- In June 2018, we found that one clinician had recently qualified as a non-medical prescriber. However, there were no checks and assurances in place that the clinician was prescribing within their scope of competence or evidence of appropriate levels of supervision and monitoring.
- Managers could evidence that some clinical supervision took place. We reviewed the last six months records for five staff and found two members of staff had only received two periods of supervision. The recording of management supervision remained inconsistent. We were informed staff group discussions were held with the lead counsellor and this was considered as a management supervision period. The staff files reviewed showed managers had carried out and documented staff appraisals.

Substance misuse/detoxification

- The provider did not have a complaints policy at this service. Staff did not provide clients with information regarding how they could complain externally. on the 16 July 2018 the provider had put a policy in place. However, some information was misleading and needed to be changed. The manager informed us there had not been any complaints since our last inspection.
- Managers at the service were not able to provide any evidence that clinical audits were taking place. The manager told us there was no audit programme in place to check how polices worked and whether they were followed. This included, a review of the 17 drug errors recorded as incidents between 5 March and 19 June 2018. This meant that clinical governance was not effective and outcomes were not monitored.
- When we inspected the service in March 2018 we found that the medicines management policy was not adequate and we were concerned about the safe and proper management of medicines. When we inspected the service in June 2018 the policy had not been updated and our concerns had not all been addressed. Following this, the policy was updated by the nurse advisor however when we reviewed the updated policy we found that it contained factual inaccuracies and there remained gaps in the policy which had not been addressed.There was no transcribing guidance. No guidance on secondary dispensing, and no guidance on titration of medication. The guidance for control drugs prescriptions was factually inaccurate. There was no guidance and process for safe transport of medication to the accommodation. Medicines management areas of concern were also found at the inspection of 24 July 2018, relating to medicine storage, controlled drug records, dispensing procedures, medicine administration/stock record charts and audits.
- In March 2018 we were also concerned about arrangements to assess capacity. Staff had received training in the Mental Capacity Act. We reviewed the admission process for clients when seen by the doctor prior to admission to the service and client's capacity was just recorded as full capacity, nothing further. This was an interim process as the service had an action plan in place to produce a specific document for capacity assessment. When we revisited the service, this was not in place. The interim process was not appropriate for long term client admission.
- There was clear evidence through client's records, medical notes and the incidents that staff recorded that the provider was not reporting safeguarding concerns to the local authority or the Care Quality Commission.
- In June 2018 the clinical information system was not robust. It was very easy to delete information from the IT system. All the documents on the system were in an unprotected, editable word processor file format meaning that these files could be changed without an audit trail. Data loss would be a risk to the individual safe care and treatment of clients. Staff members would not be able access clinical information as there was no evidence of contingency plans in place for this eventuality. On further unannounced inspection in July 2018 we found that policy documents were still on the system in the unprotected format so could be changed and an information assurance policy was still not in place.

Leadership, morale and staff engagement

- There were no reported cases of bullying or harassment at the time of inspection.
- We saw evidence staff had raised concerns with managers regarding processes to keep clients safe. During inspection some staff told staff told us the behaviour of another member of staff had previously been reported as a concern and no action was taken. Therefore, staff did not feel they could raise this or any other concerns and be supported.
- Staff were working double shifts to fill gaps. Staff said they were tired and overstretched. Managers had the option to use agency/bank staff at the service however, they did not do so. The manager of the service informed us there were no night staff at the service after 11pm. Instead staff were working on an on-call rota system overnight. Staff told us that they were not contracted to deliver this role. Staff we spoke with were not happy to do this and informed us they had raised this with managers.
- There had been a high turnover of staff since our visit in March 2018. The shortfall of staff was having an impact on the welfare of the team. When speaking to staff this was evident and staff expressed this to us.
- Staff said they were supported by the senior manager of the organisation who was visible within the service.

Substance misuse/detoxification

However, staff felt there was a level of management that is not being met to support them in their role. There were concerns that staff did not have a positive relationship with a manager at this service.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve
The Care Quality Commission did not take further action against the provider because following the inspection, the provider told us that they intended to cease treatment and de-register the service. The service was de-registered by CQC on 8 August 2018.

- The provider must ensure that they address all breaches of regulation and areas of concern that have been raised with them since March 2018.
- The provider must ensure that the policies and procedures for medicines management are fit for purpose, in date and reflect best practice and ensure the safe management of medication including controlled drugs.
- The provider must ensure that there is an environmental risk assessment in place and that they meet the regulatory reform (fire safety) order 2005, to mitigate the risk to clients, staff and visitors.
- The provider must ensure that there are sufficient staff of the right experience to meet the needs of clients.
- The provider must ensure that there is a clear, contemporaneous record of treatment for all clients and that the clinical information systems are robust.
- The provider must ensure that client's physical healthcare needs are assessed and fully met.
- The provider must ensure that staff have clear instruction regarding how to manage emergencies and that client risks are assessed following any emergency.
- The provider must ensure that there is a robust system for incident reporting, reviewing, learning and feeding this back to staff.
- The provider must ensure that staff report safeguarding concerns to the local authority.
- The provider must have a risk register that identifies and addresses all risks to the organisation.
- The provider must ensure there is a programme of audit to ensure that improvements are made to the service when concerns are identified.
- The provider must ensure that all people working for the service have an up to date DBS (disclosure and barring system) check.
- The provider must ensure that pre-employment checks are carried out to ensure that all staff employed by the service are safe, fit and appropriate to work with clients.
- The provider must ensure that their policies and procedures are fit for purpose, in date and reflect best practice.
- The provider must ensure that all staff receive regular supervision
- The provider must implement a system to ensure that clients' mental capacity is assessed and clearly documented as required.