

Briefing

Substance misuse services

The quality and safety of residential detoxification November 2017

The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. We make sure that health and social care services provide people with safe, effective, compassionate, high-quality care and encourage care services to improve. We exercise our independent voice by publishing our views on quality issues in health and social care.

Public Health England (PHE), as a part of its role to protect and improve the nation's health and wellbeing and reduce health inequalities, supports local authorities to commission and deliver alcohol and drug treatment services. PHE has supported the development of this briefing.

This briefing flags up concerns, identified during the course of CQC's inspections, about some independent sector services that offer residential care to people undergoing detoxification from drugs and alcohol. In 2016/17, it is estimated that about 1% of people in alcohol and drug treatment received this type of intervention. The briefing, which includes recommendations, is for providers, commissioners and other local and national bodies that play a part in assuring the quality of substance misuse services.

Summary

Key points

We analysed inspection reports of 68 independent sector services that offered residential detoxification for people who are withdrawing from drugs and/or alcohol. A substantial proportion of these services did not provide good quality care and treatment. Common concerns included:

- Providers that did not assess risk to individual clients adequately.
- Doctors and nurses that did not follow best practice guidance when assisting clients to withdraw from alcohol and/or drugs.
- Poor management of medicines, including controlled drugs.
- Providers that did not provide staff with the training required to work with this client group.
- Failure to safeguard clients by carrying out employment checks on staff.

Many of our findings stem from a lack of appropriately trained and competent staff to manage and oversee these services. Too often, the services lacked appropriate clinical leadership and clinical governance.

Many of these independent sector units were small providers of residential rehabilitation that also provided residential detoxification. Most did not have on-site pharmacy provision, and medicines management practices, including the supply of controlled drugs, were via community pharmacists. The poor medicines management practices might reflect a lack of ongoing oversight by a pharmacist.

Introduction

The substance misuse sector has changed considerably over the past 20 years. Overall community-based provision has expanded significantly to meet demand. At the same time, many NHS hospital-based specialist inpatient addictions units have closed and independent providers now manage more residential detoxification provision.

In 2013, the Health and Social Care Act transferred responsibility for commissioning substance misuse services from primary care trusts to local authorities. Local authorities commission detoxification provided in residential alcohol and drug treatment services on either a spot-purchase or block contract basis. There is often no single local commissioner and a number of different parties may purchase places in a particular residential substance misuse facility (for example, various local authority commissioners and/or fee-paying, private individuals).

Public Health England (PHE) supports local authorities to commission and deliver alcohol and drug services by providing evidence-based guidance and advice, and by collating and analysing alcohol and drug performance data for local authorities and treatment providers.

CQC inspects (but does not rate) independent sector services that provide structured drug and alcohol treatment. This includes services where people have to be resident in order to receive treatment. These detoxification or stabilisation services provide medicine-assisted recovery programmes (and prescribing to prevent a relapse). The programmes are often, but not exclusively, aimed at people who either have had difficulty in overcoming their dependence in a community setting, or where it would be most appropriate for withdrawal to be undertaken in a residential setting by virtue of complexity or severity of their problems. Staff teams vary according to the service's treatment programme, but may include psychosocial project workers, social workers, doctors, psychologists and nurses.

People who need help because of drug and alcohol misuse often have complex and varied healthcare needs. Those who are dependent on drugs and/or alcohol and who have physical or mental ill-health, or a history of complications during previous withdrawal or social instability, are at particular risk when withdrawing.

In 2016, in response to early inspections under our new comprehensive [inspection approach](#), we wrote to all registered independent sector residential drug and alcohol treatment providers to make them aware of our concerns about the safety of care being provided to people undergoing withdrawal from drugs and/or alcohol. We asked providers to take action to address any issues in their own services. PHE ensured that commissioners were also aware of these concerns. CQC and PHE also ran a workshop for residential treatment providers, to discuss these concerns in more detail, to highlight relevant guidelines and standards and to offer support to enhance practice.

We have now analysed reports, published up to August 2017, of our first inspection of independent services that we identified as offering residential detoxification. This analysis confirmed the concerns from our early inspections. A substantial proportion of the 68 services we looked at did not provide good quality care and treatment for people who are withdrawing from drugs and/or alcohol.

What we found

We took action to require that 49 of the 68 providers (72%) make improvements because they had breached regulations of the Health and Social Care Act and failed to meet fundamental standards of care. Of these, we took enforcement action against eight providers (12%) and we separately issued a notice to cancel the registration of another provider. Four of the services are no longer operating following the concerns that we raised on our inspections. We issued requirement notices to all other providers that breached regulations.

Figure 1 shows the regulations and fundamental standards that providers most often failed to meet. Almost two-thirds (63%) were not providing safe care and treatment. Other common breaches related to governance, staffing, and making sure that staff were fit and proper to work within the service.

Forty-one providers (60%) breached two or more regulations and 25 (37%) breached three or more.

Figure 1: Most frequent breaches of regulations by the 68 providers

Regulation	Number of locations with breaches	Percentage of locations with breaches
12: Safe care and treatment	43	63%
17: Good governance	26	38%
18: Staffing	23	34%
19: Fit and proper persons employed	16	24%
13: Safeguarding service users from abuse	7	10%

A number of themes accounted for many of these breaches of regulations.

1. Poor assessment of risk

Some units did not undertake risk assessments to determine whether it was safe to treat a person in their facility and did not respond appropriately to changing risks.

Independent sector units that offer residential care for people withdrawing from alcohol and/or drugs vary in the composition, expertise and availability of their staff team. Those that admit people who are at high risk of developing serious, and possibly life-threatening, complications should have doctors and nurses with the necessary expertise available 24-hours a day. Units that cannot provide this level of care must assess every client to identify those whose needs they cannot meet safely.

In some units, staff did not undertake a comprehensive assessment before offering admission. They did not always assess all types of risk for clients. For example, they did not fully explore what problems the client had encountered previously when withdrawing from drugs or alcohol.

Some care records showed that staff had identified risks, but had not documented any control measures to say how they would manage or mitigate these risks. For example, how they would manage alcohol withdrawal related epileptic fits in a client who had experienced these during previous episodes of detoxification, or how they would manage aggression displayed by a client with a history of violence towards others.

In other cases, sections of the risk assessment were not completed, which meant that relevant information was potentially missing and important information may not have been available to enable staff to keep clients safe. This information might have led staff to increase the level of observation or support for people potentially at risk of developing physical or mental health complications during withdrawal.

2. Failure to follow best practice guidance

Some units did not adhere to evidence-based guidance on how to assess, monitor and treat people withdrawing from drugs and/or alcohol.

The assessment, care and supervision of a person withdrawing from alcohol and/or drugs are medical procedures which carry a level of risk to the individual. They require management by staff who are skilled and competent to supervise withdrawal. They often entail doctors prescribing medicines that themselves have potential for abuse or dependence ('controlled drugs' as specified by the Misuse of Drugs Act, 1971 – such as methadone and benzodiazepines). There is a substantial body of research evidence on what constitutes good and safe practice. This evidence has

informed guidelines published by the National Institute for Health and Care Excellence¹ and by the Department of Health.²

Too often, services lacked good clinical leadership and clinical governance. In these services, the doctors overseeing detoxification did not follow relevant clinical guidelines or manage clinical risk well. Staff failed to follow guidance with respect to prescribing medication to alleviate the effects of withdrawal or to prevent complications and did not always adhere to the recommendations on monitoring the physical wellbeing of people in withdrawal. This failure to follow best practice could reduce the likelihood of successful withdrawal and increase the likelihood of complications and avoidable harm with potentially fatal outcomes.

For example, at one service that we took enforcement action against for failing to provide treatment in line with NICE guidance, staff had not prescribed a sufficient dose of medication to a client with a history of severe health issues relevant to alcohol detoxification. Also, the staff had not followed the recommendation by NICE that clients with problems of this type and severity should also be prescribed anti-seizure medication to reduce the risk of seizures. Staff did not prescribe this medication even after the client experienced withdrawal seizures.

3. Poor management of medicines

Staff in some units did not handle, store and dispense medicines in a safe way.

Controlled drugs are subject to restrictions and controls under the misuse of drugs regulations. In some units, staff did not follow the required procedures for handling these medicines. For example, staff returned controlled drugs to the pharmacy and did not destroy them on the premises as required by legislation. In one unit, a worker had completed their training only the day before the inspection, but a review of the controlled drugs book showed they had been administering medication before they had completed their training. In a number of services, we found that some staff who administered medication or witnessed administration of medications, including controlled drugs, had not been trained or assessed as being competent to do so. We also found examples of doctors prescribing controlled drugs by telephone for clients who they had not assessed in person.

In some units, we found many documenting errors on medicines administration. At one service, we found there had been a high number of medication errors. These included instances where staff were giving clients doses of paracetamol at intervals of less than four hours because these were the fixed medication administration times. Paracetamol should be given with doses at least four hours apart to prevent liver damage. This is of greater concern in this service where many clients may already

¹ [NICE Clinical Guideline 115](#), Diagnosis, Assessment and Management of Harmful Drinking and Alcohol Dependence, 2011

² Department of Health, [Drug Misuse and Dependence UK Guidelines on Clinical Management](#), July 2017. Note that this supersedes the 2007 guidelines that were in place during the period that CQC inspections were taking place.

have liver damage due to heavy alcohol use. Staff had not recognised these as medication errors because the service had not given them relevant training in medicines management. This meant that these errors had occurred repeatedly and over a prolonged period of time.

We also had concerns about the storage of medicines at a number of units. Examples included units where staff failed to store medication at the correct temperature to ensure that it remained fit to administer and a unit where staff had stored methylphenidate (a controlled drug) in a locker that was not secure.

Because many of these providers were small, non-hospital based services, they relied on community pharmacies supplying medicines, including controlled drugs. There would often be no ongoing oversight of medicines management by a trained pharmacist as would normally be the case in a hospital as part of clinical governance.

4. Staff with insufficient training

Staff in some services had not undertaken basic training to maintain safety nor the specialist training to support people withdrawing from drugs and/or alcohol.

Units that offer residential care for people withdrawing from alcohol and/or drugs should have the appropriate range of staff – medical and non-medical. Managers should ensure that staff who directly support and supervise the withdrawal process should be trained in the range of basic skills required by those working with any group of people undergoing an intervention that carries risk. These skills include basic life support, consent and mental capacity and safeguarding. Those staff who make treatment decisions, or who are directly responsible for monitoring people's care, should have specialist skills commensurate with these responsibilities.

In a number of services, the basic training provided was inconsistent. Some provided training once staff had started working with clients, with no routine refresher training. In one service, the registered manager had no records of staff training and was unable to provide the detail of what standard training was expected, or when it was required to be renewed. Some providers had not ensured that all staff received regular training on the safeguarding of vulnerable adults and children.

Senior staff in some services were not aware of national guidance that describes best practice and had not ensured that staff working with clients at high risk of developing complications during withdrawal had the training necessary to recognise and respond to these.

5. Lack of employment checks on staff

Managers in some units were not undertaking the employment checks required to protect those using their services.

People undergoing withdrawal from drugs and/or alcohol in a residential substance misuse unit are at a vulnerable point in their lives. Also, many people who are dependent on drugs and/or alcohol have experienced abuse and exploitation. It is therefore essential that managers ensure that all staff are suitable and appropriate to work with this client group.

People in recovery, who may have criminal records, often work in drug treatment services. Their experience can be an asset. They may act as role models for those recovering and assist to overcome the stigma often faced by people who use services. The process of vetting staff should not exclude such people from employment provided they have the required competencies, are properly supported/managed and all the risks appropriately managed.

Some units did not have robust procedures for ensuring that regular Disclosure and Barring Service (DBS) checks were undertaken of all staff. In one unit, not all staff had a DBS certificate in place and there was no plan in place to supervise staff whose application for DBS check had been submitted but not yet processed. Another provider requested a DBS check when staff were newly employed but did not repeat this process at routine intervals. Some DBS checks were several years old, and the service did not have any other robust methods to ensure that staff were still a fit and proper person to work at the service. In another example, DBS checks with three staff had identified criminal convictions, but managers had not made a subsequent risk assessment as to how this was to be managed in order to safeguard clients.

We also found discrepancies between start dates and DBS checks for employed staff – it was clear in these circumstances that staff had started working in the service without training, without waiting for appropriate DBS checks to be in place and with no appropriate supervision by managers.

Good practice and improvement

Although we have flagged a number of concerns in this briefing about the quality of care in some services, we should also recognise the good quality care that is being provided by a number of services, such as the one highlighted in the example below. We recommend to all independent sector providers that offer residential care to people undergoing of detoxification that they should use CQC inspection reports to learn from those services that are providing good quality care.

In addition, a number of services have already been able to act on the findings in our inspection reports, and take action to improve. Of the 68 providers in our analysis, we have re-inspected 14 since the original inspection. Three of these providers no longer have any breach of regulations following the re-inspection, and seven have been able to reduce the number of breaches that they have. One provider has stopped

admitting people who need to undergo detoxification. We are continuing to go back, at the appropriate time, to check on those providers who are still in breach of regulations.

Good practice example

Allington House provides both residential rehabilitation and detoxification services in a large detached Victorian house. Allington House is able to provide treatment for up to 16 clients; these can be either male or female.

At the time of our inspection there were 12 clients receiving treatment. Staff assessed clients prior to admission and provided clients with an individual care package tailored to their needs. This could include medical detoxification under supervision from a GP.

We spoke with clients individually and as a group and they all praised how the staff worked with them. They found the staff to be exceptionally supportive, kind and caring. They felt that the staff were very interested in their welfare and that they “went the extra mile” to make sure they were happy and able to succeed in their recovery. Clients described the service as having “saved their lives” and felt that the skills staff taught them would enable them to move back into the community safely.

We found that the leadership team was committed to the clients who used the service, were approachable and extremely knowledgeable. The service had experienced staff who received appropriate training and support to enable them to care for clients.

After a thorough assessment, staff clearly documented any risks identified and created plans to manage them. Staff made clients receiving treatment at Allington House feel safe. They understood how to recognise safeguarding issues and make referrals and they followed the organisation’s policies when doing so. Staff safely managed medicine using robust systems, and the environment was clean and well maintained.

There were positive and effective working relationships with the local GP and community mental health team. There were systems in place to monitor the quality of the service, which included regular audits and feedback from clients using the service and staff. Staff learned from incidents, and from any complaints that clients and carers had made.

Actions and recommendations

The Care Quality Commission (CQC) and Public Health England (PHE) recognise the value and cost effectiveness of good alcohol and drug treatment services, and the need for services that can provide residential or inpatient care for some people undergoing detoxification. We will continue to work together, in partnership with national and local government and treatment services, to ensure treatment is safe, effective and supports people to recover from their dependence. To this end, we will work together to promote and implement the following recommendations, based on the findings of this report.

1. The Government's 2017 [Drug Strategy](#) states that "local drug (and alcohol) treatment commissioners should assure themselves that the services they commission are safe and effective at improving individuals' health and helping people recover from drug dependency". It also stipulates that commissioners should refer to CQC reports to identify and address concerns about quality. Local authorities also have responsibilities for the safety of controlled drugs, as set out in the [Controlled drug regulations 2013](#). To support this, CQC and PHE will share this briefing with local authority directors of public health and PHE will continue to support local areas to commission safe and effective services.
2. Local authority commissioners should assure themselves that the services they commission are safe, appropriate and effective, particularly in relation to the competence of service providers to meet and safely manage complex needs and to support vulnerable people. Commissioners should ensure a range of services are available so they can meet the full range of needs, including complex need. This includes having clear quality governance processes in place with services from whom treatment is purchased on a place by place or 'spot purchase' basis.
3. Residential detoxification services should be compliant with relevant clinical guidelines, including relevant National Institute for Health and Care Excellence guidance and the [2017 update to Drug misuse and dependence: UK guidelines on clinical management](#). PHE and CQC will continue to work together to ensure that residential detoxification services are aware of this guidance and that it appropriately informs CQC inspection processes.
4. CQC and PHE will strengthen their working relationship to ensure that information of concern about specific providers is shared at the earliest possible opportunity and will work together at a regional level to coordinate action to effect improvement, in partnership with commissioners and service providers.
5. CQC's role in ensuring the effectiveness and safety of alcohol and drug treatment is prominent in 2017 Government Drug Strategy. CQC and PHE will work together to make those in local and national government responsible for the strategy's implementation aware of any significant themes from the inspection process, both in terms of good practice and areas of improvement.
6. The Department of Health has recently granted CQC the powers to rate independent sector, standalone substance misuse services. This will make it easier for CQC to communicate its findings about the quality of these services and to monitor and report on whether they are improving over time. CQC will be discussing its approach to developing a rating system for these services with PHE and will consult with the public and providers in the new year.