Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Tonbridge Recovery Service

1st Floor, 155 High Street, Tonbridge, TN9 1DH

Date of Inspection: 03 December 2013

Date of Publication: January 2014

We inspected the following standards as part of a routine inspection. This is what we found:

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Cooperating with other providers	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard
Complaints	✓ Met this standard

Details about this location

Registered Provider	CRI (Crime Reduction Initiatives)
Registered Manager	Mr. Lee Graham Ashmore
Overview of the service	The Tonbridge Recovery Service is run by CRI (crime reduction initiatives). CRI is a health and social care charity working with individuals, families and communities that are affected by drugs, alcohol, crime, homelessness, domestic abuse and antisocial behaviour. They receive referrals through the health care and social care systems and the courts. People with problems can also refer themselves for treatment.
Type of service	Community based services for people who misuse substances
Regulated activities	Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 3 December 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service and talked with staff.

What people told us and what we found

People who used the service felt that their dignity was always upheld and they were treated, "with complete respect". Other comments included," they understand (and) don't patronise us", "can talk without being judged" and "we are learning something every day and you can't do it alone".

There a thoughtful approach to treatment. Staff discussed innovative ways of helping people with difficult problems. We heard comments from staff such as, "… you can't just say goodbye to (name)" and "what is that (name) wants from us and what can we actually do". People who used the service had nothing but praise for the service. People said, "here you can speak out and the material (information) is very helpful", " I get so much from the group" , "you realise you are not alone and other people have a different take (on how problems might be solved)" and "if you have a blip you can say so here".

Staff showed a wide professional knowledge of other providers. They talked about interactions with General Practitioners and knew which other local services would be suitable for which people. Staff, when talking about people who had a combination of problems, said, " I feel the mental health teams are involved with (name)" and "… (suggest name of provider) as they can manage LD (learning disability) issues".

There were effective systems in place to monitor the quality of care. There was an effective complaints system in place.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent

judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✓ Met this standard

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was meeting this standard.

People's privacy, dignity and independence were respected.

Reasons for our judgement

People who used the service told us that their privacy and dignity were respected. They had been told by their key worker or other staff members to be aware of the privacy of others who attended the service. One person said," sometimes I get asked, 'Oh you go to (the service) don't you, does so and so still go there' but I don't tell them anything".

There was an open reception area but staff avoided mentioning any personal information. If there were personal matters to be discussed people were always taken to a private room off the reception area. There were private consulting rooms for the therapy and medical staff. We saw that staff always knocked on doors and waited for a reply before entering. Conversations could not be heard outside the consulting rooms.

There was an information guide for people who used the service. There was a range of leaflets and documents, about the type of treatments and support provided to meet people's needs. This information was available in the building's reception area. People who used the service were given the information they needed to make choices and change their lifestyle behaviours that were placing their health at risk.

People were encouraged to be independent. There were a number of activities that people using the service had initiated from discussions amongst themselves or with staff. These included a fishing club, a football club and a Christmas meal. They had approached the management for financial support for the activities. Managers had pointed out that any support they might provide could not be guaranteed over the longer term. People were asked to seek other sources of funds in the first instance. For example the Christmas lunch menu had been costed and local firms approached to help with sponsorship. This helped people to develop the skills that would be needed with everyday living.

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. There was a structure to the initial assessment which included areas such as mental health, domestic circumstances, any previous offending history and any blood borne virus, such as HIV or hepatitis.

We looked at three assessments. They followed the structure. They were detailed and often contained the words that people had used for example, "I would like to regain my sleep pattern" and (name) having been made aware of the dangers said, "it doesn't apply to me". This meant that people had been involved in their assessment. Where necessary there were joint assessments such as where there were thought to be both mental health and substance misuse issues involved.

People needs were discussed in staff meetings. We sat in on one meeting. Staff clearly knew and understood the problems that people faced. There was detailed discussion about various options and we saw that staff were encouraged to contribute to finding long term solutions. We looked at four sets of records. We saw that people had a plan of measurable objectives tailored to meet their treatment needs. These included specifics such as by how much they intended to reduce their consumption of a particular substance. In general these objectives were signed by the person concerned as an indication of their involvement in the plan. People we spoke with confirmed this, for example, one person said," It's your own plan but they give you the tools to finish it".

There was a range of activities as well as formal therapies to help people with substance miss-use problems. The issues were addressed at three levels. There was Foundation for change, for those currently miss-using substances; Foundation for growth for those who had recently stopped using substances and Foundation for life for those who were moving away from the service. Each had its own room within the service allowing people to physically move from one area to another if they progressed. People could wear wrist bracelets (red, amber or green in colour) to indicate where they were in the programme.

There were groups timetabled for each level during the week. People were supported with prescription medicines at various places in their care plan. There were two consultant

psychiatry sessions each week for people needing closer assessment or support. There was a prescribing nurse working within the service to manage the day to day administration of medicines.

We observed a therapy group during the inspection. To start with people were often quiet and did not contribute. However the groups were skilfully facilitated. We noticed that people's body language became more open as they felt more confident. They began to speak about their problems and how they could support each other. We saw also when an individual began to dominate or to drift into less relevant areas the facilitator gently but firmly brought them back to group's needs. People were clearly supported by each other. One person was worried about how changes to her life would be viewed by friends. A group member said," If they are your friends they will like the new you". Another group member was reticent about an experience saying," I'll leave it there" but the group facilitator encouraged dialogue and the person disclosed further. There were plenty of comments about the value of group work including, "before I lasted three months (without support) but know I have support" and "the strategy (for distraction) we did on Friday helped through the weekend".

There were other activities that people found helpful. There was a breakfast club. This was an activity where anyone could drop in. One person said, "it is very good… you can talk to people if you want to. If it wasn't for the breakfast club in the morning I would be in the supermarket getting lager".

Cooperating with other providers ✓ Met this standard

People should get safe and coordinated care when they move between different services

Our judgement

The provider was meeting this standard.

People's health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the provider worked in co-operation with others.

Reasons for our judgement

There was a close working relationship between the service and other providers.

The service worked with Sussex Partnership NHS Foundation Trust who supplied consultant psychiatric services.

We sat in on a team meeting. The meeting was chaired by a consultant psychiatrist. People's' needs were discussed and it was clear that collaborative working was central to the discussions. Examples included a discussion about where to place a difficult discharge from a mental health hospital. The key worker said," I have been working with the CPN (community psychiatric nurse)" Staff members made suggestions of other facilities within the area that might be suitable for the person's complex needs. Comments on other cases included, "the GP has seen (name) and knows what we are trying to do"," I have liaised with (mental health trust) and now we have a three way appointment" and (from the consultant psychiatrist) "the ward can always ring me if they have any problems".

There was a wide range of services from other providers on display in the reception area. This included a service from health trainers on eating, exercise, stress and emotional wellbeing from a local community NHS trust and those offering assistance with accommodation, training, employment and mental health. Alcoholics Anonymous, Cocaine Anonymous and Narcotics Anonymous all had sessions on the provider's weekly timetable of events. These organisations all rented accommodation at the location at on advantageous terms. This meant that people were more able to access the range of services that they might need to provide for the whole of their health and social care needs.

The service was signed up to the Kent and Medway Joint Working Protocol regarding dual diagnosis for people with mental health and substance misuse problems. The consultant psychiatrist sat on the dual diagnosis steering group. We saw examples of joint assessment for people who used the service where dual diagnosis was an issue.

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive.

Reasons for our judgement

There was a range of audits and checks to monitor the quality and effectiveness of the service. There was a series of meetings called the Integrated Governance Team meetings (IGTM). These were held at the local level, i.e. the Tonbridge office and issues were fed up to an area meeting, i.e. Kent and then to a regional level. We looked at the minutes of some of these meetings. We saw there was a standard agenda which included areas such as training, safeguarding and feedback from service users. Specific serious incidents were discussed. There was discussion about training, on understanding of domestic violence, and audits.

There was scheme of audits for the year. For example, a recent safeguarding audit had identified that only the recognised form should be used to present material at child care cases to avoid confusion. An infection control and hygiene audit in November 2013 had identified various areas for improvement. It was too soon for most of them to be actioned although one area, providing hand washing posters, had been done.

Incidents were recorded on a system called DATIX. This is a standard system used by many NHS bodies. We looked at two reports. Both had been well recorded and investigated. There was in-depth analysis of trends in incidents. Conclusions reached included that staff were unsure as to what was an incident and what a "near miss". Reports showed what had happened but often not why and medication issues were often the reason for people becoming upset. We saw from meeting minutes that these issues were discussed at different levels across the provider's services. There were several lessons for staff from the analysis and we saw that these were fed back through training, daily morning meeting and e-mails.

People who used the service were consulted about it. There were regular surveys of people who used the service, these indicated a high regard for the staff and for the service. There were questions to help identify what people wanted, for example, "would you like workshops in the … evening ,,, weekends?" The volunteers, who had themselves used the service, had regular meetings. The issues they raised were acted upon. In the November meeting the volunteers discussed holding a "Xmas buffet" and this had been

costed and planned. They had asked for better communication of training opportunities and a noticeboard had been put up. They had asked to be allocated a supervisor and this had been done.

Complaints ✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was an effective complaints system available. Comments and complaints people made were responded to appropriately.

Reasons for our judgement

Some of the people that we spoke with were aware of the complaints system. All the people felt that if they raised a concern or complaint it would be treated seriously. None had any complaints.

The complaints system was set out in a leaflet. The leaflet was available in the reception. It set out the timescales within which complainants might expect to receive a reply. We saw that where the complaint was complex or required longer investigation, resulting in delays, the complainant would be sent a "holding" letter. This informed of the reason for the delay and when they might expect to be contacted.

There had been no formal complaints during the previous year. However the service had learned from verbal comments. For example, there had been a change in a person's medication and the person had not been involved in the change. This had led to some aggressive behaviour. As a result an education regime was put in place to prepare people for the changes. Also the education was conducted in similar peer groups so young men were placed with other young men. The service had found that this offered more support, in these circumstances, than other configurations of groups.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk