Quality Standards for Community Substance Misuse Services Implementation Guide - 2016

Introduction

The Implementation Guide is written to help community substance misuse services to gather the evidence they need in a structured way in order to meet the quality standards. Throughout the guide there will be cross references to the quality standards which highlight particular policies and procedures necessary to ensure good practice. The documents should therefore be used in parallel.

The approach taken will be allied to the CQC methodology so that services which are registered can prepare well for their inspections. For services that are not registered this is still a useful framework because it ensures that providers have examined their service in an organised and focussed way.

It is important to state that some community services are registered with CQC if they fulfil the criteria of having in the multi-disciplinary team people who are medical practitioners including nurses or social workers. If so then they will be registered to provide “Treatment for disease, disorder or injury”. Usually this means that the service is a prescribing service. If these professionals are not part of the team, or if they hold a CQC registration elsewhere for example at a GP practice, then registration is not required.

Whilst the Quality Standards are grouped according to practice issues, this implementation guide groups the issues directly mapping the CQC Key Lines of Enquiry as utilised by CQC when they compile their reports. So if all these points are evidenced then a service can be assured that they have been thorough in covering all the areas which a CQC Inspector will assess as part of their inspection.

When gathering evidence it is important to understand that this is not just documentary evidence, but it can also be gained by talking with staff, people who use services, and by observation of practice. For example it is all very well having a policy on dignity and privacy of treatment but if service users say that they do not feel treated with dignity, or if facilities actually allow no privacy, then it is not achieved. Another example is service user involvement in care planning. There may well be a section for service user comments in the plan, but if it is not completed, or if service users say that they have never seen it, or they do not have a copy, then it is clearly not happening in practice.

This implementation guide will seek to be practical about exactly what evidence is required to demonstrate that quality standards are being met.

It may be helpful for managers of services to devise a routine whereby they ensure that over a year they update each of the five questions. A practical approach would be to cover the questions one at a time on a two monthly cycle, with a summary being produced on the sixth occasion for example.

Other ways of ensuring that services keep to standards could be the setting up of a "governance group" which could review crucial matters such as safeguarding, serious incidents, complaints and changes to policies as well as receiving quality assurance reports. Having a set frequency with which to review policies is helpful to ensure that none are out of date or irrelevant to the service being provided. This group could have a wide representation, including service users, to ensure that all aspects of the service are overseen and any changes to the service are understood and implemented.

The existence of a "service user forum" is also a useful way of obtaining feedback about how the service is being received. Enabling this forum to have a direct route into the senior management is important in ensuring that the service user remains at the centre of the service provision.

The overall aim will be to make sure that service users will be provided with a service that is focussed on their needs and their personal recovery journey.

1. Is the service safe?

This is the most crucial element of the operation of a community service. The key issues are the environment, the management of risk, the track record on safety, lessons learned and improvements made, safe staffing, safeguarding, and emergency planning.

So what can be considered under each of these headings?

A. Safe and clean environment *Standard 9 Service Environment*

The cleanliness and welcoming feel of the premises from which a service operates influence the experience of someone coming to use the service.

Is the service easy to find? Is the presentation of the service institutional or personal?

Good examples of welcoming services can include the availability of refreshments, a “welcome team” which can often be peer mentors or volunteers, and clear signage.

The actual premises need to be kept safe, clean and secure. In order to do this the following may be useful:

- Welcoming environment
    - Open and accessible reception facilities.
    - Staff and volunteers who are designated the task of welcoming people.
- Cleaning schedules & infection control arrangements.
    - It is important that there is an infection control lead person who implements Department of Health guidance on infection control.
    - The lead person ensures that there is a regular audit of infection control.
    - Usual infection control arrangements including hand washing signs.
    - Staff can be trained in infection control.
    - The treatment room needs particular attention if BBV and drug and alcohol testing occurs.
    - In addition, the treatment room will ideally include rescue medication, resuscitation equipment and training and a defibrillator (AED).
    - Removal of clinical waste is also important, usually through a contractor.

- An environmental risk register
    - This is useful because it clarifies any risks in the premises.
    - This should include a risk management plan.
    - Particularly look out for ligature points and access for people with disabilities.
    - Also address the issue of the level of staff observation of waiting areas and clinical rooms.

- Fire evacuation and safety procedures and equipment
    - Ensure that you have fire evacuations planned and recorded.
    - Ensure that there is a Fire Safety risk assessment. Local fire and rescue services sometimes provide this, or there are many independent companies who offer this service.

- Maintenance of premises – examples can include:

- Servicing records for any heating equipment.
- PAT testing of any electrical equipment.
- Legionella testing.

B. Risk Assessment *Standard 3 Initial Assessment*

The way in which risks to people who use services are assessed and managed is very important to ensure that they are safe.

- Prior to admission to the service
  - Focus on medical issues such as the risk of seizure, delirium tremens, and other symptoms associated with opiate or alcohol withdrawal. (Specifically cross reference NICE Guidance CG100 & CG52.)
  - A comprehensive health assessment by a qualified practitioner in order to ensure that health risks are understood and managed well.
  - Substance misuse specific risks are identified e.g. risk of overdose, poly drug use, injecting needles, BBV, etc.
  - Where there are identified risks there is an accompanying risk management plan.

- Once people are in treatment ***Standard 11 Health & Wellbeing***
  - Risks to changing health care needs are identified, especially anything related to drug and alcohol harm.
  - Procedures for monitoring health are practiced e.g. check-ups with a nurse, weight monitoring, blood tests etc.
  - There are comprehensive risk assessments in place which cover areas mentioned in the NTA Care Planning Guide e.g. drug and alcohol use, physical and psychological health, criminal involvement and offending, social functioning including family history. (NTA 2006)
  - Policy and procedures to manage the risks associated with restraint and challenging behaviour.
  - Policy and procedure to manage the risks of suicide e.g. ligature points.

- Prescribing practices ***Standard 1 Safe prescribing***
  - Ensure that the prescribing doctor, or non-medical prescribing nurse, is working on the basis of a comprehensive risk assessment.
  - Ensure that NICE prescribing guidelines are being followed.
  - Ensure that prescribing is on the basis of a face to face assessment by the practitioner.

C. Medicines management *Standard 1 Safe prescribing*

Once medication is prescribed the way in which medication is managed in a service is important for keeping people safe.

Whilst many service users will self-administer, or receive their medication at a supervising pharmacy, it is important that there are clear guidelines in place.

- Self-administration of medication
  - An overview of how each service user is managing their medication administration.

- Controlled drugs
    - Controlled drugs arrangements compliance with Misuse of Drugs Act 1971. Locked cabinet.
- Medication kept at the service.
    - Medicine management – support of pharmacy, audit of errors, administration, staff training & competency assessment, awareness of "double scripting", compliance with Medicine Act 1968.

- Management of needle exchange and BBV ***Standard 2 Needle exchange provision***
    - Have a range of syringes, needles and other equipment available to meet the needs of users of a range of substances, including those who use Image and Performance Enhancing Drugs (IPEDs).
    - Provide health advice and information.
    - Have written policies and procedures that outline the delivery of needle exchange provision in both community service site based and pharmacy-based needle exchange, including access to Hepatitis B vaccination and Hepatitis C & HIV testing.
    - Have developed care pathways with a range of health services, including sexual health, hepatology and mental health.
    - Review needle exchange provision at planned and regular intervals.

D. Track record on safety & lessons learned ***Standard 7 Clinical Governance***

It is important that a service keeps records to show that safety is well managed. Managers need to have an overview of any incidents or events which may compromise the safety of service users. Examples of good ways to do this are:

- A system for recording recent adverse events and serious incidents i.e. Integrated Governance
    - Regular multi-disciplinary reviews of incidents, accidents, adverse events, safeguarding, complaints, etc.
    - Staff who know reporting mechanisms.
    - Feedback on lessons learned from incidents to staff including a debrief.
    - Tracking of changes to procedures which result.
    - Record of who is informed e.g. line management structure.
    - Service users say that they feel safe.
    - Awareness of "Duty of Candour" when things go wrong or mistakes are made.
    - Awareness of whistleblowing policy and procedure.

E. Safe staffing ***Standard 14 – Human Resource Management***

To ensure the safety of service users it is important that there are sufficient staff available to deliver the treatment and support which the service aims to provide.

To demonstrate this the following will be helpful:

- Staff team
    - A list of the professionally qualified staff team with particular reference to the involvement of clinical staff who oversee detoxification.
    - A list of recovery workers & support staff.
    - A list of volunteers who undertake specific tasks within the service e.g. peer mentors, recovery champions.

- Staff deployment

    - Detail about how staff requirement has been estimated e.g. number of key work sessions, group work sessions, prescribing clinics, other activities.
    - Management of sickness/leave, also unexpected absences, use of agency or bank staff.

- Safe staff recruitment ***Standard 15 – Recruiting staff and volunteers***

    - Safe recruitment processes must be in place.

    - Includes DBS checks prior to starting work, a risk assessment of any offending or drug taking involvement, two references, ID check to ensure that people can work in the UK, exploration of any gaps in CV, an application form and a record of the interview.

F. Safeguarding

It is important that services understand the purpose of safeguarding procedures as these can ensure that vulnerable people are protected from abuse and kept safe. Sometimes information about possible abuse to children comes to light and it is important that this too is reported to local children's safeguarding teams as this may be vital information which helps piece together the situation of children who may be at risk. In order to do this the following is suggested:

- There is a Safeguarding policy & procedure including anti-discrimination.
- The safeguarding policy includes children and adults.
- There is an accessible poster and written procedure which clearly identifies the contact point for the local safeguarding team for adults and children.
- Staff are trained in awareness of safeguarding issues and managers are trained to investigate safeguarding concerns, commonly referred to as level 4.
- Records are kept of safeguarding incidents & alerts.

G. Emergency or business continuity plans

A service is safe if it can demonstrate that it can manage contingencies. Examples are:

- Unexpected lack of staff, or loss of use of building.
- A plan needs to be formally in place.
- Out of hours management cover if necessary.

2. Is the service effective?

This means “does the service work well?” To show this it is important that specific “building blocks” are in place. These include comprehensive assessments and robust care plans which truly reflect the goals that service users are working towards. These assessments include the initial assessment phase as well as the comprehensive assessment and care plans developed as a result. Standards 3 and 4 of the “Quality Standards Framework outlines the essential elements well.

Other key “building blocks” include a skilled and committed workforce which forms a cohesive multi-disciplinary team. When it is working well this ensures that a range of perspectives are in place meaning that the care and treatment delivered can meaningfully be described as “holistic”.

Finally there is an increasing emphasis on ensuring that service users are knowingly consenting to their care and treatment. Where they are unable to do so, the service needs to be aware of the implications of the Mental Capacity Act. If the service is registered by CQC it is important to understand that CQC has a statutory duty to oversee the implementation of the Mental Capacity Act.

A. Assessment of care *Standard 3 Initial Assessment*

It is important that a service receives good quality assessment information from a care manager or other referral routes prior to admission.

This assessment information should include:

- Professionals involved, physical and mental health issues, medication, history of substance misuse, legal issues, social & cultural issues – include family history & children, financial situation & full risk screening.
    - Also a physical health assessment by a suitably qualified doctor, including physical examination is vital so that the medical condition of the person coming for treatment is known and can be monitored accurately throughout their treatment journey to ensure that symptoms are understood and can be treated appropriately if they occur.

B. Plan of Care *Standard 4 Care Planning*

Care plans are developed as a result of comprehensive assessments. They should be based entirely on the needs of service users. So key features of a good care plan are that they:

- Reflect individual needs, risk and preferences.
- Involve the service user in their preparation.
- Offer the service user a copy so that they take ownership of the process.
- Build on people’s strengths i.e. develop “Recovery Capital”.
- Include information about nutritional management. This is particularly important where people may have been neglecting themselves and become under-

nourished. Others may have allergies which need to be taken into account and can seriously affect people's health.

- Unexpected discharge management, including harm minimisation advice.
- Are regularly reviewed with the service user to ensure that goals are being met or targets reached. Also to ensure that the service is consenting to the plan and is actively working towards the agreed goals.

C. Best Practice in treatment & care

Standard 5 Psychosocial interventions

It is vitally important that treatment delivered is evidence based and uses NICE guidance especially if detoxification and withdrawal is involved. If a service is CQC registered this will always be used as the measuring tool for practice.

Some specific NICE Guidance is:

GG 115 "Alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence" NICE 2011.

CG100 "Alcohol use disorder: diagnosis and management of physical complications" NICE 2010.

CG 52 "Drug misuse in over 16s – opioid detoxification" NICE 2007 – due to be revised in the autumn 2016.

CG51 "Drug misuse in over 16s – psychosocial interventions NICE 2007.

Also:

"Drug misuse and dependence – UK guidelines on clinical management" DoH 2007 (To be reviewed 2016)

Medications in Recovery: Re-orientating drug dependence treatment" J. Strang NTA 2012 – known as "The Strang Report".

Where psychological therapies are used then it is important that there is an independent, verified evidence base for that treatment. This also applies to any complementary therapies that may be offered as part of the service.

D. Skilled staff to deliver care and treatment

Standard 17 Managing staff and volunteer development

Standard 18 Staff and volunteer induction

This means that staff need to be competent to deliver the care and treatment offered by the service. Essentially this means qualifications, training and relevant experience.

A practical way of demonstrating this is to have a "training matrix" available so that mandatory and specialist training can be tracked across the staff team to ensure that all staff have the right raining for the role they are being asked to undertake.

It is important that staff are properly supervised and have an annual appraisal in order to monitor their development and practice and to set goals for the future.

A recent development has been the introduction of the “Care Certificate” in place of the Common Induction Standards.

Some features of staff training are:

- Staff knowledge of the treatment on offer – especially detox and its side effects, also the philosophy of the treatment programme.
- Ability to recognise deteriorating health conditions.
- Induction – checklists & Care Certificate compliance.
- Mandatory training – on a training matrix – with a training plan.
- Specialist training and continuing professional development (CPD).
- Professional Registration of medical staff (RGCP part 1 & 2), drug and alcohol workers with FDAP and counsellors with BACP.
- Supervision which must be regular, planned and recorded. This can be individual and/or group supervision which can be external where relevant.
- Appraisal must be annual, preceded by a probationary timeline.

E. Multidisciplinary and interagency team work

Standard 10 Joint working

It is vital that treatment is delivered from a multidisciplinary team framework so that the needs of service users are comprehensively assessed and plans are well coordinated. In order to achieve this the following will be helpful:

- Regular meetings with stakeholders.
- Communication across the team, for example clinical meetings or telephone contact to especially highlight medical and other professional input.
- Involvement of Community Mental Health Team (CMHT).
- Handover meetings for communication of service user issues bearing in mind confidentiality issues.
- Staff meetings.
- Transition between services well managed e.g. community services to hospital or residential settings.
- Links with local recovery community groups and mutual aid.

Adherence to the Mental Health Act

- If service users have mental health issues then it is important that they receive the right psychiatric assessment and intervention. So good referral routes need to be established if the need arises.
- Where mental health issues are psychiatrically diagnosed and severe people may be a risk to themselves or others so there needs to be an awareness of the mental health services which will be relevant to this situation.

Good practice in applying the Mental Capacity Act 2005

- It is important that staff have basic understanding of the Mental Capacity Act 2005 through training so that they can be aware of the need for people to have capacity in order to engage in treatment.
- So staff need to know that they must check if someone has capacity to consent to treatment.
- Clinical and medication records must show that staff seek consent to treatment as well as consent to share information.
- If there are any restrictions or boundaries which are necessary within the treatment plan then are explained, agreed, reviewed and form part of ongoing treatment.

3. Is the service caring?

It is sometimes difficult to quantify how to measure whether or not a service is caring as it largely focusses on the values that staff demonstrate in their work as well the values of the organisation.

As an organisation, a service may have service user involvement strategies such as peer mentors or service user involvement forums. Listening to service users demonstrates an inclusive approach to service delivery.

The question of accessibility of the service is important in terms of the premises, the location and the services ability to be available to the range of vulnerable groups in society.

Some of the ways in which some evidence is obtained are through observation of interactions and through asking service users directly or through surveys. Areas to cover are as follows:

A. Kindness, dignity, respect and support

- Managers can directly ask service users if their staff are kind and supportive, emotionally and practically.
- Positive interactions between staff and service users are observed as being warm, respectful, kind, supportive, conscientious, empathetic, sensitive, encouraging and professional.
- Service users say to managers, or through surveys that they feel respected & not judged.
- Existence of a structure to promote dignity e.g. dignity champions.
- Handover meetings are respectful and confidential.

B. The involvement of people in the care they receive

Standard 12 Developing service user involvement

This can be on an individual level as well as organisation level and includes elements such as:

- Service user involvement in planning of care & treatment evidenced through signatures of service users on care plans, and use of the service users' own words.
- The allocation of peer support or a buddy.
- Room for visitors including children at suitable times.
- Feedback through surveys and questionnaires.
- Structure for listening to service users e.g. house meetings.

C. Involvement of carers or families in treatment

Standard 13 Developing carer involvement

- Families and carers involved if service user gives consent.
- Advocacy where relevant e.g. vulnerable groups or no family support.

D. Meeting the needs of all people who use the service

Ensuring diversity is respected for example:

- Policies and procedures compliant with Equalities Act.
- Personal, cultural, social & religious needs highlighted in care plans – relevance to substance misuse.
- Availability of interpreters.
- Access to spiritual support.
- Vulnerable groups and complex needs e.g. dual diagnosis, multiple drug use, homelessness, pregnant women, criminal justice element, LGBT, young people.
- Reasonable adjustments for disability – tour of premises, access to premises & treatment programme.

4. Is the service responsive?

This focusses on whether the service can meet the needs of service users in a timely and professional way. It also asks if concerns and complaints are listened to and form part of a services ability to reflect on its own practice. Important elements are as follows:

A. Access and discharge *Standard 10 joint working*

It is important that community services have efficient access and discharge arrangements to ensure that service users receive treatment at the point when they need and it can be efficiently delivered. Similarly when service users leave treatment they need to be reassured that there is ongoing support in the community which benefits them. When they are being referred service users need to have accurate information about the service so that they can consciously choose where to go for their treatment. In order to do this the following is useful:

- Good information is available in an accessible form which describes the treatment on offer at the service.
  Standard 8 Service Information
- Waiting times are kept to a minimum.
- Early discharge arrangements if terms of treatment are breached are made explicit.
- After care plans involve stakeholders as relevant e.g. care managers, housing providers, education, members of recovery community & mutual aid.
- Outcomes for service users discharged are monitored.

B. The facilities promote recovery, comfort, dignity and confidentiality

- Privacy is available for consultations and key work.
- In group work settings, there are boundaries which preserve people's privacy and confidentiality.
- Environment is suitable for the use to which it is put.
- Additional activities are relevant to the recovery journey and are planned.

C. Listening to and learning from concerns and complaints

- Response to feedback – individual and group e.g. service user forums.
- Service user awareness of complaints procedure – displayed and individually available?
- Demonstrate learning from concerns and complaints.
- Manager keeps complaints log to demonstrate responsiveness.

5. Is the service well led?

It is absolutely crucial that a service is well managed and that leadership is visible. There are many elements to this and a service needs to demonstrate them all in order to be reassured that it is being well led.

Some key elements are:

A. Vision and Values of the organisation

- There is a statement of the values of the organisation, including an understanding of what recovery means.
- The organisations values are communicated to teams.
- Staff understand the vision and values well.
- Chief Officers of the organisation regularly visit and monitor and evaluate.

B. Good governance *Standard 6 Organisational Governance*

This topic is about the organisational structure, the lines of accountability within the structure and the way in which risks within the organisation are assessed. A useful way of overseeing this is to establish a “Governance meeting” which may be referred to as “Clinical Governance” if there are a significant amount of medical services involved or “Quality Governance” if other modalities predominate. Overall there needs to be a “Management Body” which takes responsibility for the running of the service, usually through the appointment of a manager, or if it is a larger organisation there will be a line management system in place.

Some key elements of governance are:

- A strategic business plan with objectives.
- A line management structure which has clearly defined accountabilities.
- A service wide risk register exists, normally considered at a “Governance meeting”.
- If there is medical practice e.g. prescribing, then clinical audits are carried out and reported through a clinical governance structure.
- Examples of audits are – medication administration, medical reviews, care plans, risk assessments.
- Lessons learned are communicated well to staff and influence the development of practice.
- Staff understood the implications of the audits.
- Senior staff review audits at Board level, or equivalent.
- Incidents are investigated promptly, lessons learned identified and practice based learning is implemented.

- Systems ensure that mandatory training as well as role specific training is provided for staff.
- Information is obtained from previous service users about the quality of the service.
- Staff understand whistleblowing through a well communicated procedure.

C. Leadership, morale and staff engagement

An open and transparent management style is healthy for the development of trust within an organisation. Some features which may help to develop this are:

- Senior managers are seen as supportive.
- A positive level of morale in staff team.
- Opportunities for staff development.
- Transparency when staff reported back to service users if anything had gone wrong (this is the Duty of Candour).
- Staff feel that they have opportunities to suggest improvements to the service.

D. Commitment to quality improvement and innovation

When looking to the future it is inevitable that the context of treatment for drug and alcohol misuse will change. There will also be theoretical, legal and clinical developments as well as wider social and political changes. In addition service user's expectations may vary over time. It is therefore essential that services continually look to develop practice and scan the horizon in order to remain up to date as well as innovative in the way the service works. Some features may include:

- A well-developed quality assurance process which seeks continual improvement.
- A system for keeping up-to-date with legislative changes.
- An up-to-date overview of best practice in the field.
- Commitment to innovation through service development initiatives.
- Participation in research, practice placements or other developments.
- Links with external agencies where there are new initiatives taking place.