Requires improvement

Charterhouse Clinic Flore Ltd

Charterhouse Clinic

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-1995160073	Charterhouse Clinic	Charterhouse Clinic	NN7 4LZ

This report describes our judgement of the quality of care provided within this core service by Charterhouse Clinic. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Charterhouse Clinic and these are brought together to inform our overall judgement of Charterhouse Clinic.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service	Requires improvement 
Are services safe?	**Requires improvement** 
Are services effective?	**Requires improvement** 
Are services caring?	**Good** 
Are services responsive?	**Good** 
Are services well-led?	**Requires improvement** 

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards
We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

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Summary of findings

Overall summary

We rated Charterhouse Clinic as Requires Improvement because:

- The service did not robustly manage the risks associated with detoxification from drugs and alcohol. Staff did not regularly review client's physical health observations during detoxification in line with national guidance. The provider did not use dependency scales on admission or consistently use withdrawal scales such as the opioid withdrawal scale to monitor the severity of the client's withdrawal symptoms in line with national guidance.
- Governance systems were not robust. The service did not have a system to monitor areas for improvement identified through self-auditing and leaders did not maintain a robust risk register.
- Staff did not robustly mitigate the risks associated with mix gender accommodation by conducting risk assessments.
- The service did not hold regular staff team meetings. The last team meeting was held in August 2018.
- The training matrix was not up to date and did not accurately reflect the dates staff had completed their annual training.

However:

- Staff spoken with, reported good team morale and said they were proud to work for the provider.
- Staff provided a range of psychological therapies recommended by The National Institute for Health and Care Excellence. These included cognitive behavioural therapy and group therapy. Some of the topics covered in group therapy were mindfulness, meditation, reflection and relapse prevention.
- The provider had a whistle blowing policy in place. Staff were aware of the policy and told us they were confident in raising a whistle blowing.
- We observed staff interacting with clients in a kind and respectful manner throughout the inspection.
- Clients told us they felt safe whilst in treatment and that staff were kind and caring. All clients had a named key worker who met with their client weekly.
- We saw evidence that clients were involved in developing and setting their own care plan and goals.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

Requires improvement

- Staff did not regularly review client's physical health observation during detoxification in line with national guidance.
- Staff did not robustly mitigate the risks associated with mix gender accommodation by conducting risk assessments.
- Staff did not manage clinical waste effectively. We found a clinical waste bin that was full, and there was no open or closed date on the label. This did not meet the safe requirements for the disposal of clinical waste. This was an issue identified at our inspection in 2018.
- The provider did not use dependency scales, for example severity of alcohol dependence questionnaire on assessment, in line with national guidance and best practice.
- The provider did not consistently use withdrawal scales such as the opioid withdrawal scale to monitor the severity of the client's withdrawal symptoms during detoxification.
- Staff did not have access to emergency alarms to summon help in an emergency.

However

- The provider had an infection control policy in place which staff were aware off.
- The service was clean and well maintained.
- The registered manager had established the number of recovery workers to meet the needs of the clients.
- We reviewed the staffing rota and found shifts were appropriately filled by regular staff.
- The provider had a service level agreement with a consultant psychiatrist who attended site one day per week.
- We found 100% of core staff had completed their mandatory training which included, safeguarding, mental capacity act and medication management.
- The provider had a process in place for clients who unexpectedly left the treatment programme.
- The service had a duty of candour policy which staff were aware of.

Are services effective?

Requires improvement

We rated effective as Requires Improvement because:

- Not all staff received annual appraisal. We found 38% of staff had received an annual appraisal within the last 12 months.

Summary of findings

- Staff did not consistently use recognised risk assessment tools including the clinical withdrawals scale and the clinical opioid scale or substance dependency scales such as the severity of alcohol dependence questionnaire in line with national guidance.

However:

- We reviewed six care files and found care plans were person centred and goal orientated.
- The provider had a plan in place for clients who unexpectedly left their treatment programme early.
- Clients had access to local physical health services such as the GP and dentist if required.
- The service had an equality and diversity policy in place. Staff had undertaken equality and diversity training as part of their induction and mandatory training.
- Staff spoken with had a good understanding of the Mental Capacity Act.

Are services caring?

Good

We rated Caring as good:

- We observed staff interacting in a kind and respectful manner throughout the inspection.
- Clients told us they felt safe whilst in treatment and that staff were kind and caring.
- We saw evidence that clients were involved in developing their care plans setting their smart goals.
- Weekly community meetings were held. Clients spoken with told us they were able to raise issues or concerns at the meetings and staff would address the concerns promptly.
- Clients completed a satisfaction survey when they had finished the programme and were ready for discharge.
- All clients had a named key worker who met with their client weekly.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Clients had access to healthy and balanced meals.
- Clients spoken with told us the service catered for cultural and dietary preferences, for example, cooking with halal meat or preparing vegetarian dishes.
- Clients were able to access local cultural and religious facilities if requested.

Summary of findings

- The service had a complaints policy in place. Posters were displayed throughout the location detailing how to raise a complaint.
- Clients spoken with told us they knew how to raise a complaint and were comfortable in doing so.
- The service had an activity time table that covered seven days per week and included evening activities for clients to participate in.

However

- We were told if a client could not speak English they would not be admitted to the service. The provider should ensure they consider the Equality Act when assessing clients needs.
- The provider did not have disabled access for clients with mobility difficulties.

Are services well-led?

Requires improvement

We rated well-led as Requires Improvement because:

- Governance systems were not robust. The service did not have a system to monitor areas for improvement identified through self-auditing.
- Managers did not maintain a robust risk register. Risks identified included generic risks such as not meeting the Care Quality Commission standards, however there were no specific risks identified. There was no evidence staff were able to contribute towards the risk register.
- The provider did not hold regular staff team meetings.
- Managers did not keep the training matrix (used to monitor staff training compliance) up to date.
- Managers did not have a robust system to maintain oversight of staff supervision and appraisal.

However

- Staff spoken with were aware of the services vision and values.
- The service held daily handover meetings which were comprehensive and person centred.
- Clients and staff were aware who the senior managers were.
- Staff reported good team morale.
- The provider had a whistle blowing policy in place. Staff spoken with were aware of the policy and told us they were confident in raising a whistle blowing.
- Staff we spoke with said they were proud to work for the provider.

Summary of findings

Information about the service

Charterhouse Clinic is a specialist substance misuse service that provides residential support to clients who wish to enter treatment for addiction. The clinic provides treatment for a range of addictions ranging from, drug and alcohol including detoxification, to gaming and gambling addiction.

Charterhouse Clinic has 13 mixed gender, single occupancy bedrooms which were located on the ground floor and first floor. Nine bedrooms were ensuite and four bedrooms shared two bathrooms.

The service provided a holistic therapy approach to addiction that included supporting clients access the 12-Step principles of Narcotics Anonymous and Alcoholics Anonymous. Clients could engage in one to one cognitive behavioural therapy, family relationship groups and group therapy sessions.

There was a registered manager in post at the time of inspection who registered with the Care Quality Commission in November 2018. Charterhouse Clinic was last inspected by the Care Quality Commission February 2018. Charterhouse Clinic is registered with the Care quality commission to provider Accommodation for persons who require treatment for substance misuse.

There were no requirements found however there was a recommendation that the provider should ensure that clinical waste bins were disposed of promptly. The provider had not addressed this issue.

Our inspection team

Team leader: Scott McMurray

The team that inspected the service comprised of one CQC lead inspector and two other CQC inspectors.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme to make sure health and care services in England meet the Health and Social Care Act 2008 (regulated activities) regulations 2014.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about the location, asked a range of other organisations for information and sought feedback from clients at three focus groups.

During both inspection visits, the inspection team:

- inspected the location, looked at the quality of the environment and observed how staff were caring for clients;
- spoke with four clients who were using the service;
- spoke with the registered manager and the treatment director;

Summary of findings

- spoke with six other staff members; including the responsible psychiatrist, therapists, health care support workers and the head of housekeeping;
- attended and observed one morning meeting and one hand-over meeting.
- examined six care and treatment records of clients;
- carried out a specific check of the medication management and reviewed 12 medication cards in depth;
- examined a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

Clients told us that staff were kind, caring and responsive to their needs. A Client told us that when they had raised an issue with their room the staff acted upon the issue and resolved the request promptly.

Clients told us they felt safe and that staff were always available at the service and they were involved with all aspects of their treatment.

Clients told us they had not raised any formal complaint with the provider but were aware of the complaints process should they wish to do so.

Areas for improvement

Action the provider MUST take to improve

- The provider MUST ensure that clients privacy and dignity is not compromised in their management of mixed sex accommodation in line with same sex guidance.
- The provider MUST ensure that they use dependency scales on assessment and monitor client's physical health in line with national guidance.
- The Provider MUST ensure medication cards are complete in full, with no missing doctor signatures.
- The provider MUST ensure all staff receive an annual appraisal.
- The provider must ensure they hold regular team meetings and minute discussion points.
- The provider MUST ensure staff have access to emergency alarms to summon help in an emergency.
- The Provider MUST review governance procedures to ensure robust procedures are in place relating to the risk register and self-auditing practices and accurately recording staff mandatory training

Action the provider SHOULD take to improve

- The provider SHOULD ensure all staff receive supervision in line with the providers policy.
- The provider SHOULD ensure their exclusion criteria adheres to the Equality Act 2010 for non-speaking English speaking clients.

Charterhouse Clinic Flore Ltd

Charterhouse Clinic

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Charterhouse Clinic	Charterhouse Clinic

Mental Health Act responsibilities

The provider did not admit clients detained under the Mental Health Act as they were not registered to do so. However, the provider did provide Mental Health Act awareness training to all staff.

Mental Capacity Act and Deprivation of Liberty Safeguards

The provider had a Mental Capacity Act and Deprivation of Liberty Safeguarding policy in place which was reviewed annually. We found all relevant staff had completed this training.

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

- Charterhouse Clinic was clean and well maintained. There was a dedicated housekeeping team who worked on site daily. We saw some clients were allocated roles such as doing their own laundry and tidying the kitchen after use, to aid their recovery.
- Clients told us their rooms were comfortable and if they had a maintenance issue it was resolved in a timely manner.
- Managers had completed environmental risk assessments, and we saw evidence that these were up to date. The ligature audit identified ligature spots and actions had been taken to reduce ligature points were possible. Staff undertook screening of the client's history of self-harm on admission. The registered manager told us that if a client was identified at risk of ligature, that they would not be admitted to the service and would be referred to a more suitable environment to meet their needs.
- Managers ensured that the fire risk assessments were up to date. We saw firefighting equipment such as fire extinguishers were tested annually.
- Client bedrooms were not wheelchair accessible. All rooms required a degree of physical capability to access due to the layout of the building. The provider told us, if a client was unable to access the bedrooms independently they would not admit them to the service and support the client find a service suitable to meet their needs.
- The clinic room was organised, well stocked and visibly clean. Staff monitored the refrigerator temperatures and knew what to do if the temperatures were out of range. There were robust systems in place for the safe storage, auditing and disposal of medications.
- The provider and clients conducted urine testing as part of the treatment programme in the clinic room toilet. This ensured that clients privacy and dignity was protected.
- Emergency medications such as Naloxone, which is used to reverse the effects of an opioid overdose and an Epi pen which is used to reverse an allergic reaction were stored appropriately and staff knew how to access them in an emergency.
- The provider had an infection control policy. We saw hand wash posters which were located throughout the building reminding staff and clients to wash their hands. However, we found a clinical waste bin that was full. This was stored on the floor of the clinic toilet. There was no open or closed date on the label which does not meet the safe requirements for the disposal of clinical waste. We raised this as an issue at our inspection in 2018.
- Managers purchased physical health monitoring equipment such as a blood pressure machine annually, as it was cost effective to buy a new one rather than have it calibrated. However, the breathalyser was calibrated in line with manufacturing guidelines.
- The provider did not use panic personal alarms. Staff we spoke with were aware of safety procedures if they felt at risk from an aggressive client or if they were required to summon help in a medical emergency, such as working in pairs and being aware of where their colleagues are in the building. There had been no recorded incidents were staff had to summon help in an emergency over the last 12 months prior to the inspection.
- There were nine single occupant ensuite bedrooms and four single occupancy bedrooms that shared two bathrooms. At the time of the inspection, the mixed sex accommodation was not split into male and female areas only bedroom areas. The arrangement at the time of inspection meant that clients may have their privacy and or dignity compromised. The potential risks associated with mixed gender accommodation were not acknowledged or robustly mitigated by risk assessments. We were told there was an incident when a female client posted a note to a male client in the middle of the night. Staff told us they reminded the client of appropriate behaviour and interactions.

Safe staffing

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

- The registered manager had established the number of staff required to meet the needs of the clients. At the time of inspection, there were two therapist vacancies which were being advertised at the time of our inspection. In the interim the treatment director was supporting therapists to ensure all groups and one to one sessions with clients were not affected.
- We reviewed the staffing rotas and found all shifts were filled appropriately with substantive staff. Substantive staff worked together as a team to cover staff sickness and annual leave. The service reported no agency use over the last 12 months leading up to the inspection.
- The provider had a service level agreement in place with a consultant psychiatrist who visited the service once per week in person and conducted skype assessments with clients where required.
- Clients were registered with the local GP as a temporary client if required. In case of a medical emergency staff spoken with told us they would call 999 in line with their policy.
- Staff received training relevant to their role. Staff spoken with had an understanding of alcohol and opioid detox, health and safety, first aid, Mental Capacity Act and safeguarding.

Assessing and managing risk to clients and staff

- We examined six care and treatment records in depth and found all clients received an assessment on admission. The provider did not use dependency scales as stated in their policy and in line with best practice guidance. This was escalated to the provider at the time of inspection. During the follow up inspection the provider had printed copies off and discussed the need to use tools such as the severity of alcohol dependence questionnaire (SADQ) for measuring alcohol dependency before admission.
- The provider screened client's physical health observation on admission but did not regularly review client's physical health observation during detoxification in line with best practice guidance. This was escalated to the registered manager and consultant psychiatrist at the time of inspection. After the inspection, we were told staff would be trained and instructed to check physical health observations and that the psychiatrist would develop a document, which identified what normal and out of range general observations should be.
- The provider gave clients information regarding the service and the detoxification programme and the risks involved during detoxification at the pre- assessment stage. Clients spoken with confirmed this.
- We found risk assessments were thorough and covered a range of risks such as medication, community access and what action to take for a client who unexpectedly left the treatment programme. Staff spoken with were aware of this.
- Smoking cessation was offered to clients who wished to take part. At the time of inspection one person had shown interest but no one had taken part in the programme.
- Restrictions in place were proportionate to the treatment programme. For example, Clients had access to their mobile phones restricted whilst access groups to ensure they took part in the therapy programme. All clients were informed of the providers rules and expectations such as appropriate interactions and inappropriate behaviour would not be tolerated.
- All staff had received safeguarding adults and children training. Staff spoken with where able to describe the process and gave good examples when to raise a safeguarding. There was further information informing staff and clients how to raise a safeguarding on display throughout the service.
- The service used a paper based recording systems for individual care plans, risk assessments and progress notes.

Medicines management

- There were robust systems in place for the monitoring, ordering and auditing medications which included controlled drugs. There was evidence controlled drugs were stock checked at the start of each shift keeping a running balance and were also audited weekly and monthly.
- The provider used a local pharmacy who delivered client medicines. All relevant staff had completed medicines management training

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

- We reviewed 12 medication charts in depth. Although there were some missing doctor signatures, the medication cards were clear, easy to follow and audited regularly.
- There was some evidence the provider used withdrawal scales such as the opioid withdrawal scale (OWS) to monitor the severity of the client's withdrawal symptoms but they were not consistently used for all clients going through detox. We also found the provider did not monitor the client's physical health observations through detox in line with national guidance.

Track record on safety

- The service had not reported any serious incidents over the last 12 months prior to the inspection. This was confirmed by records we reviewed.

Reporting incidents and learning from when things go wrong

- The service had an incidents policy, which all staff were familiar with. Staff spoken with gave us examples of incidents which had occurred, including trips and falls. Incidents were recorded by all staff on an incident form and stored in the secure office.
- During the inspection we reviewed six incidents. All incidents were adequately recorded with follow up actions documented. The registered manager reviewed all incidents and all incidents were discussed at the daily morning meeting. There was evidence that learning from incidents was shared amongst the team via emails.

Duty of candour

- The service had a duty of candour policy. Staff spoken with told us they were open and honest with clients if things went wrong. The registered manager provided an example when they followed their duty of candour policy and apologised following the outcome of a partially upheld complaint.

Are services effective?

Requires improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

- We reviewed six care and treatment records in-depth and found evidence that clients were involved in the planning of their care. Client care plans were recovery focused, linked to risk assessments and had the views of clients documented. All clients met regularly with their key worker to review the care plans and set new goals as required.
- Clients were registered with the local GP surgery as a temporary patient if required. The provider had a service level agreement in place with a consultant psychiatrist who attended the site once per week and a nurse who attended the site on an as and required basis to administer IM medication if required.
- Staff completed risk management and reintegration into treatment plans for clients who exited from treatment early.
- Client files were stored in a locked cabinet in a locked office. All staff had access to client files as required.

Best practice in treatment and care

- The service had an alcohol and opioid detoxification policy which staff did not adhere too. The service did not consistently use recognised risk assessment tools including the clinical withdrawals scale and the clinical opioid scale or substance dependency scales such as the severity of alcohol dependence questionnaire (SADQ) in line with national guidance. This was escalated at the time of inspection and the provider gave us assurances they will use the scales moving forward.
- Clients had access to psychological and psychosocial therapies in line with the guidelines produced by the National Institute for Health and Care Excellence. For example, that clients have access to mutual aid support groups such as alcoholics anonymous which clients attended at a third-party location.
- The provider did not routinely offer blood borne virus testing's in line with best practice guidance. However, the registered manager told us they could use local third-party services for these checks.
- The service employed two chefs who regularly met with clients to discuss diet, nutrition, likes and dislikes.
- All clients had access to local opticians and dentists if required as temporary clients.
- Staff used technology to support clients effectively for example. The service had a room available for clients to use skype for to speak with the consultant psychiatrist if required before the psychiatrist attended the site on a Saturday.
- Staff participated in clinical audits such as medication audits, health and safety and client record audits.

Skilled staff to deliver care

- All staff received a comprehensive induction which included shadowing experienced staff, reviewing policies and procedures and some training before they were deemed competent by the registered manager to work with clients independently.
- All staff had completed their annual mandatory training. However, managers had not updated the training matrix provided to reflect the most recent training dates. Staff had access to further specialist training such as the qualification and credit framework diploma level two and three which replaced the national vocational qualifications in health and social care.
- The registered manager had a robust recruitment processes in place. We reviewed five staff personnel files in depth and there was evidence of two references, interview questions and disclosure barring service checks had been completed. Where there was a disclosure on the form, a risk assessment was completed.
- We found there was a supervision structure in place clearly demonstrating who was responsible for supervising who. At the time of inspection 75% of staff had received supervision. However, leading up to the date of inspection staff supervision was inconsistent and not in line with the provider's policy. The provider did not have a system in place for monitoring supervision compliance which was escalated to the registered manager at the time of inspection who gave assurances they would audit all staff files to monitor staff supervision moving forward.

Are services effective?

Requires improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- We found 38% of staff had received an annual appraisal. This was escalated to the manager at the time of inspection who audited all files and had a plan in place to ensure relevant staff receive the annual appraisals.
- The registered manager had addressed issues regarding staff performance, for example, where a medication error was identified the registered manager discussed it during supervision and the staff member had subsequently refreshed their training.

Multi-disciplinary and inter-agency team work

- Staff conducted a daily handover meeting, which we observed. This meeting covered all areas of the client's needs such as, appointments, activities and any areas of concern.
- The therapists met regularly where they discussed all clients, their outcomes and progress made.
- The service did not hold regular staff team meetings. Staff used a communication boo to escalate concerns if required. The last team meeting was October 2018. The registered manager told us it was difficult for staff to attend the team meetings as some staff need to travel long distances to attend. To mitigate the risks associated with not having regular team meetings all staff ready the handover sheets from the last time they were on shifts and any significant incidents, learning or changes to the service was emailed to all staff by senior staff.
- The registered manager told us the service had good working relationships with the local authority and referring agencies if required. However, some staff spoken with were not aware of the drug and alcohol liaison service at the local acute accident and emergency department. We saw evidence the provider completed progress reports which were sent to the clients registered doctor.
- Staff had an awareness of local third-party services clients who were ready for discharge were informed of such as, local alcohol anonymous groups.

Adherence to the MHA and the MHA Code of Practice

- The service did not admit clients detained under the Mental Health Act.

Good practice in applying the MCA

- The provider had a Mental Capacity Act policy in place which staff were aware off. Staff spoken with were able to demonstrate an understanding of the five guiding principles and the process they would take if a client lacked capacity.
- There was evidence the client's capacity was considered during the assessment stage. For example, if a client was intoxicated at admission and unable to consent to care and treatment the provider would wait until the client was able to consent.

Equality and human rights

- The provider had an equality and diversity policy in place which staff were aware off. Staff spoken with were able to demonstrate an understanding of cultural differences and were able to meet the needs of culturally diverse clients.
- The service had a clear admission criterion and were clear that the service could not admit clients with mobility needs due to the layout of the service.
- The service restricted patient access to their mobile phones during their treatment and agreed a time where clients could access their phones as part of their treatment plan. Plans were in place for named contacts to contact clients through the providers phone in case of an emergency.

Management of transition arrangements, referral and discharge

- The service had an admission criterion which staff were aware off. The registered manager and treatment director screened all referrals and discussed them with the consultant psychiatrist to assess if they were able to meet the client's needs. If the provider was not able to admit he client due to their complex needs the provider was able to advise on other speciality services.
- Recovery workers supported clients access to specialist advice such as, benefit advice, housing and debt Management if required.
- Staff completed discharge plans for all clients and provided information on services available in their local area after graduating the programme.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

Kindness, privacy, dignity, respect, compassion and support

- We observed staff interacting in a kind and respectful manor throughout the inspection**.**
- Staff spoken with were able to demonstrate an understanding of positive behaviour support and how to address inappropriate behaviours with clients. For example, through one to one engagement and the use of behaviour contracts.
- There was evidence that all staff had read and understood the providers confidentiality policy. Staff spoken with had a good understanding of confidentiality and protecting people's personal information.

Involvement in care

- Clients new to the service were given a welcome pack which included what to expect, key staff and the facilities on offer. Clients were orientated to the service by their peers and key worker.
- We saw evidence that clients were involved in developing and setting their care plan goals. Clients had a named key worker who they met with weekly. Clients spoken with confirmed this.
- Staff held weekly community meetings. Clients told us they were able to raise issues or concerns at the meetings and staff would address the issues raised.
- The provider had a plan in place for clients who unexpectedly left their treatment programme early which included the client's preferred method for reengaging in the treatment programme.
- There were suitable areas for families, friends and carers to meet with their relatives whilst visiting.
- Clients were given a satisfaction survey to complete when they had completed the programme and were ready for discharge. The satisfaction survey included patient views on the programme and made suggestions how to improve the programme. We reviewed the recent analysis of the satisfaction survey and it was positive.
- We saw evidence the provider had access to local advocacy services and informed clients of local advocacy services were available if they wanted to access them.

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

Access and discharge

- The pre-admission assessment did not use recognised dependency scales however clients were asked to disclose their daily level of substance consumption.
- The registered manager told us if the service was unable to meet the needs of the client. The registered manager and consultant psychiatrist would inform the client of further treatment providers.
- At the time of inspection, the provider had 13 clients admitted. There was no waiting list and all clients ready for discharge had written discharge plans.
- Clients spoken with told us they felt supported through the admission process and reported the pre-assessment was thorough.
- Staff developed care plans and risk assessment on the day of admission. These were reviewed weekly thereafter during one to one sessions between the key worker and client.
- Clients were assessed over skype on the day of admission by the consultant psychiatrist and then seen on each Saturday thereafter for the duration of their treatment.
- An aftercare group was provided to all clients who had used the service and completed their treatment programme on an ongoing basis. The aftercare group met every Tuesday afternoon where clients had access to the therapists and peer support.

The facilities promote recovery, comfort, dignity and confidentiality

- All clients had their own bedrooms. Nine bedrooms were ensuite and four bedrooms shared two bathrooms. At the time of inspection one bathroom was out of order however the registered manager was able to provide evidence the work to repair the bathroom was planned.
- At the time of the inspection, the mixed sex accommodation was not split into male or female only bedroom areas. The arrangement at the time of inspection meant that clients may have had their privacy and or dignity compromised. The potential risks associated with mix gender accommodation were not acknowledged or robustly mitigated by risk assessments.
- There were adequate therapy rooms located throughout the site where therapists could meet with clients to engage in their care and treatment which included therapy rooms, one to one session rooms, a large living room and a large dining room, a well-equipped gym and private heated swimming pool. Clients also had access to the laundry facilities as required.
- Clients were able to lock their rooms and had access to their room keys throughout the day if they requested.
- Two chefs met with the clients regularly to discuss the food options, and to support clients with preparing healthy, culturally appropriate balanced meals. We saw the service had achieved a level five hygiene safety rating from the food standards agency.
- The service had an activity time table that covered seven days per week and included evening activities for clients to participate in, for example, clients told us they could attend thai-chi, yoga, mindfulness and peer led groups.
- Clients spoken with told us they were able to make snacks and drinks when they wanted.

Clients' engagement with the wider community

- Clients were encouraged to access family therapy sessions if required. The focus of the family therapy sessions was to promote a positive relationship with their family members.
- All clients were encouraged to access the local community for shopping trips and third-party services such as Alcohol and Narcotics Anonymous.
- Out of area clients were given information regarding groups and services in their local area upon discharge.

Meeting the needs of all people who use the service

- Staff were able to demonstrate an understanding to potential issues faced by monitor groups such as the lesbian, gay and bisexual (LGBT) and black and ethnic (BME) groups as well as older people, sex workers and were able to offer appropriate support.

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

- Clients spoken with were able to access the treatment needed to meet their needs in a timely manner and was never cancelled.
- There were 13 single occupancy bedrooms. Nine bedrooms were en-suite and four bedrooms shared a bathroom. We were told the providers considered the clients gender when considering which bedroom, they allocated the client. However, there was no formal risk assessment completed in relation to mix gender accommodation.
- The service had access to a variety of leaflets in a range of languages. We were told if the client was not able to speak English and they were unable to access an interpreter they would not admit them to the service as they would not be able to meet their needs. The manager did say they would support the client were possible to find a suitable placement.

Listening to and learning from concerns and complaints

- There were two formal complaints raised over the last 12 months leading up to the inspection One complaint was partially up held. We saw evidence the provider responded to the complaints in line with their policy.
- Staff spoken with were aware of the providers complaints policy and were able to demonstrate how they would manage a complaint.
- Clients spoken with told us they felt confident they could raise a complaint without the fear of discrimination or harassment. We saw evidence that the provider displayed their complaint policy throughout the service.

Are services well-led?

Requires improvement

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Leadership

- The registered manager of the service was registered with the Care Quality Commission November 2018.
- The registered manager attended the morning handover meeting and was aware of daily incidents and client progress.
- Staff and clients spoken with told us managers and the treatment director was visible and approachable if they wanted to speak to them.
- The registered manager had a good understanding of the services, their goals and daily operations of the service.

Vision and strategy

- Staff spoken with told us they knew what the services values where and were able to tell us how they applied them through their daily work.
- Staff were able to contribute to the daily operations of the service and were aware the service had a recruitment campaign. However, there were no recorded team meetings where staff were able to provide input and have discussion strategy for their service, especially where the service was changing.

Culture

- Staff told us they felt respected and valued by their peers and managers. Work related stress was manageable and did not impact their job.
- Staff reported good morale amongst the team. Staff spoken with told us they enjoyed coming to work and the team worked well together.
- There was some evidence the service recognised staff success, for example, the registered manager was promoted from the lead therapist role to the registered manager role. However, there was a lack of staff appraisal to formally review staff career development plans annually.
- There were no recorded evidence of bullying and staff we spoke with reported there was good staff morale amongst the team. Staff confirmed that they felt proud to work for the service and had positive job satisfaction by helping people overcome their addictions.

Governance

- Managers did not ensure that governance systems were robust enough to ensure the service provided was in line with national guidance. The service was clean, well maintained and well-staffed. However, the systems in place to monitor staff via staff supervision and appraisal were not robust. We found evidence that managers conducted clinical audits, however there was evidence of mediation audits which were scored as fully compliant, when there were some missing doctor signatures.
- The provider did not hold regular team meetings however there was evidence of quarterly board meetings that followed a set agenda.
- There was no recorded evidence of staff implementing change from complaints or lessons learnt. However, staff spoken with were able to give us examples of how practice has improved.
- The service provided mandatory training for all staff however the training matrix used to track individual expiry dates were not up to date.
- The registered manager demonstrated his responsibility to submit statutory notifications to notify the Care Quality Commission of certain events that happen at the service.
- The service had a whistle blowing policy in place. Staff spoken with were able to demonstrate they knew where the policy was and what actions they would take if a person 'blew the whistle' and disclosed information to them.

Management of risk, issues and performance

- The provider did not use key performance indicators to monitor operational and clinical performance over a period of time to compare audits outcomes on a monthly basis.

Are services well-led?

Requires improvement

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- The risk register was not robust. Risks identified included the provider not meeting the Care Quality Commission regulations, however it did not include local risks identified though quality improvement and staff input.
- There was evidence the provider did not follow their own policies. For example, we found the provider did not use dependency scales as set out in their prescribing policy.
- There was no evidence staff were able to contribute towards the risk register.
- The provider had a contingency plan in place that covered in key themes such as, flu outbreak, loss of heating and fire.

Information management

- Client information was recorded on a paper based system in their individual personnel files. All files were stored in a lockable cupboard in a locked office. Staff spoken with told us they had access to the files as and when required.
- There was evidence that confidentiality agreements were in place and staff requested client's permission before sharing personal information with their family.
- The provider followed their confidentiality policy when sharing information with the GP and local authority.

Engagement

- Managers maintained and updated information about the service regularly. For example, client welcome pack and a range of leaflets displayed throughout the service contained up to date information.
- Clients were given the opportunity to provide feedback during weekly community meetings and at the end of treatment clients were offered a satisfaction questionnaire. There was evidence of the provider taking action of suggestions from client's community meetings.
- Families and carers were also given the opportunity to provide feedback in the form of questionnaires, over the phone and face to face.

Learning, continuous improvement and innovation

- The service did not participate in any nationally recognised accreditation schemes.
- Where staff had an annual appraisal, staff discussed their annual objectives and learning needs.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect • The provider did not adequately consider clients privacy and dignity in their management of mixed sex accommodation

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • **The provider did not use dependency scales on assessment** • **The provider did not complete client physical health observation throughout detoxification treatment** • **Not all medication cards had Dr signatures**

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The service did not hold regular staff meetings • **The provider did not have operate effective systems and processes to make sure they assessed and monitored their service against Regulations 4 to 20A** • **The provider did not robustly manage risk, self-audit or accurately record staff mandatory training**

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Requirement notices

- Only 38% of staff had received an annual appraisal