Shardale St Annes

Quality Report

385 Clifton Drive North
Lytham St Annes
FY8 2NW
Tel: 01253 728898
Website: www.shardalerehab.co.uk

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

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

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

Summary of findings

Overall summary

We rated Shardale St Annes as **requires improvement** because:

- Risks identified through assessments were not formulated into individual risk management plans that provided guidance for staff.
- Recovery plans were limited in detail. They did not set out clearly what clients needed to do to complete the recovery programme or how they were progressing through the recovery programme.
- Essential information about clients' individual risk and progress through recovery was discussed and contained in handover notes but was not always transferred to clients' individual records following discussions.
- There was no date for review of therapeutic interventions.
- The policy that provided guidance for staff working alone did not set out how the risks of working alone would be mitigated.
- The provider's monitoring systems had not identified the issues we found in care and treatment records.

However:

- The provider had developed a recovery programme based on seven core values and incorporating a disciplinary scaling process. The model focused on developing communication, resilience and personal responsibility within a supportive community environment.
- There was an aftercare support programme that clients could access following completion of the recovery programme, to maintain their recovery and develop their peer support networks in the community.
- Clients who were senior members of the community had roles of responsibility such as gatekeeper, safeguarder and community leader. The provider gave clients training and guidance in these roles so they could carry them out effectively.
- Staff provided a range of care and treatment interventions suitable for the client group, delivered in line with national guidance and best practice.
- The provider had a clear definition of recovery that all staff shared and understood. There was a clear sense of common purpose based on shared values. Staff were positive and proud about their work.
- Managers had access to information about the performance of the service that supported their management role. Clients and carers could give feedback on the service they received.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Substance misuse services	Requires improvement 	Shardale St Annes provides residential rehabilitation for opiate addiction and alcohol addiction to males and females over 18 years of age.

Summary of findings

Contents

Requires improvement

Shardale St Annes

Services we looked at:
Substance misuse services

Summary of this inspection

Background to Shardale St Annes

Shardale St Annes is an independent substance misuse service situated near Blackpool, in a residential area close to public transport and local amenities.

The ground floor is accessible for clients with mobility needs. The service provides residential rehabilitation for opiate addiction and alcohol addiction to males and females over 18 years of age. There are 34 beds. At the time we inspected there were 25 clients.

Shardale St Annes admits clients from across England. Most clients are funded by statutory bodies.

Shardale St Annes is registered to provide the following regulated activities:

- Accommodation for persons who require treatment for substance misuse.

There is a registered manager and a nominated individual.

The service has been inspected twice before but not rated.

Our inspection team

The team that inspected the service comprised two CQC inspectors and an assistant inspector.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

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

During the inspection visit, the inspection team:

- visited the location, looked at the quality of the environment and observed how staff were caring for clients;
- spoke with three clients who were using the service;
- spoke with the registered manager;
- spoke with two other staff members;
- received feedback about the service from one commissioner;
- attended and observed one group session;
- collected feedback from five clients using comment cards;
- looked at three care and treatment records of clients:
- carried out a specific check of the medication management; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this inspection

What people who use the service say

All the clients who told us about their experience of using the service spoke positively. They told us they felt well supported and the treatment programme was excellent.

Clients said the staff were caring, helpful and approachable. They said they felt very safe in an environment where they were treated with dignity and respect, and where their voice mattered.

They described feeling a sense of belonging and purpose, and told us that taking roles in the house was an excellent experience that gave them a sense of responsibility.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as **requires improvement** because:

- Risks identified through assessments were not formulated into individual risk management plans that provided guidance for staff. Detailed information relating to individual risk was contained in the handover notes but was not transferred to clients' individual records following discussions.
- There was no date for review of therapeutic interventions.
- The policy that provided guidance for staff working alone did not set out how the risks of working alone would be mitigated.

However:

- The premises were safe, clean, well equipped, well furnished, well maintained and fit for purpose. Bedrooms for male and female clients were located on different floors and landing areas were protected by CCTV.
- Staff carried out a comprehensive pre-admission assessment for treatment that included an assessment of health and general presentation, and identified risks and potential triggers. Harm minimisation was an integral part of the recovery programme.
- Staff managed risk through continuous application of the disciplinary scaling process within the recovery programme. They reviewed individual risk every week. Clients in the roles of community leader and the safeguarder were also involved in the review.
- There were therapeutic interventions designed to create a safe environment conducive to community living. The interventions were part of the therapeutic model. Clients understood and agreed to them before they were admitted.
- Staff adhered to best practice in implementing a smoke-free policy.
- Staff knew how to protect clients from abuse. They had training on how to recognise and report abuse and they knew how to apply it.
- Clients were given information about safeguarding to help them recognise abuse.
- Staff followed good practice in medicines management and they completed annual medicines administration training.

Are services effective?

Good

We rated effective as **good** because:

Summary of this inspection

- The provider had developed a unique recovery programme based on seven core values and incorporating a disciplinary scaling process. The core values included realisation, reconnection and communication, personal responsibility and building resilience. Families and people close to clients were involved in some parts of the recovery programme. The model focused on developing communication, resilience and personal responsibility within a supportive community environment.
- Staff assessed the physical and mental health of all clients, including their lifestyle, general presentation and dependency.
- Staff provided a range of care and treatment interventions suitable for the client group, delivered in line with national guidance and best practice. Staff supported clients with their physical health and encouraged them to live healthier lives and helped them develop recovery capital.
- There was an aftercare support programme that clients could access following completion of the recovery programme, to maintain their recovery and develop their peer support networks in the community.
- Staff worked together to benefit clients. They supported each other to make sure clients had no gaps in their care. Recovery included referrals to other supporting services. The service worked with health, social care and other agencies to ensure integrated and coordinated pathways of care.

However:

- Recovery plans were limited in detail. They did not set out clearly what clients needed to do to complete the recovery programme or how they were progressing through the recovery programme. Detailed information about clients' progress was contained in handover notes but was not transferred to clients' individual records following discussions. However, clients understood how to achieve their goals and could explain their progress through the recovery programme.

Are services caring?

Good

We rated caring as **good** because:

- Staff treated clients with compassion and kindness. They supported clients to understand and manage their care, treatment or condition.
- Every month, clients were assigned roles such as gatekeeper, safeguarder and community leader. Clients in these roles took part in handover meetings and the weekly disciplinary scaling review. They also organised escorts for those going out to appointments, watched out for and reported safeguarding incidents, and supervised community activity.

Summary of this inspection

- Clients were encouraged to support each other and to challenge behaviour deemed unacceptable by the community.
- Staff enabled families and carers to give feedback on the service.

Are services responsive?

Good

We rated responsive as **good** because:

- All admissions were planned in advance and clients could access the service when they needed it. Clients were mostly referred via community substance misuse services. They completed pre-admission work in the community then underwent detoxification, before they were admitted for rehabilitation. This helped ensure their needs could be met and they were prepared for the rehabilitation process.
- Staff planned for clients' discharge, including liaising with care managers. They supported clients during referrals and transfers, for example, if they moved to community services.
- Clients had space in their rooms where they could keep personal belongings safely. There were quiet areas for privacy and where clients could be independent of staff.
- Staff supported clients with activities outside the service. The provider had rented allotments in the local community and the clients were working on them. Every year, there was a group holiday where clients could participate in rural activities, such as dry stone wall building.
- The service took account of clients' individual needs. The pre-admission process identified issues such as communication, cultural or dietary requirements and helped ensure clients' needs could be met.
- The service treated concerns and complaints seriously. They investigated them and learned lessons from the results. There was a suggestions box that clients could use to make anonymous suggestions.

Are services well-led?

Requires improvement

We rated well-led as **requires improvement** because:

- The provider's governance systems had not identified issues we found with care and treatment records. Identified risks were not formulated into risk management plans. Recovery plans did not set out clearly what clients needed to do to complete the recovery programme and they did not set out clearly how the clients were progressing through the recovery programme.

However:

Summary of this inspection

- The provider had a clear definition of recovery that all staff shared and understood. Staff had the opportunity to contribute to discussions about the service strategy and there was a clear sense of common purpose based on shared values.
- Staff undertook local clinical audits. The audits were sufficient to provide assurance and staff acted on the results when needed.
- Managers had access to information about service performance that supported their management role.
- Clients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs.
- All staff had objectives focused on improvement and learning.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

Clients consented to care and treatment before admission. Staff supported clients to make decisions about their care. The provider did not admit clients who lacked capacity as they would be unable to engage with the recovery programme. If there were concerns about a client's capacity, staff informed the provider. The provider then liaised with the funding body to arrange a capacity assessment. There was a policy on the Mental Capacity Act 2005 to provide guidance for staff.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Substance misuse services	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

Requires improvement

Substance misuse services

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Requires improvement

Are substance misuse services safe?

Requires improvement

Safe and clean environment

The premises were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Staff knew about any ligature anchor points and actions to mitigate risks to clients who might try to harm themselves.

Bedrooms for male and female clients were located on different floors. Landing areas were monitored by CCTV. All bedrooms had a sink and there were adjacent bathrooms. Members of one sex did not have to pass through an area occupied by the other sex to reach toilets or bathrooms.

Every month, one client acted as gatekeeper. They took responsibility for answering the door, which helped ensure the safety of everyone in the house.

Safe staffing

The service had enough staff to meet clients' needs and was staffed 24 hours a day, seven days a week. Staff knew the clients well and received training to keep them safe from avoidable harm.

There was a registered manager, a deputy manager and an admissions co-ordinator. The provider employed nine support staff. No staff had left the service in the 12 months before this inspection, there were no vacancies and there had been no staff sickness.

However, one commissioner told us that sometimes, due to low staffing levels, clients did not always get enough 1-1 time.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. For example, all staff had completed training in fire safety, first aid and food hygiene.

Assessing and managing risk to clients and staff

We reviewed three sets of care records.

Staff carried out a comprehensive pre-admission assessment for treatment that included an assessment of health and general presentation, and identified risks and potential triggers, such as lifestyle, dependency, emotional state, offending behaviour and family dynamics. However, the risks identified through assessments were not formulated into individual risk management plans. This meant there was no evidence to show that actions to reduce clients' individual risks were considered and documented by staff. This could result in clients' risks not being managed consistently or effectively by staff.

Clients' risk status was recorded on white boards in the therapy rooms, but this was not a permanent record and was overwritten when there was new information to record. Risk status was linked to the disciplinary scaling and reviewed every week by the staff team. Clients moved through the scale according to their progress and motivation within the recovery programme.

Staff also used a handover book which contained comprehensive notes relating to individuals' risks, but these were not transferred to individual care records.

Requires improvement

Substance misuse services

Staff ensured clients were aware of the risks of continued substance misuse, and harm minimisation was an integral part of the recovery programme. The recovery programme included educating clients about the risks of continued substance misuse and how to maintain their own safety.

Staff managed clients' compliance with the recovery programme through continuous application of the disciplinary scaling process. The disciplinary scaling process was designed to address risky behaviours, such as striking up unhealthy relationships or aggression, and to check them at an early stage. Staff and clients reviewed every client every week and clients moved within the process accordingly. Clients in the roles of community leader and the safeguarder were also involved in the review. Moving down in the process resulted in loss of acquired freedoms, such as home leave, going out or having time to spend as they wished, or additional tasks within the community. Moving up increased freedoms as clients demonstrated their progression through the recovery programme.

The provider had a protocol for unexpected exit from treatment that included what action staff should take and who should be contacted. This included signposting to other recovery options, such as mutual aid groups.

Staff did not use restrictive interventions such as physical restraint.

There were therapeutic interventions designed to create a safe environment conducive to community living. The therapeutic interventions set boundaries, defined the house code of conduct and established an expectation that clients would be involved in the day to day running of the house. The rationale was to introduce discipline and routine, to engender a culture of respect and trust, privacy, safety and personal responsibility and commitment, and to enable clients to develop a sense of value and self-respect.

There were limits on, for example, lending and borrowing, gambling, playing music in communal areas outside authorised times or taking food and drink into bedrooms. The use of mobile phones was forbidden throughout the programme.

Some therapeutic interventions, such as restricted access to sharp objects and cleaning materials, having visitors, going out and home leave were limited during the early weeks of recovery and reviewed as the client progressed through the recovery programme.

Clients understood and agreed to the therapeutic interventions before they were admitted. Breaching the interventions incurred penalties that could eventually cumulate in discharge. If a client reached this stage of the disciplinary scaling process, the community would vote on giving them a chance to improve before they were discharged.

The interventions were part of the therapeutic model. They were clinically justified by ensuring clients were not distracted from the recovery programme and to provide guidance for overcoming addiction in a therapeutic environment by managing and reducing risky behaviour. They were set out in the disciplinary scaling process but there was no date for review.

Staff responded promptly to sudden deterioration in people's health.

Staff adhered to best practice in implementing a smoke-free policy.

There was a policy that provided guidance for staff working alone; however, it did not set out how the risks of working alone would be mitigated.

Safeguarding

Staff knew how to protect clients from abuse. They had training on how to recognise and report abuse and they knew how to apply it.

Clients were also given information about safeguarding to help them recognise abuse.

Clients took a safeguarding role in the house. The role was reallocated to a different client every month via the community meeting. All clients voted on who should be allocated the role, depending on their progress and motivation in their recovery. Clients in this role received safeguarding training and reported to the handover meeting at each shift change.

Following confidential handover discussions, the safeguarder came into the meeting separately and advised the team about any potential safeguarding issues developing within the community, such as lending or borrowing money, clients doing jobs for other clients or whether any clients had been distressed.

There was a suggestions box that clients could use to raise concerns anonymously.

Requires improvement

Substance misuse services

Staff access to essential information

The provider maintained a paper recording system and staff had appropriate access.

However, information relating to individual risk and progress through recovery was contained in the handover notes but was not formulated to individual records. For example, the handover notes made reference to a client needing to see a doctor but this was not noted in the client's individual record. This meant staff may not be fully aware of the risks posed by, or to, clients.

Medicines management

No medicines were prescribed at the service. All medicines stored on site were prescribed externally. Staff followed good practice in medicines management. There was a policy that provided guidance for staff. Medications were secured safely in a locked cupboard. Staff carried out six-weekly medicines audits and acted on the results if necessary.

Staff completed annual medicines administration training.

Track record on safety

This service did not report any serious incidents in the last 12 months.

Reporting incidents and learning from when things go wrong

The service managed client safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the team at handovers and team meetings. When things went wrong, staff apologised and gave clients honest information and suitable support.

Are substance misuse services effective?
(for example, treatment is effective)

Good

Assessment of needs and planning of care

We reviewed three care records.

Staff assessed the physical and mental health of all clients, including their lifestyle, general presentation and dependency. They then recommended the length of rehabilitation required, which included a day care programme.

The provider had developed a recovery programme that was based on seven core values and incorporated a disciplinary scaling process. The core values included realisation, reconnection and communication, personal responsibility and building resilience.

The recovery programme consisted of timetabled group work and individual pieces of work that helped clients identify their strengths, needs and goals, and develop strategies for dealing with their feelings, supported by individual key worker sessions. Six sessions of individual therapy could be arranged if a client needed it. Community activities, home leave and visits were incorporated through the weekends. Families and people close to clients were involved in some parts of the recovery programme.

The recovery plans we saw incorporated the strengths, needs and goals identified through assessments but they were limited in detail. The recovery plans did not set out clearly what clients needed to do to complete the recovery programme and they did not set out clearly how the clients were progressing through the recovery programme. However, clients understood how to achieve their goals and could explain their progress through the recovery programme.

There was discussion about progress at handover meetings and there were detailed notes in the handover book, such as notes about a client's feelings following a therapy session, clients becoming aware of their own risky behaviour and reference to a client needing to see a doctor, but these were not transferred to clients' individual records. Clients' progress was recorded on white boards in the therapy rooms but it was not a permanent record and was overwritten when there was new information to record.

Key worker sessions took place at least every three weeks. Staff and clients reviewed progress through the recovery programme, re-assessed needs and planned their goals.

The provider had a protocol that addressed clients' unexpected exit from treatment.

Best practice in treatment and care

Requires improvement

Substance misuse services

Staff provided a range of care and treatment interventions suitable for the client group, delivered in line with national guidance and best practice. Staff supported clients with their physical health and encouraged them to live healthier lives.

On admission, clients were registered with a local GP, who carried out a physical health assessment, including testing for blood borne viruses where appropriate.

The recovery programme followed a unique model based around seven core values, supported by key worker sessions and individual therapy sessions if the client needed them. The model focused on developing communication, resilience and personal responsibility within a supportive community environment.

Treatment interventions included group therapy, cognitive behavioural therapy and activities intended to help clients to develop personal responsibility and acquire living skills. Clients took responsibility for duties such as budgeting, shopping for food, cooking and cleaning. These helped clients build the skills required to help them function and maintain their independence when they returned to the community. Clients who were senior members of the therapeutic community had roles of responsibility such as gatekeeper, safeguarder and community leader. Every month, all clients voted on who should take on these roles, depending on the motivation they had shown in completing the recovery programme. The provider gave clients training and guidance in these roles so they could carry them out effectively.

Staff helped clients to develop recovery capital. Recovery capital is the social, physical, human and cultural resources clients need to help them in their recovery.

Clients told us that the groups and sessions they attended had helped them understand and manage their health and social needs. Group work gave them the opportunity to discuss their feelings, and to challenge and support each other. They could explore the reasons for their substance misuse and develop ways to deal with it. Staff supported clients to access other organisations and encouraged them to develop their social support network. Clients said the community was a very safe environment where they felt supported.

Every day, clients completed a significant event form and a feelings journal. They reflected on their day, at what had happened and what they had learned. They discussed any concerns they had in group sessions. The forms and journals were used to help structure therapy and counselling sessions.

Staff encouraged clients to live healthier lives through offering support, advice and information about behaviours, goals and future planning. This included education around healthy eating advice, smoking cessation and regular exercise. The provider encouraged clients to register as patients with a local GP. Clients were supported to attend appointments at the GP, dentist or other health appointments they needed.

There was an aftercare support programme that clients could access following completion of the recovery programme. The programme was facilitated by staff and helped clients strengthen the skills they had learned during the recovery programme, to maintain their recovery and develop their peer support networks in the community.

Monitoring and comparing treatment outcomes

Staff regularly reviewed recovery plans with clients. They used treatment outcome profiles to monitor patients' progress.

The provider reported outcomes to the National Drug Treatment Monitoring Service, which collates data on substance use. The national drug treatment monitoring service is managed by Public Health England.

In the 12 months before this inspection, 92 clients had started treatment; 53 for alcohol, 27 for opiates, 12 for opiates and alcohol.

Of those, 50 (54%) had completed treatment successfully; 34 for alcohol (64% compared with the national average of 31%), 11 for opiates (41% compared with the national average of 6%), five for opiates and alcohol (41%). Of the remainder, 25 (27%) were still in treatment. The remaining 17 did not complete treatment.

Skilled staff to deliver care

Staff had the skills they needed to provide good quality care. They were supported with appraisals, supervision, and opportunities to update and further develop their skills and knowledge. Group supervision took place every four weeks. There was no programme of individual supervision but staff could request it if they needed to. Staff told us they were well supported.

Requires improvement

Substance misuse services

All staff had completed a diploma in health and social care.

Multi-disciplinary and inter-agency team work

Staff worked together as a team to benefit clients. They supported each other to make sure clients had no gaps in their care. There were monthly team meetings that all staff attended.

There was a handover meeting at every shift change that included information about each client.

Every three months, staff reviewed clients' progress at a meeting with their care co-ordinator.

Recovery included referrals to other supporting services. The service worked with health, social care and other agencies to ensure integrated and coordinated pathways of care.

The service discharged clients when specialist care was no longer necessary and worked with relevant supporting services to ensure the timely transfer of information.

Good practice in applying the MCA

Clients consented to care and treatment before admission. Staff supported clients to make decisions about their care. The provider did not admit clients who lacked capacity as they would be unable to engage with the recovery programme. If there were concerns about a client's capacity, staff informed the provider. The provider then liaised with the funding body to arrange a capacity assessment. There was a policy on the Mental Capacity Act 2005 to provide guidance for staff.

Are substance misuse services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

Staff treated clients with compassion and kindness. They respected clients' privacy and dignity, and supported their individual needs**.**

Staff supported clients to understand and manage their care, treatment or condition. They directed clients to other services when appropriate and, if required, supported them to access those services.

All the clients who told us about their experience of using the service spoke positively. They told us they felt well supported. They said the staff were caring, helpful and approachable. They said they felt very safe in an environment where they were treated with dignity and respect, and where their voice mattered. They described feeling a sense of belonging and purpose, and told us that taking roles in the house was an excellent experience that gave them a sense of responsibility.

The provider had clear confidentiality policies that staff understood and adhered to. Staff maintained confidentiality of information about clients.

Staff said they felt able to raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards clients without fear of consequences.

Involvement in care

Staff actively engaged clients in understanding and planning their care and treatment. They involved clients in decisions about their care, treatment and changes to the service.

The service empowered and supported access to appropriate advocacy.

Every month, clients were assigned roles such as gatekeeper, safeguarder and community leader. Clients in these roles took part in handover meetings and the weekly disciplinary scaling review. They also organised escorts for those going out to appointments, watched out for and reported safeguarding incidents, and supervised community activity. The roles were reallocated by the community every month, so all had an opportunity to take on responsibility.

Community meetings took place four times a week. Clients could also request a community meeting if they had concerns about anything. They were encouraged to support each other and to challenge conduct deemed unacceptable by the community.

Staff actively engaged clients in planning their care and treatment; however, although recovery plans addressed clients' strengths, needs and goals, they were limited in detail.

Staff enabled families and carers to give feedback on the service via questionnaires and a suggestions box.

Requires improvement

Substance misuse services

Are substance misuse services responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

Clients were admitted from across England. All admissions were planned in advance and clients could access the service when they needed it. Admission criteria were clearly documented. The service was able to take urgent referrals quickly if necessary.

Clients were mostly referred via community substance misuse services. They completed pre-admission work in the community then underwent detoxification, before they were admitted for rehabilitation. This helped ensure their needs could be met and they were prepared for the rehabilitation process. Potential clients visited a minimum of three services before deciding where they would prefer to receive treatment.

Discharge and transfers of care

Staff planned for clients' discharge, including liaising with care managers. They supported clients during referrals and transfers, for example, if they moved to community services.

The facilities promote recovery, comfort, dignity and confidentiality

Clients had their own rooms where they could keep personal belongings safely. There were quiet areas for privacy and where clients could be independent of staff.

Clients were not expected to sleep in dormitories. Most bedrooms were shared; room sharing was part of the therapeutic model and was planned so that clients could support each other during their treatment. Sharing was between clients of the same gender.

There was a payphone that clients could use.

Clients' engagement with the wider community

Staff supported clients with activities outside the service. The provider had rented allotments in the local community and the clients were working on them. Every year, there was a group holiday where clients could participate in rural activities, such as dry stone wall building.

Staff supported clients to maintain relationships with people that mattered to them.

Meeting the needs of all people who use the service

The service was accessible to all who needed it and took account of clients' individual needs. The pre-admission process identified issues such as communication, cultural or dietary requirements. This helped ensure clients' needs could be met.

Staff used accessible rooms to see clients in, both for group work and individually. There were two accessible bedrooms on the ground floor.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Staff understood what they should do if a client raised a concern.

There was a complaints policy that provided guidance for staff. It set out how complaints were managed and lessons learnt acted upon to improve the quality of the service. This included discussion of complaints and outcomes at a formal business meeting.

There was a suggestions box that clients could use to make anonymous suggestions. They could also raise concerns at community meetings if they wished. Concerns raised informally were discussed openly and resolved by the community wherever possible.

There had been no formal complaints in the 12 months before this inspection.

Are substance misuse services well-led?

Requires improvement

Leadership

Requires improvement

Substance misuse services

Managers had the skills and abilities to run a service providing sustainable care.

The provider had a clear definition of recovery that all staff shared and understood. Managers had a good understanding of the service and they could explain clearly how the team was working to provide care. They were visible in the service and approachable for clients and staff.

Vision and strategy

The service aim was to enable clients to develop the skills they needed to make informed choices and decisions to support their personal recovery. This was achieved with involvement from staff, clients, and groups representing the local community.

Staff knew and understood the service vision and values, and they could explain how they were working to deliver care within the budgets available. They had opportunities to contribute to discussions about plans for the service, especially where the service was changing.

Culture

Managers promoted a positive culture that supported and valued staff. There was a clear sense of common purpose based on shared values.

Staff felt respected, supported and valued. They were positive and proud about working for the provider and with the team. They worked well together and where there were difficulties managers dealt with them appropriately. Staff appraisals included conversations about development and how it could be supported.

Governance

There was a systematic approach to delivery of care. The service was safe and clean, there were enough staff who were trained and supervised, clients were assessed appropriately, they were treated well, and admissions and discharges were planned.

Policies and procedures were reviewed regularly but some were generic and did not contain guidance that was specific to the service.

Discussion in handovers and team meetings ensured that essential information and learning was shared.

Staff undertook local clinical audits and staff acted on the results when needed. However, the provider had not identified the issues we found in care and treatment records. Risks identified through assessments were not formulated into individual risk management plans. Recovery plans did not set out clearly what clients needed to do to complete the recovery programme and how they were progressing through the recovery programme. Essential information contained in handover notes was not transferred to clients' individual records.

Data and notifications were submitted to external bodies as required.

Staff understood the arrangements for working with others to meet clients' needs.

The service had a whistle blowing policy.

Management of risk, issues and performance

The service had systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

Staff had access to the risk register. They could escalate concerns when required and submit items to be included on the risk register.

Where cost improvements were taking place, they did not compromise client care.

However, the guidance contained in the lone working policy was unclear and did not set out how risk would be mitigated.

Information management

Managers had access to information about the performance of the service, staffing and client care. This supported them in their management role.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care; for example, training was available online.

Staff made notifications to external bodies as needed.

Engagement

Clients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs.

Clients and staff could meet with the senior leadership team to give feedback.

Requires improvement

Substance misuse services

Leaders engaged with external stakeholders such as commissioners.

Learning, continuous improvement and innovation

The service assessed quality and sustainability impact of changes, including financial.

All staff had objectives focused on improvement and learning.

The provider had achieved the gold standard in Investors in People.

Outstanding practice and areas for improvement

Outstanding practice

Clients who were senior members of the therapeutic community had roles of responsibility such as gatekeeper, safeguarder and community leader. The provider gave clients training and guidance in these roles so they could carry them out effectively. Every month, the roles were reallocated by the client group, so all had an opportunity to decide who should take on responsibility, depending on the motivation they had shown in completing the recovery programme. Clients in these roles took part in handover meetings and the weekly disciplinary scaling review. They also organised escorts for those going out to appointments, watched out for and reported safeguarding incidents, and supervised community activity.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all essential information about clients' individual risk is contained in clients' individual records.
- The provider must ensure that risks identified through assessments are formulated into individual risk management plans.
- The provider must ensure that all essential information about clients' individual progress through recovery is contained in clients' individual records.
- The provider must ensure that all recovery plans set out clearly what clients need to do to complete the recovery programme and how they are progressing through the recovery programme.
- The provider must ensure their monitoring systems are robust and fit for purpose.

Action the provider SHOULD take to improve

- The provider should ensure that therapeutic interventions are reviewed regularly, with clients.
- The provider should ensure that the policy that provided guidance for staff working alone sets out how the risks of working alone are mitigated.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Risks identified through assessments were not formulated into individual risk management plans. Staff did not always record essential information about clients' individual risk in their individual records. This was a breach of regulation 12 (2) (c)

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider's governance systems had not identified the issues we found with care and treatment records. Recovery plans did not set out clearly what clients needed to do to complete the recovery programme and how they were progressing through the recovery programme. Essential information contained in handover notes was not transferred to clients' individual records. This was a breach of regulation 17 (1) and 17(2)(c)