

The Forward Trust

Clouds House

Inspection report

Clouds House
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location

Good



Are services safe?

Good



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

Overall summary

Clouds House is a residential substance misuse and addiction service offering detoxification and a therapeutic recovery programme.

We rated Clouds House as good because:

- The service provided a safe medically assisted detoxification and therapeutic recovery programme for clients with substance and alcohol dependency. The environment was clean and fit for purpose. Staff routinely carried out environmental assessments. Staff and clients were able to call for assistance if needed.
- The service had enough staff to safely meet clients' needs. Staff managed referrals well to ensure clients were suitable for admission. Staff had appropriate skills, knowledge and experience to provide the right care and treatment.
- Care plans were recovery-orientated and reflected the assessed needs of the client. Staff provided a range of clinical and therapeutic interventions suitable to the needs of clients that were informed by best practice guidance. Staff used a range of evidence-based assessments tools and outcome measures to support their practice.
- Staff assessed and managed risk well. The service had clearly defined and embedded processes in place to keep people safe. Staff had training on how to recognise and report abuse. The service had clear and robust policies in place for safeguarding adults and children.
- Staff worked well together as a multidisciplinary team and with relevant services outside the organisation to provide good handovers of care and treatment for clients. Staff told us that they felt supported in their role. The service manager was visible and approachable. Managers ensured that staff received supervision and annual appraisals.
- Staff treated clients with compassion and kindness and respected their privacy and dignity. Clients were fully involved in choices regarding their care and treatment. Clients told us they felt supported and well prepared in terms of understanding the 12-step model of recovery ethos.
- Staff planned and managed discharge well and ensured unexpected exits from treatment were managed safely. The service helped to identify alternative pathways for people whose needs it could not meet.
- The service provided a variety of forums for clients and staff to give feedback on the service and raise any concerns or complaints. The service monitored operational risk through a local risk register which staff could contribute to.

However:

- There was a lack of clinical oversight with regards to the review process, actions taken, and lessons learned from medication incidents. A recent external pharmacy quarterly report highlighted a lack of evidence of actions being undertaken for areas identified as a concern. The checklist in relation to medicines due to expire in 3 months was unclear in terms of what the dates were referencing, and the entries had not been signed off.
- The service did not have a controlled drug policy specific to residential accommodation (prison and community only) and the generic policy pre-dated the external pharmacy contract. Clinical staff were working from the Adverse Incident Policy dated September 2020 and were unaware of the revised policy dated April 2022.
- Some clinical staff reported a lack of clarity around the day to day, weekly or monthly oversight of the service and that some clinical information was not shared with the wider clinical team. The concern meant that there was a lack of clinical governance with regards, for example, the timely completion of clinical audits.
- The equipment checklist did not include the ECG machine or scales to monitor height and weight, therefore we were not assured staff were regularly checking the equipment was in working order before use.

Summary of findings

- The main clinic room was multifunctional and being used as a staff room. Clients received medicines alongside staff working or eating in the room. This meant that there was a risk of a confidentiality breach whilst receiving their medication and a lack of client privacy and dignity if staff not involved in medication administration were present.

Summary of findings

Our judgements about each of the main services

Service

**Residential
substance
misuse
services**

Rating

Good



Summary of each main service

We rated it as good. See the summary above for details.

Summary of findings

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Summary of this inspection

Background to Clouds House

Clouds house is a 38-bed residential substance misuse and addiction treatment centre for clients aged 18 years and over provided by The Forward Trust. At the time of the inspection there were 20 clients at the facility. The service is in Wiltshire and provides residential treatment for people with addictions, including alcohol and drug dependency, to clients across the country. The programme is based upon a modernised version of the 12-step model of recovery. This is a set of principles that assists people experiencing addiction by providing individual action steps.

The service accepts both private and statutory funded clients and where applicable, can access a charitable fund.

Clouds House is registered by the Care Quality Commission to provide the following regulated activities:

- Accommodation for persons who require treatment for substance misuse
- Treatment of disease, disorder or injury.

The service had a registered manager and nominated individual in place at the time of the inspection.

The service was previously inspected under a different provider in October 2018 and was rated good.

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

What people who use the service say

Clients were overwhelmingly positive about the service. Clients spoke highly of the care and treatment they received, their counsellors and other support staff including housekeeping and kitchen staff. Clients told us that staff went above and beyond to help them, were approachable, friendly and kind.

All clients told us the food was high quality.

How we carried out this inspection

The team that inspected this service on 24 January 2023 comprised of 2 CQC mental health inspectors and 1 specialist advisor. The specialist advisor had professional experience of substance misuse services.

The team that visited the service on 31 January 2023 comprised of 1 CQC mental health inspector and 1 specialist advisor.

Before the inspection, we reviewed information that we held about the service.

During the inspection, the inspection teams:

- Toured the service and completed checks on the safety of the environment
- Spoke with 6 clients using the service
- Spoke with the registered manager for the service
- Spoke with the head of residential services for The Forward Trust

Summary of this inspection

- Spoke with 11 other staff members; including three therapists, two qualified nurses, one health care assistant, the consultant psychiatrist, the GP, the team lead for the admissions team, the facilities manager and the clinical administrator.
- Spoke to the external pharmacist
- Attended 2 multi-disciplinary team (MDT) handover meetings
- Looked at 11 records relating to the care and treatment of clients
- Reviewed 5 prescription records
- Completed a check of the clinic room and medication stock
- Reviewed a range of policies, procedures and other documents relating to the running of the service.

You can find information about how we carry out our inspections on our website: <https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection>

Areas for improvement

Action the service **SHOULD** take to improve:

- The service should ensure that there is continuous and robust clinical oversight in place to effectively assess, monitor and improve the quality and safety of the services provided.
- The service should ensure that all equipment is properly maintained and that there are suitable arrangements in place for the renewal and replacement of equipment.
- The service should consider the compatibility of Forward Trust's controlled drugs policy with the specific requirements of the residential rehabilitation service.
- The service should ensure that staff are aware of the most up to date version of policies and procedures.
- The service should ensure that all client care plans are personalised and include specific, measurable, achievable, relevant and time bound (SMART) targets, including short and long-term goals and the steps required to achieve them.
- The service should review the multifunctional use of the clinical room and consider providing a dedicated area for staff and a clearly defined and separate area for clients to receive their medicines.
- The service should ensure that concerns identified in the external pharmacy quarterly review are addressed routinely.






Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Residential substance misuse services	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Residential substance misuse services

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

Is the service safe?

Good 

We rated it as good.

Safe and clean care environments

All clinical premises where clients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Safety of the facility layout

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. The service employed a dedicated facilities manager responsible for the oversight and management of estates, housekeeping, facilities and responding to environmental risk. An external company completed a review in December 2022 of the facilities, maintenance and compliance. The facilities manager had developed an action plan based upon this review and the recommendations were being completed. All health and safety audits had been completed and were up to date. There were evacuation chairs in situ and staff had received training on how to use them. We saw up-to-date risk assessments regarding fire evacuation.

The service managed risk and client safety where there was mixed sex accommodation. Male and female bedrooms were located on separate floors and had clear signage. There was a locked door between the male and female floors which was alarmed. Bedrooms were single sex and shared by up to 4 clients. Shared bedrooms enabled clients to utilise peer to peer support as part of the 12-step recovery program. There was a single occupancy bedroom located near to the medical centre.

Staff knew about any potential ligature anchor points and mitigated the risks to keep clients safe. Staff completed yearly ligature audits and ligature risks were clearly documented. The service had a current ligature policy. Client bedrooms were undergoing refurbishment. We viewed a recently completed bedroom that had some anti-ligature furniture and fittings. The bedrooms were not fully ligature-proof, but the risk of harm was mitigated by the exclusion policy in place and the low risk nature of the client group.

Residential substance misuse services

Staff had easy access to alarms and clients had easy access to call systems. Portable two-way radios were allocated to staff members on duty who responded to any concerns. Staff from reception, maintenance, nurses and doctors responded to any alarm raised.

Maintenance, cleanliness and infection control

Most areas were clean, well maintained, well-furnished and fit for purpose. However due to the age of the property some areas needed refurbishment. A five-year refurbishment program was underway to address this.

Staff made sure cleaning records were up-to-date and the premises were clean. Clients were responsible for keeping their bedrooms clean and tidy and were assigned house duties to maintain the communal areas.

Staff followed infection control policy, including handwashing. The service had enough hand washing facilities and hand sanitiser gel. The service completed hand hygiene and infection control audits. Staff disposed of clinical waste in identified bins.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. The clinic room was clean and tidy.

There were handwashing facilities. However only one sink out of three had taps for use by elbows. There was examination and monitoring equipment including an examination couch, blood pressure monitor and scales. There were facilities for taking blood samples. Emergency medications were kept in stock, including medicines used to reverse or reduce the effects of opioids and medicines used to treat serious allergic reactions.

Staff cleaned equipment. However not all equipment was checked and maintained by staff. The height and weight scales and ECG machine were not on the medical equipment check list.

Safe staffing

While the service did not have enough permanent and/or substantive staff, they used bank and agency staff who knew the clients well to keep people safe from avoidable harm.

Nursing staff

While the service did not have enough permanent substantive staff or support staff they used bank and agency to provide a safe service. The service had in post registered nurses, including an advanced nurse practitioner, health care assistants, qualified counsellors, a consultant psychiatrist, and a GP. The service was staffed 24 hours a day, 7 days a week, by at least 1 registered nurse and 1 health care assistant. There was comprehensive on call cover.

No incidents had been identified due to staffing levels. However, there were 5 qualified nursing post vacancies, including the clinical services manager post and 1 vacant health care assistant post. The service was actively recruiting to these vacancies. A job offer had been made and accepted for the clinical services manager post and a further job offer had been made to one of the qualified nurse vacancies.

Residential substance misuse services

Managers were reliant on bank and agency staff however they requested staff familiar with the service. Agency staff familiar with the service were block booked to ensure consistency of care to clients. The service had onsite staff accommodation available at no cost to the staff member.

Managers made sure that agency and bank staff worked alongside a permanent staff member and that they understood the service before starting their shift. However, there was no formal induction in place for agency or bank staff. The registered manager was developing an induction checklist for agency staff at the time of the inspection.

The service had experienced a high turnover of clinical staff following a change of provider. This was reducing and staff turnover was more settled.

The service reported very low levels of sickness, less than 3% over the last 12 months. Arrangements were in place to ensure client safety in the event of staff sickness and absence.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. A fixed 4 week rolling rota for permanent clinical staff was in place. This helped identify staffing gaps and promoted fairness and equitable cover of shifts.

The manager could adjust staffing levels according to the needs of the clients. Staffing levels and client needs were discussed at least twice daily at multidisciplinary team (MDT) handover meetings and shift to shift handovers. The manager was able to bring in extra staff to respond to changing risks to clients, including medical emergencies and deteriorating health and wellbeing.

Clients had regular, weekly one to one sessions with their named counsellor. Clients were also able to request one to one time with their named counsellor as and when needed.

Clients rarely had activities cancelled, even when the service was short staffed. The service had contingency plans in place to provide cover.

Staff shared key information to keep clients safe when handing over their care to others. The service had twice daily handover meetings attended by clinical and counselling staff. The meetings updated staff on clients care and treatment as well as any changes to risk or incidents. We observed 2 of these meetings. They were detailed, well-structured and fit for purpose.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to see clients quickly in an emergency. The service had a permanent GP with a special interest in substance misuse and a permanent consultant psychiatrist who provided onsite cover between them 5 days a week. Both the GP and the consultant psychiatrist could be contacted in an emergency via the on-call rota and could be onsite within 2 to 3 hours. The medical on-call rota was supplemented by 4 further GPs. Clients described being able to see medical staff at any time, including evenings and weekends. There was also an advanced nurse practitioner who was a non-medical prescriber. The medical team were able to accompany clients to a local general hospital if necessary and stay with them.

Mandatory training

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Staff had completed and kept up to date with their mandatory training. Eighty-seven per cent of permanent staff had completed mandatory training. The mandatory training programme was comprehensive and met the needs of clients and staff. The training program included infection control, safeguarding adults and children, Mental Capacity Act, data protection and confidentiality. All staff we spoke with could describe the mandatory training they had attended and knew when their refresher courses were due for completion.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to clients and staff

Staff screened clients before admission and only admitted them if it was safe to do so. They assessed and managed risks to clients and themselves well. They responded promptly to sudden deterioration in clients' physical and mental health.

Assessment of client risk

Staff completed risk assessments for each client during the pre-admission stage and on arrival, using a recognised tool, and reviewed this regularly, including after any incident.

The admissions team completed an initial risk assessment at the pre-admission stage and clients were screened against the service exclusion policy. Some clients were offered preparatory pre-admission sessions to fully understand the treatment program and this enabled staff to reduce the risk of inappropriate referrals.

Managers held an admission planning meeting every Monday. This was an MDT meeting which reviewed risk assessments and how to mitigate any identified risks.

Upon admission and to avoid duplication in the risk assessment process one clinician was identified to complete the clients' comprehensive risk assessment. The risk assessment was then reviewed and updated on a weekly basis and following any incident.

We reviewed 11 client care records overall. We found that no stand-alone client risk assessment was used. Risk assessments formed part of the wider comprehensive assessment and risk assessment and management plans were not always complete. The manager advised that the service had developed and were looking to introduce their own separate risk assessment tool.

However by the time we revisited the service we found that the new separate risk assessment tool had been implemented and was on the electronic management system. Client records had been updated together with a review of all risks. There was a flagging system embedded in the new risk assessment to highlight specific concerns such as safeguarding.

Management of client risk

Staff knew about any risks to each client and acted to prevent or reduce risks. Staff were knowledgeable about client risk and risk issues were discussed during twice daily MDT meetings. However, risk assessments did not always include

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enough detail on how to manage the identified risks or identify steps for staff to take to reduce them. Although it was clear from talking to staff and reviewing notes elsewhere in the electronic client records that staff knew how to manage client risk. We were also given examples of how staff responded when a client experienced suicidal ideation and self-harm behaviours.

The service had a zero-tolerance policy on aggression and violence. Client self-regulation was encouraged. Clients had therapeutic contracts which formed part of their written condition of treatment within the service with clear guidelines on expectations required to remain in treatment. Part of the pre-admission screening included previous history of violence and aggression.

Debriefs were held with staff and clients following any adverse incident to explore what went well and identify areas of learning/improvements.

When clients were detoxing from alcohol, staff closely supervised them. Staff completed a chart with the alcohol detox programme clearly laid out. Staff monitored clients for symptoms of alcohol withdrawal using a recognised alcohol-withdrawal tool. Staff we spoke with, and records confirmed, that staff were very knowledgeable about any adverse symptoms including action to take in the event of a person having a seizure. The service had medical and nursing staff onsite.

Staff identified and responded to any changes in risks to, or posed by, clients. If risks escalated clients could be placed on enhanced observations. The service also had an observation room opposite the medical centre and clients could be accommodated there with 24-hour observations.

Weekly meetings were held to discuss whether the placement was working for the client or if they needed to be referred to another service which could accommodate their needs better.

All clients had contingency plans in place in case of unexpected early exit from treatment. Clients received a harm reduction briefing. Naloxone training was provided to the client if indicated. Naloxone is a life-saving medication used to reverse the effects of an opiate overdose. Significant risk to client's safety and wellbeing were reported to the police. Community mental health teams were informed and the clients GP. The service ensured that clients were safely transported to their discharge address.

Staff followed procedures to minimise risks where they could not easily observe clients. The service was based in a large building across four floors. Due to the low risk nature of the client group it was not always necessary for staff to be able to observe clients at all times. However, staff were present in all communal areas and clients spent much of their day engaging with them during one to one sessions, group sessions and other activities.

Staff did not carry out searches. However, the service had policies and procedures in place to keep clients safe from harm. Clients were provided with a list of banned articles prior to admission. Upon arrival clients were helped to unpack and any prohibited items were removed from their belongings and secured in a locked cupboard. This was a collaborative process that clients were aware and gave consent to. All clients we spoke to understood this was to keep themselves and others safe from harm.

Use of restrictive interventions

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Staff ensured that the rules and boundaries that were in place as part of the client's therapeutic treatment did not restrict client choice. The rules and boundaries that could be perceived as restrictive practice were under constant review and were clearly explained and conveyed to clients during the pre-admission assessment. However, this was not documented as a policy.

We saw the restrictive practice review log embedded in the minutes of the monthly treatment team's communication meeting. Any potentially restrictive practices were reviewed monthly and changes were made accordingly. Examples of recent changes included providing regular mobile phone slots to clients who, for example, need to place orders, access personal accounts, make calls from their mobile phones, conduct education / business from their phones.

Safeguarding

Staff understood how to protect clients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. The service had a designated safeguarding lead (DSL), the DSL had completed level 3 and level 4 safeguarding training. All staff were kept up to date with their safeguarding training, 94% of all staff had completed mandatory level 2 safeguarding training and 2 members of staff had completed level 3 safeguarding training.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. We saw examples of this documented in the safeguarding log maintained by the service. These included contact with the local authority and the Multiagency Safeguarding Hub (MASH). Staff were able to differentiate between clinical risk and safeguarding concerns.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

The Forward Trust had a designated safeguarding leads forum which was attended by the DSL at Clouds House. The forum shared complex cases and best practice.

Staff could give clear examples of how to protect clients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff followed clear procedures to keep children visiting the service safe. The visitor policy included guidance on visits by children under 16 years. Child visits were always supervised by an accompanying adult. Visits took place in a designated room away from other clients. Child visits were subject to risk assessment by children and family's team if a child was in care.

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records.

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Client records were comprehensive, and all staff could access them easily. Records were stored securely on an electronic management system that staff had a log-in and password to access. Some intermittent connectivity issues were reported, but a back-up system was in place with dongles available, and staff could connect to wi-fi hotspots on their work mobiles. Paper records were available if required. Any paper notes were scanned and uploaded to the electronic system.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each client's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely. Clouds House had a medicine management policy in place. The service had a contract with an external pharmacy, prescribing was monitored and audited monthly by the external pharmacy. The service had electronic prescribing in place. Staff used dongles to access the system if connectivity was an issue. However, there was no back up system provided by the external pharmacy although prescriptions could be downloaded.

We reviewed the external pharmacy quarterly medicine report. Staff confirmed that no action had been taken in relation to concerns raised. This meant that there were outstanding issues that had not been addressed. This was the role of the clinical services manager who had left the service and staff were unaware of the process. Following the inspection the service appointed a new clinical services manager who will be taking responsibility for addressing clinical concerns arising from the quarterly medicine reports and clinical audits.

Staff administered all medicines and recorded when medicines were taken by clients or if a dose was missed or refused. Medicines errors and incidents were reported electronically.

The service had a generic controlled drug policy. The policy was not specific to residential accommodation and included reference to prison and community services only and pre-dated the external pharmacy contract, so the details were not up to date. The service had a controlled drug licence although this was not on display and had not been viewed by the external pharmacist. The external pharmacist completed a quarterly controlled drug stock take. The controlled drug register was clear, accurate and up to date.

The service completed a weekly medical equipment checklist which included emergency drugs, first aid and emergency medication bag. There was a dedicated checklist in relation to medicines due to expire in three months. However, it was unclear in terms of what the dates were referencing, and the entries had not been signed off.

Medicine on discharge (TTOs) were ordered through the external pharmacy.

The service had processes in place for the safe disposal of unwanted and unused medication.

Staff reviewed each client's medicines regularly and provided advice to clients and carers about their medicines. The external pharmacist visited monthly and checked medicines remotely on a weekly basis. The pharmacist was also able to log on daily and responded to any needs raised on the system. The medical centre on site was staffed by a minimum of 1 registered nurse and 1 health care assistant 24 hours a day 7 days a week. Clients were able to seek medical advice at any time, day or night.

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Staff completed medicines records accurately and kept them up to date. We reviewed 5 client prescription charts. All prescriptions were signed and dated; consent forms completed. PRN (as required) medicines were listed and reviewed daily by clinicians.

Staff stored and managed all medicines and prescribing documents safely. All controlled drugs were stored safely and securely. Keys to the controlled drug cupboards were kept in key safes that only authorised staff could access. Clients named medicines and stock medicines were in locked cupboards with padlocks in the main clinic room.

Staff followed national practice to check clients had the correct medicines when they were admitted, or they moved between services. Medicines reconciliation was completed with GP notes prior to the client's admission to the service. Medications not in stock were ordered via the external pharmacy prior to admission.

Staff did not always learn from safety alerts and incidents to improve practice. Clinicians had regular meetings where information was shared. Medicine incidents were recorded online. We reviewed 3 recorded medicines incidents, including a medicine error and incorrect medicine dispensed. However, while medicine incidents had been reported in line with the adverse incident policy, within 24 to 72 hours, there was a lack of oversight with regards to the review process, actions taken, and lessons learned.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. A clinician completed checks on admission for excessive use of multiple medicines and over prescribing. Any concerns were reviewed by one of the doctors. The prescribing app had the ability to flag up contra indicated drugs and drug interactions.

Staff reviewed the effects of each client's medicines on their physical health according to NICE guidance. Dependency status and physical and mental well-being was assessed prior to any prescribing. Assessments were comprehensive and carried out by clinicians qualified in the addiction's speciality. Facilities were in place to carry out required tests, including blood tests.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

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

Staff knew what incidents to report and how to report them. The service had an adverse incident policy in place. Incidents were recorded by all permanent staff on an electronic tool.

Staff understood the duty of candour. They were open and transparent and gave clients a full explanation when things went wrong.

Managers debriefed and supported staff and clients after any serious incident.

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Managers investigated most incidents thoroughly. However, we found that some clinical incidents lacked oversight of the review process, actions taken, and lessons learned. Examples we found included the wrong medicine being dispensed to a client. Notes did not document how this incident was responded to or actions taken to mitigate future risk. Evidence of actions taken for areas identified as a concern in the quarterly pharmacy medicine report was also lacking.

Staff received feedback from investigation of client safety incidents. Lessons learned were collated and shared at monthly team meetings. Patterns and themes were identified and cascaded to all staff.

Staff met to discuss the feedback and look at improvements to client care. Managers told us that learning from lessons were discussed to make sure that action was taken to improve client safety. Whilst we saw evidence of client safety improvements highlighted in the minutes of the quarterly governance meetings, we did not find evidence of this in relation to some clinical incidents.

Is the service effective?

Good 

We rated it as good.

Assessment of needs and planning of care

Staff completed comprehensive assessments with clients on admission to the service. They worked with clients to develop care plans and updated them as needed. While care plans reflected the assessed needs and were recovery orientated, they were not always personalised. Some care plans were generic and did not contain specific, measurable, achievable, relevant and time bound (SMART) targets, including short and long-term goals and the steps to take to achieve them.

Staff completed a comprehensive assessment of each client. Staff completed pre-admission assessments with all clients following receipt of referrals. A more comprehensive assessment was completed following admission. All care records we reviewed contained a client history, a detailed assessment of current need, a risk assessment, a crisis plan and clearly documented evidence of patient involvement.

All clients had their physical health assessed soon after admission. These were regularly reviewed during their time at Clouds House. The service had an onsite 24-hour medical centre with comprehensive clinical staffing arrangements to assess and monitor clients' physical health.

Staff did not always develop care plans that contained SMART targets for each client. We reviewed 11 care plans out of the 20 clients during the inspection visits. Whilst care plans were recovery orientated, some care plans were generic. For example, not all care plans contained personalised steps and actions in the management of self-harm behaviours or a mental health crisis.

However, we saw that staff regularly reviewed and updated care plans when clients' needs changed. Staff reviewed patients' care plans and risk assessment weekly.

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Staff recorded clients' consent to share and code of conduct in their care records. All 11 records we reviewed contained signed consent and code of conduct forms.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the client group and consistent with national guidance on best practice. They ensured that clients had good access to physical healthcare and supported clients to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audits, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the clients in the service. Staff delivered care in line with best practice and national guidance. The service offered supervised withdrawal from alcohol and drug dependency if needed. There was a structured recovery and rehabilitation programme which included psychosocial interventions. Staff supported clients' in line with "Drug misuse and dependence: UK guidelines on clinical management (2017)" and guidance from the National Institute for Health and Care Excellence.

The service provided treatment for clients' which included psychological approaches to managing addiction and relapse prevention. This helped them to understand and change for example, their behaviour, rehabilitation and occupational activities, training and work opportunities intended to help with acquired living skills.

Clients accessed individual counselling, interpersonal group therapy, creative activities such as art therapy and dance movement and physical activities including gardening and a walking group.

Clients were also able to access complimentary therapies such as; acupuncture, reflexology and massage.

The service supported clients to develop life skills relevant to their individual needs. For example, debt management, improving health and hygiene, cooking lessons and nutrition, harm reduction, anger management, and emotional regulation.

Staff identified clients' physical health needs and recorded them in their care plans. All clients received a full physical examination on admission. This provided a baseline for on-going monitoring. This was recorded in the clinical notes.

Staff made sure clients had access to physical health care, including specialists as required. Physical health screening was routinely offered. The service made sure that clients had access to dentists and opticians as required.

Staff met clients' dietary needs and assessed those needing specialist care for nutrition and hydration. Clients often arrived at the service malnourished. The catering staff were familiar with each client and their nutritional needs including those undergoing detox or with an eating disorder. The menu catered for all types of diet, offered choice and was described by clients as being of high quality with a focus on good nutrition and healthy choices.

Staff helped clients live healthier lives by supporting them to take part in programmes or giving advice. Every 3 weeks the advanced nurse practitioner delivered a health lecture to clients that covered topics such as harm reduction, abstinence and nutrition.

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Staff used recognised rating scales to assess and record the severity of clients' conditions and care and treatment outcomes. Medical staff used nationally recognised tools to assess the acuity of a clients' withdrawal symptoms and used these to assist during detox. The service specifically used the Clinical Institute Withdrawal Assessment (CIWA-r) and the Severity of Alcohol Dependence Questionnaire (SADQ) for alcohol scale and the Subjective Opiate Withdrawal Scale (SOWS).

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Staff were involved in several quality improvement projects, including, participation at the Wiltshire dual diagnosis forum, designated safeguarding lead (DSL) forum and the choices forum. The clinical administrator completed clinical audits which were reviewed by the manager. However, staff reported they did not always receive feedback from these.

Skilled staff to deliver care

The teams included or had access to the full range of specialists required to meet the needs of clients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the clients. The service provided a specialist onsite medical team including a consultant psychiatrist, GP, advanced nurse practitioner, registered nurses and health care assistants and a clinical administrator. Prescribers were knowledgeable and demonstrated expertise in this area. There were appropriately trained, qualified and competent staff to administer medicines.

The service had a therapy team comprised of qualified addiction counsellors, including an art therapist. In addition, the service had a dedicated admission team, a family and aftercare team and a client finance and welfare officer onsite.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the clients' in their care, including bank and agency staff. The service followed a safe recruitment process. All staff had pre-employment checks including criminal record (DBS) checks.

Managers gave each new member of staff a full induction to the service before they started work. The service had a comprehensive induction program for permanent staff which included an induction checklist completed over several weeks from the start of their employment. The induction programme was a combination of online training and on the job training. However, there was no formal induction process for agency and bank staff. Following the inspection, the manager told us the service had finalised the structured induction for agency staff and that this had been implemented.

Managers supported staff through regular, constructive appraisals of their work. All staff received supervision, both group and individual and received an annual appraisal. We saw staff supervision notes recorded on the computer system. The line management supervision rate over the last 12 months was 81%.

The clinical team received monthly supervision. However, some clinical staff reported that supervision was infrequent and unplanned. The clinical supervision rate over the last 12 months was 79%. The therapy team had access to a weekly group supervision and received clinical supervision externally which was funded by the provider. Staff appraisals included structured questions on performance, wellbeing and training needs. Managers also had an open-door policy and offered informal staff check-ins.

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Managers made sure staff attended regular team meetings or gave information to and from those that could not attend. Weekly client community meetings were represented by a staff member from each discipline. The service held monthly staff leaders' meetings. Monthly meetings for the whole staff group were due to restart once the current recruitment had been completed.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Training needs were identified through supervision and appraisals. Training opportunities were also identified at quarterly governance meetings.

Managers made sure staff received any specialist training for their role. Staff described the training programme available to them as comprehensive. They had access to specialist and additional training suitable for their role and interests. Agency staff received appropriate training through their agency and were invited to attend additional training by the service. Leadership training was available to staff with management responsibilities.

Managers recognised poor performance, could identify the reasons and dealt with these. Any concerns were raised to the relevant line manager or if not deemed appropriate to another manager from a different discipline. Staff were offered support and a performance improvement plan developed. This was reviewed regularly. There was a disciplinary process in place if required.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit clients. They supported each other to make sure clients had no gaps in their care. The team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss clients and improve their care. Daily morning handover meetings were attended by all disciplines and the registered manager. Afternoon handover meetings were held between the clinical and therapy team.

Staff made sure they shared clear information about clients and any changes in their care, including during handover meetings. We observed 2 multi-disciplinary team (MDT) meetings and saw that discussions focused on client care and sharing risk information. Staff processing meetings and shift handovers enabled further client information to be shared amongst the staff team.

Teams within the service had effective working relationships with other teams in the organisation. Clouds House was able to link with other teams within The Forward Trust to share information, access training and support and share good practice.

The service had effective working relationships with external teams and organisations, including local authorities, families and children services, community mental health teams, maternity services and local mutual aid organisations.

Good practice in applying the Mental Capacity Act

Staff supported clients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for clients who might have impaired mental capacity.

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The service provided treatment to people deemed to have the capacity to consent at the point of referral and acceptance to the service was based upon this. This formed part of the Clouds House Exclusion Policy.

There was a clear policy on Mental Capacity Act which staff knew how to access.

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of the five principles. Staff were able to explain how mental capacity was relevant to their client group. Staff explained that clients would not be admitted to the service if they lacked capacity to consent to the programme.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). Following admission any concerns in relation to a clients' capacity were discussed with the registered manager and consultant psychiatrist.

Staff gave clients all possible support to make specific decisions for themselves. Clients we spoke with understood their treatment and care, and had made informed choices about the necessary restrictions, such as limited access to their mobile phones to promote attendance on the programme. They knew that they were free to leave at any time.

Staff assessed and recorded capacity to consent clearly each time a client needed to make an important decision. We saw staff recording clients' capacity to consent in their care records.

Staff made applications for a DoLS authorisation only when necessary and monitored the progress of these applications. If a DoLS was required, then the client was discharged and transferred to a more appropriate service. This was included in Clouds House exclusion criteria. The manager highlighted a recent example of a client assessed as having dementia. The client was transferred to a more appropriate service in line with their individual needs.

Is the service caring?

Good 

We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated clients with compassion and kindness. They respected clients' privacy and dignity. They understood the individual needs of clients and supported them to understand and manage their care, treatment or condition.

Feedback from clients was overwhelmingly positive about the way they were treated by staff.

Staff were polite, respectful, and responsive when caring for clients. Clients told us that all staff were friendly and understanding. Relationships between clients and staff were strong, caring, respectful and supportive. Clients described having excellent relationships with their counsellor. Staff we spoke with were passionate and highly motivated and inspired to provide high quality care that was recovery focused.

Staff gave clients help, emotional support and advice when they needed it.

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Staff supported clients to understand and manage their own care treatment or condition. Staff promoted self-help and client empowerment. This was embedded in the ethos of the 12-step recovery model. Clients' told us they were encouraged and supported to take ownership of their own recovery and that staff gave them back responsibility for themselves.

Staff directed clients to other services and supported them to access those services if they needed help. The service had a dedicated finance and welfare officer onsite. Clients were supported to access community self-help groups as part of their recovery, including alcoholic anonymous (AA) and narcotics anonymous (NA) groups.

Clients said staff treated them well and behaved kindly. Clients told us that staff paid attention, were consistent, always had time for them and were never in a rush. Clients felt safe in the service. Clients felt that the service provided truly person-centred care.

Staff understood and respected the individual needs of each client. Clients told us that staff treated them with dignity and respect. They told us they received personalised care that focused on their wellbeing and that they felt truly valued as individuals. Clients stated that staff had clear boundaries in place to support their care and treatment.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards clients. Staff were aware of the whistleblowing policy and the equality, diversity and inclusion policy.

Staff followed policy to keep client information confidential.

Involvement in care

Staff involved clients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that clients had easy access to additional support.

Involvement of clients

Staff introduced clients to the service as part of their admission. Some clients were offered pre-admission preparatory sessions to familiarise themselves with the 12-step recovery model. Upon admission clients were supported by staff and peers in orientating themselves to the service and the surroundings.

Staff involved clients and gave them access to their care planning and risk assessments. All clients we spoke with said they were actively involved in their treatment and therapy options. Staff were involved in continuously reviewing and setting goals. All care plans reviewed were person-centred and showed patient involvement. Clients were able to receive paper copies of their care plans.

Staff made sure clients understood their care and treatment (and found ways to communicate with clients who had communication difficulties). Clients said they were involved in detailed discussions about their recovery, the options for treatment, including risks and benefits of the proposed treatment. Client care records reflected this.

Staff involved clients in decisions about the service, when appropriate.

Clients could give feedback on the service and their treatment and staff supported them to do this. The service routinely sought feedback from clients. Clients could provide feedback in several different ways, by completing a feedback form

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for each part of the service from pre-admission to discharge, through a complaints and compliments form or via an anonymous suggestion box. Weekly community meetings gave clients an opportunity to talk about any issues as well as airing their views and ideas. The information was collated monthly by the manager and used to improve the service. Feedback was provided to clients at weekly community meetings.

Staff supported clients to make advance decisions on their care. Clients were supported by their individual counsellor throughout their treatment to develop crisis plans and contingency plans these included advance decisions made by the client.

Staff made sure clients could access advocacy services. Information was displayed on the noticeboard and support was available via the finance and welfare officer onsite.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Staff obtained client consent prior to involving family members and carers. The service had a dedicated family and aftercare team onsite. They were able to provide individual support to family members and carers. The team could facilitate 3-way meetings between clients and their families. They also offered a regular weekly family support group.

Staff helped families to give feedback on the service.

Staff gave carers information on how to find the carer's assessment.

Is the service responsive?

We rated it as good.

Access and discharge

The service was easy to access. Staff planned and managed discharge well. The service had alternative care pathways and referral systems for people whose needs it could not meet.

Bed management

The service did not restrict the occupancy to the service. Acceptance and admission to the service was regularly reviewed and was based on risk and clinical cover. This ensured the safety of clients being admitted to the service. The service did not have a waiting list.

Managers regularly reviewed length of stay for clients to ensure they did not stay longer than they needed to. The service offered a flexible and adaptable approach to length of stay in line with assessed client need and their progress. The average length of stay was 6 to 12 weeks.

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The service accepted referrals from local and out of area commissioners. The service also accepted privately funded clients.

Managers and staff worked to make sure they did not discharge clients before they were ready. The service did not discharge clients unless there was a safe discharge plan in place. This included clients who left the programme before completion.

Staff did not move or discharge clients at night or very early in the morning. Planned discharges took place in the mornings.

Discharge and transfers of care

Staff carefully planned clients' discharge and worked with care managers and coordinators to make sure this went well. From the point of the pre-admission assessment discharge was discussed, including accommodation and second stage treatment. Clients received a discharge planning help pack and more definite discharge arrangements were made at the halfway stage of their treatment.

The service had a dedicated finance and welfare officer who assisted clients with housing, employment, training and state benefits and a dedicated aftercare team who arranged ongoing support for clients, either face to face or virtual. Staff worked closely with care managers and clients' families to ensure safe discharge plans were in place.

Clients attended a graduation ceremony upon completion of the programme and could invite family members and professionals involved in their care from external organisations. This provided a complete ending to their treatment.

The service had a successful alumni society which clients could join. There was an annual alumni event held at the service.

Staff supported clients when they were referred or transferred between services.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the service supported clients' treatment, privacy and dignity. Each client shared a bedroom with up to four other clients and could keep their personal belongings safe. There were quiet areas for privacy.

Clients were able to personalise their bedroom space and had access to their own personal safe where they could store personal possessions.

The service had a full range of rooms and equipment to support treatment and care. Staff and clients could access the rooms. During the day, clients accessed the onsite group and therapy rooms. There was a range of activities and equipment available including musical instruments, DVDs, books, jigsaws and board games for recreational activities. Clients were able to access their bedroom during the day if needed.

The service had quiet areas and several rooms where clients could meet with visitors in private. This included both inside the building and in the grounds.

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Clients could make phone calls in private at pre-arranged times. Clients needed to request access to their mobiles to make calls and used a daily sign-up sheet located on the noticeboard. Pay phones were provided which were in small private rooms.

The service had outdoor space that clients could access easily. The grounds were extensive and well maintained. There were 3 outdoor pods available for clients to use which were heated and had electricity. Outdoor games equipment was also available. There was a balcony off the communal lounge that could be used for smoking as well as an outside shelter. There was also provision for non-smokers to exclusively use the balcony.

Clients could make their own hot drinks and snacks and were not dependent on staff. Clients had access to a pantry where they could make their own drinks and snacks. However caffeinated drinks were restricted after lunchtime as part of the pre-admission agreement. Clients were able to request caffeinated drinks after this time, but this was not encouraged. Clients were also encouraged to remain in their bedroom between 11pm and 6am to promote healthy sleep hygiene.

The service offered a variety of good quality food.

Meeting the needs of all people who use the service

The service met the needs of all clients, including those with a protected characteristic or with communication needs.

People's individual needs and preferences were central to the delivery of tailored services.

The service could not accommodate disabled people. The building was not accessible to clients who used wheelchairs or who had limited mobility. Exclusion criteria set out guidance on admission for clients with reduced mobility. A ramp had been built for access into the main building, however the building had no further adjustments for disabled access. The service was able to signpost people whose needs they could not meet to alternative services.

The service could accommodate those with communication needs or other specific needs. The service had used a mobile app to support a client who was deaf.

Staff made sure clients could access information on treatment, local service, their rights and how to complain. There was information available and displayed on a noticeboard relating to support groups, local services and health-based information.

The service had information leaflets available in languages spoken by the clients and local community. Leaflets were available in different languages, different formats and on different types of paper.

Managers made sure staff and clients could get help from interpreters or signers. This was discussed at the pre-admission stage. However, managers told us that due to the confidential nature of the treatment program the service was unable to provide translators or signers for the duration of the clients' admission.

The service provided a variety of food to meet the dietary and cultural needs of individual clients. Dietary needs were discussed at pre-admission and the chef met with clients upon admission to discuss individual need. Clients were able to choose their own meal for the chef to prepare on Saturdays.

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Clients had access to spiritual, religious and cultural support. There was an onsite multi faith room with areas set aside for different faiths. Links had been established within the local community to enable clients to access places of worship.

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 the whole team and wider service.

Clients, relatives and carers knew how to complain or raise concerns. Clients were given information about how to complain in their induction folder together with complaints forms, feedback forms and compliment forms. Clients could offer feedback or raise a complaint at any time to any member of staff in any format they chose.

The service clearly displayed information about how to raise a concern in client areas. Information was displayed on the noticeboard.

Staff understood the policy on complaints and knew how to handle them. Staff responded promptly to acknowledge client concerns, offer an apology and outline the investigation process. Staff recorded complaints on an electronic recording system.

Managers investigated complaints and identified themes. An investigator was appointed, and an initial response was provided to the client within 48 hours. A full fact-finding investigation was completed, and a decision based upon the evidence was conveyed to the client. Clients can appeal as per the complaints policy.

Staff protected clients who raised concerns or complaints from discrimination and harassment. Managers told us that all investigations were kept confidential. There was a suggestion box for anonymous feedback, concerns and complaints. The service had a clear equality, diversity and inclusion policy. A whistleblowing policy was also in place. CQC information on raising a complaint was also displayed.

Staff knew how to acknowledge complaints and clients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

The service used compliments to learn, celebrate success and improve the quality of care.

Is the service well-led?

We rated it as good.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for clients and staff.

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Managers reported that they received regular visits from the Board of Trustees and senior leaders.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

Staff were consulted through an online forum regarding the development of the new Forward Trust's vision, mission and values. All the information was collated and adopted. All staff we spoke to described the same ethos of recovery and we saw this was embedded in the way staff treated one another and their clients.

Culture

Staff felt respected, supported and valued. The service recognised staff contributions through annual staff awards. All staff spoke highly of the service manager and described them as being very approachable, supportive and accessible. They said the provider promoted equality and diversity in daily work and provided opportunities for development and career progression. Staff said they were encouraged and supported to build and develop their professional skills with opportunities for in-house career progression. They could raise any concerns without fear. Staff described the service as nurturing with a focus on wellbeing.

Staff surveys were used by the service to enable staff to feedback on areas such as wellbeing, flexible and hybrid working and pay and reward. The results were collated and used to improve staff benefits, an example of this included offering staff a more flexible approach to hybrid working to support them in managing their own individual circumstances when required.

Governance

Our findings from the other key questions demonstrated that most governance processes operated effectively at team level and that performance and risk were managed well.

Managers did not always have a clear and robust system in place to ensure clinical oversight. For example, there was no evidence of a clinical review process, actions taken, and lessons learned with regards to medicine incident reporting. The external pharmacy quarterly medicine report showed no evidence of actions being undertaken for any areas identified as a concern. The controlled drug policy was generic and contained no reference to residential accommodation, it also pre-dated the external pharmacy contract.

In the absence of a dedicated clinical services manager there was lack of clarity amongst the clinical staff group regarding responsibility for clinical oversight. Staff told us this included delegation of day to day duties and weekly or monthly oversight of the service. For example, the clinical administrator identified that the monthly pharmacy audit had not taken place and arranged for this to be completed. It was clear that some clinical staff carried out individualised work and this had not been shared with the wider clinical team.

However following the inspection the service employed a clinical services manager to address the identified gap in the provision of robust clinical oversight, acting on clinical audits and ensuring effective systems and processes are in place in terms of clinical governance.

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The remaining governance policies, procedures and protocols were regularly reviewed and were up to date. There were systems in place to check performance and compliance with the assessment, planning and evaluation of clients' care and treatment.

There were effective ways of monitoring the service and routes for raising concerns. Managers completed a range of audits to ensure that the service was safe and effective such as health and safety, cleanliness, client involvement and care file audits.

Managers attended a quarterly governance review meeting.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

There was a strong commitment to best practice performance and risk management with problems identified and addressed quickly and openly. Each client had a personal risk assessment which was updated weekly. The staff team had quarterly performance management supervision and annual appraisals.

The managers maintained a risk register and items on the register matched concerns raised by staff. A monthly communication bulletin was distributed to all staff.

Key performance indicators (KPIs) were in place for the service to enable strategic goals to be measured effectively. The audit schedule was being reviewed at the time of the inspection to ensure performance measures were completed in the required timeframe. We saw the clinical service action plan which included continuous review of policies and protocols to ensure best practice.

Managers attended a regional quarterly service review meeting. Information on service improvement and development was shared with staff via a monthly staff bulletin.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities. The manager had access to a dashboard for the service that gave information on service performance in areas such as staff training and incident reporting. However, some staff described the current IT system connectivity as being reduced at times. The IT infrastructure was being refreshed to address this.

Engagement

Managers engaged actively with local and broader health and social care providers and commissioners to ensure that there was an integrated system that met the needs of the client group. Managers attended a monthly quality of service forum.

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Managers gathered feedback from clients, and there was a demonstrated commitment to acting on feedback. Staff, clients and carers had access to up to date information about the work of the service through the internet, notice boards and leaflets. Clients and staff held weekly community meetings at which they could give feedback about the service. Clients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. The service carried out regular staff surveys.

Learning, continuous improvement and innovation

The service had an established approach and commitment to innovation and improvement. The manager participated in a local safeguarding forum and the service had developed their own in-house stand-alone risk assessment. The service had a named Equality, Diversity and Inclusion champion within the team to respond to areas of development at Clouds House including the lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI) community.

The service had taken part in trialling a pilot programme designed and created by the Families and Young People's Directorate within Forward Trust. This is an evidence-based programme with outcome measures focussed on learning about how an individual relates to others. Clouds House had provided the data and feedback from participants to enable the pilot programme to be progressed across the whole organisation.

The service offered bursary treatment via donations from fundraising for clients who might not otherwise be able to access treatment due to insufficient financial means.

Other examples of improvement and innovation included:

- Providing pre-admission preparatory sessions
- Employing a dedicated finance and welfare officer
- Providing a dedicated Family and Aftercare team.