Cranstoun - Trelawn House

Quality Report

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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

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.

Overall summary

We do not currently rate independent standalone substance misuse services.

We found the following issues that the service provider needs to improve:

- Medicines management was unsafe. Multiple medicine errors had occurred. Staff were not assessed as competent to dispense medicines.
- Risk information was not always appropriately recorded or detailed. Clients did not have risk management plans.
- Staff did not always recognise issues which were safeguarding matters. Staff did not know how to make safeguarding referrals.
- The providers senior management team had not acted on the findings of a previous CQC inspection at another location with sufficient speed or impact. The same and similar issues were identified during this inspection.
- Rates of mandatory training for staff were low. Not all staff had the core skills and knowledge necessary for their role.

Summary of findings

- Some staff did not have the required pre-employment checks before they started their employment.
- All incidents in the service were not reported as incidents. Only one incident had been reported in the previous year.
- Clients care plans were not specific or measurable. They did not reflect clients involvement and preferences.
- The manager and staff had little or no understanding of the Mental Capacity Act.
- There was no integrated governance system to underpin the quality and safety of the service.

However, we also found the following areas of good practice:

- Clients were very positive regarding staff in the service. They reported that staff were approachable and supportive.
- Clients had an induction pack and a peer mentor when they were admitted to the service.
- Feedback from clients was sought and clients could make suggestions for improvements in the service.
- Staff discussed and agreed new procedures, documents and changes before they were put in place.

We issued Warning Notices to the provider and took other regulatory action. Details can be found at the end of the report.

Summary of findings

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Cranstoun - Trelawn House

Services we looked at
Substance misuse services

Summary of this inspection

Background to Cranstoun - Trelawn House

Cranstoun – Trelawn House provides a residential rehabilitation service for people who have substance misuse problems. The service can accommodate 15 clients. At the time of our inspection there were nine clients in the service.

Clients in the service were funded by different local authorities on an individual client basis.

Cranstoun – Trelawn House is registered to provide: Accommodation for persons who require treatment for substance misuse.

There was a registered manager in post at the time of the inspection.

We have previously inspected this service twice since 2010. Our last inspection in November 2013 found that the service was meeting the essential standards which were inspected. The essential standards against which we inspect are now known as fundamental standards.

Our inspection team

The team that inspected the service comprised two CQC inspectors, a specialist advisor who was a senior substance misuse nurse, and an expert by experience. An expert by experience is a person who has personal experience of using, or supporting someone using, similar services.

Why we carried out this inspection

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

How we carried out this inspection

To understand the experience of people who use services, we ask the following five questions about every service:

- 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 and asked other organisations for information.

During the inspection visit, the inspection team:

- visited the service, looked at the quality of the physical environment, and observed how staff were caring for clients
- spoke with six clients
- spoke with the registered manager and the provider's deputy director

Summary of this inspection

- spoke with five other staff members including a team leader, project workers and bank staff
- spoke with two volunteers
- attended and observed a staff handover meeting and a client group
- collected feedback using three comment cards from clients
- looked at nine care and treatment records, including medicines records, for clients
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

Clients were very positive regarding staff in the service. They reported that staff were approachable and supportive. Clients spoke positively about their one to one sessions with their named worker. Clients reported that they felt safe with the staff in the service.

Before the inspection, a comment box had been placed in the service. We received three comment cards from clients using the service. Two of the comment cards were positive and one was mixed with positive and negative comments. The positive comments cards praised the staff and how they worked with clients. The comment card with mixed comments also praised the staff. The negative comments concerned the lack of alternative therapies and timekeeping issues.

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?

We do not currently rate standalone substance misuse services.

We found the following issues that the service provider needs to improve:

- Medicines management was unsafe. Multiple medicine errors had occurred. Staff were not assessed as competent to dispense medicines.
- Some clients did not have a risk assessment on admission to the service. Risk information was not always appropriately recorded or detailed. Clients did not have risk management plans.
- Staff did not always recognise issues which were safeguarding matters. Not all staff had undertaken safeguarding training. Staff did not know how to make safeguarding referrals.
- Rates of completion of mandatory training for staff were low. Not all staff had the core skills and knowledge necessary for their role. Some areas of core knowledge were not identified as mandatory training.
- Some staff did not have the required pre-employment checks before they started their employment.
- All incidents in the service were not reported as incidents. Only one incident had been reported in the previous year. We identified over 15 incidents which should have been reported.
- At night and during the weekends one staff member was on duty. The provider's lone working policy was directed at community staff.

Are services effective?

We do not currently rate standalone substance misuse services.

We found the following issues that the service provider needs to improve:

- Clients care plans were not specific or measurable. They did not reflect clients involvement and preferences.
- The manager and staff had little or no understanding of the Mental Capacity Act.

However, we also found the following areas of good practice:

- Clients had structured days which involved attending different types of group. Clients were also given assignments to complete outside of the groups.

Summary of this inspection

- Client outcomes were measured using the treatment outcome profile.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- We observed that staff always treated clients with dignity and respect. Staff took time to listen to clients and offered support to them.
- Clients were very positive regarding staff in the service. They reported that staff were approachable and supportive. Clients reported that they felt safe with the staff in the service.
- Clients had an induction pack and a peer mentor when they were admitted to the service.
- Feedback from clients was sought and clients could make suggestions for improvements in the service.

However, we also found the following issues that the service provider needs to improve:

- Clients did not receive a copy of their care plan.

Are services responsive?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Clients had keys to their own bedrooms.
- Most clients had a face to face assessment before admission.

However, we also found the following issues that the service provider needs to improve:

- The complaints policy did not include the names of outside organisations clients could appeal to if they were not happy with the outcome of their complaint.

Are services well-led?

We do not currently rate standalone substance misuse services.

We found the following issues that the service provider needs to improve:

- There was no integrated governance system for the service. There were no regular audits and no service risk assessment.
- The providers senior management team had not acted on the findings of a previous CQC inspection at another location with sufficient speed and impact. The same and similar issues were identified during this inspection.

Summary of this inspection

- Some key performance indicators were not specific or measurable.

However, we also found areas of good practice, including that:

- Staff discussed and agreed new procedures, documents and changes before they were put in place. Staff consultation and discussion was viewed as key to the successful implementation of changes.
- Staff members described working as a team with a positive staff and team culture. Staff felt supported by each other and the manager.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

Two staff members (23%) had undertaken training in the Mental Capacity Act (MCA). The manager and staff had a poor understanding of the MCA. They had difficulty understanding how it could relate to clients in the service.

If a client lacking capacity attempted to leave the service, staff were unaware of what action they could legally take. Further MCA training was due to commence shortly after the inspection.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

- The service was not clean. There were thin layers of dust on furniture and bookshelves. The windows had not been cleaned. Clients undertook some cleaning duties and a rota was displayed. At the time of the inspection, the rota had not been completed. There was no cleaning schedule, itemising each task and how frequently it should be undertaken. This meant that the provider could not be sure that all parts of the service were cleaned frequently. The service did not follow the provider's infection control policy.
- Two bedrooms had holes in the carpet and one bedroom required a new sink splashback. These rooms were not being used. Mattresses for client's beds were being gradually replaced, as they were in poor condition.
- Posters were displayed by each hand basin illustrating the five steps to effective handwashing. Using the five steps is the most effective way to prevent transmission of infection. There were no infection control audits undertaken in the service. This meant that infection control risks were not assessed, monitored and minimised. The infection control policy stated that when cleaning body fluids, such as blood, staff should use disposable wipes. The policy did not mention blood spillage kits, and none were available in the service. This was not best practice in a service where clients were at risk of blood borne viruses.
- The refrigerator in the client's kitchen had a poster indicating where different foods should be stored in it. However, the poster indicated raw meat should be stored above cooked food. This is how the food was stored. This increased the risk of food poisoning and was not in accordance with food hygiene guidance. Staff had not undertaken food hygiene training. The temperature of the refrigerator was recorded daily. However, at times the temperature was too warm. The manager was monitoring the temperature with different thermometers.
- An alcohol breath test machine was used to detect if clients had used alcohol. There was no record that this machine had been calibrated. This meant that the machine may not produce accurate measurements. Disposable drug testing kits were also used in the service. The kits were within their expiry date.
- Portable electrical equipment had not been safety tested since 2013. The provider was arranging testing at the time of the inspection. The fire alarm and emergency lighting were tested weekly. Fire drills took place monthly. The quiet room in the service was small and the sofa partially blocked the door. This could have caused a delay in leaving in the event of a fire.
- The service had an environmental risk assessment. This document assessed risks relating to the building. Weekly health and safety checks were undertaken. These checks recorded maintenance issues such as fire doors not closing correctly. These issues were then reported for repair. A daily building check conducted by staff and a client was also undertaken. This had not been recorded but plans were in place to do so. The service also had a risk assessment for control of substances hazardous to health. However, this risk assessment did not include all chemicals which were used in the service and which could harm people.

Safe staffing

- In addition to the manager, the service had a team leader and three project workers. During the weekdays two staff worked from 9am. They finished work at 5pm. One staff member worked from 1pm to 10pm. This staff

member also slept in the service at night and was on call for clients. During the weekend, one staff member worked all day. The staffing rota had been changed recently and had been developed according to planned activities and groups. Staff told us that there were not enough staff in the service at all times. Groups were often facilitated by one staff member. One client reported that staff could not undertake a search at the weekend, as two staff were required to search client's property. There was no clear plan of how staff should respond if a client required hospital at the evening or weekend. The provider was in the process of reviewing the rota and recognised that further changes were needed.

- There were no staff vacancies and all shifts were covered. The staff sickness rate in the previous year was 8% and the staff turnover rate was 11%, which was 0.5 of one post.
- The service had four bank staff, two of whom were also volunteers. These staff undertook shifts when there were not enough permanent staff. The service used these staff so that consistent care could be provided to clients. The service did not use staffing agencies.
- The manager and team leader were able to increase the level of staffing for specific events, such as outings. They could also increase staffing levels based on client's needs. Groups and activities were not cancelled due to a shortage of staff. However, groups often operated with only one staff member present. Clients had regular individual meetings with their named member of staff. These meetings were not cancelled due to a shortage of staff.
- The provider listed nine types of mandatory training all staff were required to undertake. Four staff (45%) had undertaken health and safety training. Five staff (56%) had undertaken fire warden, incident reporting, equality and diversity and data protection training. Seven staff (78%) had undertaken first aid training. Medicines training and infection control training were not listed as mandatory training. This meant staff may not recognise medicine errors or follow best practice.

Assessing and managing risk to clients and staff

- When clients were admitted to the service staff undertook a risk assessment of most clients. Two clients had not had a risk assessment when they were admitted to the service. This meant that staff did not know potential risks or the best way to manage them. One of these clients had a risk assessment after they had been in the service for several days. The client's initial risk assessment included the client's history of previous risk incidents. However, two clients were recorded as having no history of violence or suicidal ideas. The referral information for these clients recorded that they had previous risk incidents involving suicidal ideas and violence. Clients previous history of risk incidents was stated. The dates and circumstances leading to risk incidents were not recorded. This meant that staff could not always assess and identify signs of an increase in client's risk. Some clients' previous risk incidents included suicide attempts, self harm and threatening behaviour. Following the initial risk assessment, each client risk was rated 'high', 'medium' or 'low'. Clients risk assessments did not contain enough information to understand how each risk was rated. Clients risk assessments were reviewed after risk incidents or every six weeks.
- Following risk assessment, risk management plans for clients were not developed to minimise risks. This meant that different staff would not be aware of how to identify and minimise client risks. There had been 11 early exits of clients from the service in the previous year. Clients did not have early exit plans. When clients leave treatment early and use illegal drugs they are at an increased risk of overdose. The manager was aware that standards of risk assessment and risk management required improvement. A staff training day was planned which included these areas.
- When clients were admitted to the service they signed a contract agreeing to a number of restrictions. The restrictions included restricted visiting times, no cooking at night, and clients not having mobile phones. Clients could not leave the service or have visitors for the first week. As clients progressed they could leave the service, initially with another client, then alone. Clients could not leave the service at night unless they had overnight leave. Clients were supervised taking their medicines and had to provide urine samples for drug testing.
- Five staff (55%) had undertaken safeguarding adults and safeguarding children training. A further member of staff had undertaken safeguarding adults training. Three staff

had undertaken no safeguarding adults or safeguarding children training. Three staff members were unable to describe how they would make a safeguarding adults referral to the local authority. Staff in the service had not recognised that repeated medicine errors and omissions should have led to a safeguarding adults referral. The provider's policy did not clearly describe how staff could make a safeguarding adults referral. Staff were also required to undertake 'hidden harm' training. This training identified the effects of substance misuse on client's children. Four staff (45%) had undertaken this training.

- One staff member worked in the service during the night and for periods at the weekend. The provider's lone working policy had last been reviewed in February 2013. The policy provided guidance to the provider's community staff. The policy did not provide guidance for staff that were lone working in the service.
- The management of medicines was unsafe. We reviewed the medicines administration records (MAR) of two clients. There were over 50 medicine errors or omissions over 19 days. Clients were not given their medicines as frequently as prescribed, or were given the incorrect dose. One client's medicine was recorded to be used when required. However, the medicine bottle stated the client should receive the medicine three times a day. If clients could not have their medicines or refused this was not always recorded. The MAR charts did not record if clients had any allergies. General practitioners (GPs) prescribed medicines for clients in the service, and staff dispensed prescribed medicines. When clients required a new prescription a number of days passed before they received the prescription. This meant they could not continue with their medicine. When clients were admitted to the service there was no policy for them to bring a supply of prescribed medicines. Some clients had arrived at the service with very few, if any, prescribed medicines. This meant that the client had to temporarily register with a local GP immediately to receive their prescribed medicines. Medicine audits were not undertaken in the service. Staff in the service had not had their competency to dispense medicines assessed. Two staff members who dispensed medicines had received no medicines training. This meant that they did not have knowledge of best practice in medicines management. There was an increased risk of medicine errors. The provider made a safeguarding adults referral regarding medicines management immediately after the inspection.
- Clients' children were able to visit clients at the service. This included children under 16 years of age. The provider did not have a policy or procedure to ensure that child visiting took place in a safe way. At the end of the inspection, the provider told us that child visiting would no longer take place at the service.
- We reviewed the human resources records of two staff and one volunteer. The two staff members had gaps in their employment history. There was no record that these gaps had been discussed with them. One of the staff members had one written reference. The author of the reference was not in a position to provide such a reference. The other staff member had two references. However, one reference did not have an official stamp, headed paper or a compliment slip attached. This meant there was no confirmation that the reference was authentic. Both staff and the volunteer had enhanced disclosure and barring service (DBS) criminal records checks.

Track record on safety

- The service reported no serious incidents requiring investigation in the previous year. However, we found evidence of a number of incidents which should have been reported
- The providers' incident review team monitored all serious incidents and investigations. Learning from all incidents was shared with the managers of the providers' services on a regular basis.

Reporting incidents and learning from when things go wrong

- One incident had been reported in the service in the previous year regarding a medicine error. Other medicines errors or omissions had not been reported as incidents. Two other incidents involving clients in the service were not recorded as incidents and should have been. At least fifteen incidents had occurred which had not been reported as incidents. The providers' incident policy stated that staff should report every incident,

however minor. The policy did not describe the types of incidents which needed to be reported. The service was in the process of transferring to an electronic incident reporting system.

- Six accidents had been recorded in the accident book in the previous year. One of the accidents involved a client having a minor burn injury from the door to the oven. This fault was reported and the client was advised to have two people present when opening the oven door. Three days later another client had minor burns from the oven door. Following this a loop was attached to the door to hold it secure and warning signs were displayed. There had been no further injuries from the oven door. The actions taken following the second accident could have been taken after the first accident. These actions may have prevented the second accident.

Duty of candour

- Duty of candour is a legal requirement, which means providers must be open and transparent with clients about their care and treatment. This includes a duty to be honest with clients when something goes wrong.
- Training in the duty of candour was mandatory for all staff. Two staff (23%) had undertaken training. The provider's accident, incident reporting and investigation policy did not make any reference to the duty of candour or how this was implemented. If a client seriously was seriously harmed in the service the manager knew they should receive a written apology. The manager knew that the client should also be informed of the outcome of the incident investigation.

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

Assessment of needs and planning of care

- Clients had an assessment by staff when they were admitted to the service. Client assessments recorded their history of drug and alcohol use. The drug and alcohol outcomes star was used to assess some clients. The assessment also included clients' social circumstances and relationships. Clients' mental and physical health problems were also recorded. However, in most cases, there was no explanation of how a health condition affected the client. Prescribed medicines for clients' physical and mental health problems were also recorded.
- Care plans for clients did not include all of the client's needs. Several clients had mental or physical health problems which were not addressed in care plans. For instance, one client had a condition which could affect their daily routines and could cause anxiety. The client did not have any care plans. Another client with diabetes did not have a care plan addressing this. Clients' emotional needs were not always described in care plans. Clients had a number of care plans and these contained pre-printed client goals. Additional individual client goals were added. Most of the pre-printed and individual goals were general statements. For instance some client goals were recorded as 'depression, anxiety' or 'lose weight, healthy diet'. The goals were not specific or measurable. There was a lack of meaningful recovery focus in clients' care plans. Some clients pre-printed care plans were blank. The manager planned to focus on care planning standards on a staff training day.
- Daily records for clients were brief and lacked detail. The information in the daily records was copied from the handover record.
- Clients' care records were a mix of paper and electronic records. Initial assessments of clients, medicine administration recordsand correspondence were stored in files in the staff office. All of the other client records were stored electronically which only staff could access.

Best practice in treatment and care

- Clients in the service attended groups based on the integrative recovery approach to substance misuse. Integrative recovery is a recognised model focussing on clients making and sustaining changes in their thinking and behaviour. Clients had structured days which involved attending different types of group. Groups included relapse prevention, life stories, choosing to change and yoga. Clients were also given assignments to complete outside of the groups. The provider was planning to change the recovery model to acceptance commitment therapy (ACT). ACT is also a recognised recovery model.

Substance misuse services

- Clients had to provide urine specimens for drug testing as part of their treatment. Drug testing took place every week. It could also take place if staff suspected a client had used drugs. There was no written procedure or guidelines for staff to follow when clients provided urine samples. This meant that the procedure could be undertaken inconsistently by different staff. The steps to be taken, to minimise the risk of a client adulterating a urine sample, were not recorded.
- Clients received treatment for physical health problems from a local GP. However, one client was to attend an urgent GP appointment regarding their high blood sugar. There was no record that the client attended the appointment or how their blood sugar should be monitored in future. Clients were prescribed a range of medicines, including antidepressants and a medicine for thyroid problems. These medicines were not always dispensed as prescribed. Outside of GP working hours clients went to the urgent care centre or emergency department of the local hospital.
- Clients' progress was measured using the treatment outcome profile (TOP). The TOP was undertaken at the start and end of clients' rehabilitation.
- Clients' care records were audited once a year. There was no regular or ongoing audit to monitor any areas of improvement identified in the audit. Staff were not involved in any systematic, ongoing audits.

Skilled staff to deliver care

- All of the staff in the service had worked in the substance misuse field for three or more years. Volunteers working in the service worked under the supervision of employed staff.
- Staff supervision had not been recorded in the previous year. This meant there was no record of when supervision had taken place and what was discussed. Staff told us that supervision took place every month. Staff appraisals had taken place and were documented. Two staff appraisal records we reviewed were completed to a high standard. The records were very detailed, and personal development plans included self assessment, performance and regular reviews. Appraisal records were written in a way which was supportive of staff members. Staff also attended a weekly team meeting to discuss operational issues.
- Staff had undertaken a range of specialist training. All permanent staff had undertaken motivational interviewing and solution focussed brief therapy training. Self harm awareness, 'working with complex needs' and 'working with personality disorder' training was also undertaken. However, regular bank staff had undertaken little, if any, specialist training. This meant they may not have all of the skills required to meet client's needs. The manager had started a training needs analysis for individual staff members.

Multidisciplinary and inter-agency team work

- Handovers between staff took place twice a day, in the morning and after lunch. Each client was discussed in detail including any issues, concerns and activities they had undertaken. If clients had a drug test or been alcohol breath tested this information was included. Two months before the inspection, the manager had introduced a formal record of the handovers. In addition to handover of clients, this included any incidents or accidents, maintenance issues and other service issues. The handover record added structure to the handover and ensured it was as effective as possible.
- The service maintained a good relationship with a local general practitioner. There were also links with a mutual aid organisation and a local college.

Good practice in applying the Mental Capacity Act

- Two staff members (23%) had undertaken training in the Mental Capacity Act (MCA). Staff had a poor understanding of the MCA. They had difficulty understanding how it could relate to clients in the service. If a client lacking capacity attempted to leave the service, staff were unaware of what action they could legally take. Further MCA training was due to commence shortly after the inspection.

Are substance misuse services caring?

Kindness, dignity, respect and support

- We observed that staff always treated clients with dignity and respect. Staff took time to listen to clients and offered support to them.

Substance misuse services

- Clients were very positive regarding staff in the service. They reported that staff were approachable and supportive. Clients spoke positively about their one to one sessions with their named worker. Clients reported that they felt safe with the staff in the service.
- Overall, staff had a good understanding of client needs. Clients' named workers had in-depth knowledge of clients emotional, psychological and social needs. However, such needs were not addressed consistently in care plans. This led to a some confusion regarding clients' needs.

The involvement of clients in the care they receive

- Clients were provided with an induction pack when they were admitted to the service. This included the contract for them to sign regarding the restrictions in the service. Information concerning making a complaint was also included. When a new client was admitted an induction group was facilitated. This group introduced clients to the service and rehabilitation programme. Clients were also assigned a mentor. This was another client who had been in the service for some time. The mentor's role was to assist the new client to understand how the service operated.
- Clients were involved in their care plans and risk assessments. However, this often involved clients giving information to staff. In almost all cases, there was no record of how clients viewed their own care and their needs. Clients were not given copies of their care plans.
- Clients in the service did not have access to an advocacy organisation.
- Families and carers were encouraged to become involved in clients' care, when clients had provided consent.
- The provider had conducted a client feedback survey in 2016. Seven clients responded. Clients rated the service highly across a range of areas. The highest ratings were given for staff being approachable and professional, feeling supported, making positive life changes and goal setting. Clients also provided feedback by completing feedback cards when they left the service. A suggestion box was available for clients to make suggestions regarding the service.

Are substance misuse services responsive to people's needs?

(for example, to feedback?)

Access and discharge

- All clients being admitted to the service were required to be alcohol and drug free. Most clients in the service were transferred directly from a detoxification service. Some clients were transferred directly from prison. Clients in detoxification services had a face to face assessment before admission to the service. However, this assessment was not always undertaken by staff in the service. The providers' referral team also undertook these assessments. Clients in prison had a telephone assessment prior to admission.
- The service did not have clear inclusion and exclusion criteria for people admitted to the service. The service advertised that it worked with clients with comorbid mental health and substance misuse problems. This included clients prescribed antipsychotic medicines. The service required a mental health assessment as part of the referral process for these clients prior to admission.
- The rehabilitation programme was 12 weeks duration, but was almost always extended for clients, due to lack of progress. At the time of the inspection three clients had been in the service for more than 14 weeks. One client had been in the service for 22 weeks. The provider was in the process of making changes to the rehabilitation programme. This was so clients could be discharged in 12 weeks.
- Clients' discharge from the service was not planned at an early stage or in a systematic way. This had been identified and the manager was planning to structure the discharge planning process. The aim was to start discharge planning when clients were admitted.

The facilities promote recovery, comfort, dignity and confidentiality

- The service did not have the full range of rooms required. There was no clinical room, and medicines were dispensed in the staff office. This meant there were more distractions for staff and increased the risk of medicine errors. The bathroom used for clients to

provide urine specimens for drug testing was the staff bathroom. The bathroom contained sink and bath taps and a shower spray. Whilst the sink and bath taps were covered in tape, the shower spray was not. In any event, the tape on the taps was easy to remove. This meant that clients could adulterate their urine specimens without difficulty. Clients worked with a volunteer to develop their information technology (IT) skills.

- The service had a quiet room for clients to use. However, clients could not freely access this room. They were required to collect a key from staff to access this room.
- The clients' payphone was near the front entrance to the service and had a privacy hood. However, clients calls could be overheard. A notice was clearly displayed next to the telephone. This reminded clients to respect the confidentiality of other clients and not to discuss them on the telephone.
- The front garden in the service was well cared for. However, the rear garden was overgrown and had not been maintained for some time.
- Clients undertook food shopping based on the meals clients would cook during the week. This meant that the menu changed regularly.
- Clients could make hot drinks at any time.
- Clients were able to personalise their bedrooms with their own property. Some clients had done this whilst others had not. Two bedrooms were for two clients to share each bedroom. These bedrooms were not occupied during the inspection.
- Clients had keys to their own bedroom. This meant they could safely store personal possessions.
- Clients had a highly structured week. The week included undertaking domestic tasks, attending groups and attending key working sessions. Every morning, clients attended a morning meeting. This meeting involved reviewing the day's diary and clients explaining their current hopes. During weekdays, housekeeping issues were also discussed during the meeting. Every evening at dinner, clients 'checked in'. This meant clients spoke about their mood and thoughts that day. It also meant if clients anticipated issues arising they could discuss them. Clients also attended evening mutual aid groups, such as cocaine anonymous and alcoholics anonymous. An ex-residents group took place every Saturday.Previous clients of the service attended to support current clients.

Meeting the needs of all clients

- The service was unable to accept clients with significant mobility problems. The entrance was not wheelchair accessible and adjustments were not in place. However, adjustments to individual clients' care were made. We observed this during the inspection. Staff spoke of not treating all clients as the same, and recognising when adjustments were required.
- There were no leaflets available in the service. We were told that when clients required information this was printed from the internet.
- The service was able to obtain interpreters when required.
- The service was able to purchase food to meet clients individual dietary requirements.
- The service had links with local places of worship. Following clients admission, when they could not leave the service, religious leaders were contacted and came to the service.

Listening to and learning from concerns and complaints

- The service had received no complaints in the previous year. Information for how clients could complain was included in clients' induction pack. Clients confirmed that they knew how they could make a complaint. The service had not received any complaints in the previous year.
- Staff knew how to deal with complaints. Wherever possible, staff resolved the complaint immediately, and it was unnecessary for the client to make a written complaint. However, there was no central record of these complaints. The service did not analyse these types of complaint over the long term to identify trends or patterns.
- The providers' complaints policy described how complaints were to be investigated. It also described how the complainant could appeal against the initial

investigation outcome. However, the complaints policy did not identify other organisations clients could appeal to when they had exhausted the providers complaints process.

Are substance misuse services well-led?

Vision and values

- The provider had a clear set of values which were publicised. Members of staff values and attitudes aligned with the provider's values.
- Staff reported that the deputy director visited the service on a regular basis.

Good governance

- The governance systems for the service were not effective. The provider's clinical governance framework was dated 2011. The framework stated it should have been reviewed annually. Mandatory training, safeguarding, infection control, risk assessments, care planning, medicines, complaints and incident reporting were not monitored effectively. The service did not have an accurate record of training staff had undertaken. The provider's list of training staff had undertaken did not include records of training in staff employment records. The service did not conduct regular audits to continuously assess, monitor and improve the quality of the service. The service did not have clinical governance meetings and did not have a service risk assessment. There was no systematic way the service could mitigate and monitor operational risks without a service risk assessment. Some of the provider's policies had not been reviewed for three years. This meant they may not reflect current practice and standards. There was a lack of effective systems to underpin safe, high quality care.
- The service had several key performance indicators. Some of the indicators were specific. However, other indicators were neither specific or measurable. How the service was to meet these performance indicators was unclear.

Leadership, morale and staff engagement

- The staff sickness rate was 7% in the previous year.
- There had been no staff grievances concerning bullying and harassment in the previous year.
- The providers senior management team had not acted on the findings of a CQC inspection of another of the provider's services with sufficient speed or impact. The same and similar issues were identified during this inspection.
- Staff were aware of how they could raise concerns or whistleblow. They described how they could approach various managers if required. Staff described being confident to raise concerns, and did not fear they would receive negative treatment for doing so.
- Staff had a high level of morale. This had increased recently with the arrival of a new manager. Staff were enthusiastic about their work and planned changes, and had a sense of job satisfaction.
- Staff were able to progress in their role. One project worker had been given further responsibilities as part of their career progression. They were also undertaking introductory management training. The team leader had undertaken management training.
- Staff members described working as a team with a positive staff and team culture. Staff offered each other mutual support and felt supported. Staff felt supported by the new manager and described them as having a positive impact.
- Staff in the service were open and transparent when mistakes were made. They acknowledged mistakes to the client and attempted to rectify the mistake as soon as possible.
- Staff were able to provide feedback regarding changes to the service or suggestions for improvement. New procedures, documents and changes were not put in place until staff had discussed and agreed them. Staff consultation and discussion was viewed as key to the successful implementation of changes.

Commitment to quality improvement and innovation

- The service was not engaged in any peer review or quality improvement schemes. The new manager was aware of areas for improvement and was committed to improving quality and safety in the service.

Outstanding practice and areas for improvement

Outstanding practice

Staff discussed and agreed new procedures, documents and changes before they were put in place. Staff consultation and discussion was viewed as key to the successful implementation of changes.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that best practice in medicines management is followed. All staff who dispense medicines must be trained and assessed as competent to do so.
- The provider must ensure that all staff, including bank staff, undertake all mandatory training. The provider must ensure that mandatory training is provided for all areas where staff require core skills and knowledge.
- The provider must ensure that all clients have a risk assessment on admission to the service. Risk assessments must include detailed information, and when risks are identified, clients must have a risk management plan.
- The provider must ensure all staff know how to recognise safeguarding matters. All staff must know how to make a safeguarding adults and safeguarding childrens referral. All safeguarding referrals must be recorded as incidents.
- The provider must ensure that all appropriate pre-employment checks are undertaken for all staff.
- The provider must ensure that all incidents occurring in the service are identified and reported.
- The provider must ensure that an integrated governance system is in place for the service. This must include regular audits and a service risk assessment.
- The provider must ensure that clients' care plans are specific and measurable and reflect clients' involvement.
- The provider must ensure that food is used and stored in a way which minimises risks to clients.
- The provider must ensure that the service is clean. The provider must be able to demonstrate how cleaning is undertaken and the frequency.

Action the provider SHOULD take to improve

- The provider should ensure that staff in the service understand the basic principles of the Mental Capacity Act.
- The provider should ensure that clients are given a copy of their care plan.
- The provider should ensure the safety and needs of residential lone worker staff are incorporated into a policy.
- The provider should ensure staff supervision is documented.
- The provider should ensure the complaints policy includes details of other organisations clients can appeal to if they remain dissatisfied.

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 9 HSCA (RA) Regulations 2014 Person-centred care Assessment of service users did not always include all relevant information. Clients care plans were not specific to all of the clients needs, and did not reflect their preferences. This is a breach of Regulation 9(1)(b)(c)(3)(b)

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service was not clean and no cleaning schedule was available. Food was stored in a way which increased the risks to clients health. This is a breach of Regulation 12(1)(2)(b)(h)

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Staff did not have all of the pre-employment checks required in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is a breach of Regulation 19(1)(a)(2)(a)(3)(a)

This section is primarily information for the provider

Enforcement actions

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 Clients risk assessments did not always contain documented client risks. Client risk assessments lacked detail. Clients did not have risk management plans. Medicines management was not safe. There was a lack of appropriate medicines reconciliation on clients admission. Multiple medicine errors had occurred. This is a breach of Regulation 12(1)(2)(a)(b)(g)

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Staff did not know how to make a safeguarding adults referral. Staff did not always recognise incidents which should have prompted safeguarding referrals. This is a breach of Regulation 13(1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 17 HSCA (RA) Regulations 2014 Good governance The systems or processes in place to operate the service and assess and improve quality and safety were not effective.

This section is primarily information for the provider

Enforcement actions

The provider's governance framework was out of date. The provider's infection control policy was not followed. Some policies did not reflect best practice. Incidents which occurred in the service were not always reported. There was no service risk assessment to assess and mitigate operational risks. There was no policy for children visiting the service. The COSHH risk assessment was not accurate. There was a lack of regular audits. Some key performance indicators were not specific or measurable.

This is a breach of Regulation 17(1)(2)(a)(b)(f)

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were low rates of staff undertaking mandatory training. Medicines management training was not mandatory. Staff were not assessed as competent to dispense medicines. This is a breach of Regulation (1)(2)(a)