Longreach

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

We rated Longreach as requires improvement because:

- There was insufficient attention to safeguarding children and adults. The service did not adhere to safeguarding principles. Staff did not consistently recognise or identify safeguarding concerns. Staff were not trained in child safeguarding. Staff did not update the safeguarding log and information was not shared between staff about safeguarding concerns. Staff told us that if they identified a safeguarding concern, they informed their manager who made a referral to the local authority. Staff identifying the concern should be confident and competent to make the referral themselves.
- The service had blanket restrictions in place that impacted on client's freedom. Clients told us that the environment was too restrictive. For example; clients had no access to mobile phones throughout treatment including when on community leave in the local area but were able to take mobile telephones on home leave and were unable to have unsupervised access to the community until week four of treatment. Clients had to seek approval from staff for their visitors and visitors with a current of substance use would not be approved. The provider did not have a blanket restrictions policy in place and a log of their use was not kept. The provider did not consider restrictions on an individual basis or regularly review the use of blanket restrictions.
- The medicines reconciliation process put people at risk of harm. Community staff were provided with a GP summary, including list of medication, up to four weeks prior to admission. Clients brought in 28 days of medication with them and this was checked against the GP list. There was no process in place to ensure this was the most up to date and accurate list of medication.
- The provider did not have governance processes in place to ensure sufficient oversight, quality assurance and risk management of the service. Managers did not ensure that staff supervision considered the quality of safeguarding practices within the staff team nor did they offer staff training in child safeguarding. The organisation did not hold a risk register for the service to ensure that all service risks are identified and managed. The provider did not have systems in place to monitor the effectiveness of their therapeutic program or have sufficient quality assurance processes in place. The provider did not have systems in place to ensure that client feedback was always acted upon.
- The service also did not audit the program against the National Institute for Health and Care Excellence (NICE) guidelines or have a quality assurance process. The service did not monitor the efficacy of the therapy program. This meant the programme was not evidence based.
- Staff did not follow infection control principles. Staff carried contaminated clinical waste, following urine drug testing, across the house for disposal in the clinic room. There was no hand washing sink available in the clinic room for staff to use.
- At the time of inspection, the location of the clinic room compromised safety, privacy, dignity and confidentiality of clients. The clinic room formed the walkway into the dining room. Confidential information was on display in the clinic room that was visible when clients accessed the dining room. The door to the clinic room was left unlocked. Clients could access sharps bins and medical equipment which could be used to cause harm to themselves or others. Following the inspection, the provider informed us they had moved the clinic room.
- There was no evidence of crisis plans or unplanned discharge plans for clients. Crisis plans should contain personalised information on what support is available during a deterioration of mental health and a relapse prevention plan. Staff were not assessing whether clients were at risk of unplanned discharge or creating robust unplanned discharge care plans with clients.
- The service did not routinely act on client feedback. Clients raised issues regularly through house meetings and evaluation forms but these were not addressed by the provider.
- The service did not routinely supply take home naloxone to all clients and carers following treatment for opiate rehabilitation.

However:

- Staff completed high quality, collaborative and individualised care plans.

Summary of findings

- Staff were provided with a comprehensive induction and had relevant qualifications to provide clients with effective care and treatment. Managers had appropriate qualifications to perform their role. Counsellors were qualified to deliver the therapeutic programme.
- Staff treated clients with kindness, dignity and respect. We observed staff interacting with clients in a respectful, caring and appropriate manner.
- The service had clear referral criteria and referrals were screened and assessed to check for suitability. Admissions were agreed at a weekly multidisciplinary team meeting.
- Clients had access to a local community project for women in recovery from addiction. The project provided counselling, housing support, outreach, a therapeutic group program and parenting support.

Summary of findings

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Services we looked at
Substance misuse services

Summary of this inspection

Background to Longreach

Broadreach House provides substance misuse services at three registered locations: Broadreach, Longreach and Closereach. Before this inspection of Longreach, inspections took place at Broadreach and Longreach. Reports have been published separately for each registered location.

Longreach is a residential rehabilitation service for women with a history of drug and alcohol misuse. Longreach admits clients who have completed detoxification at Broadreach House and other detoxification services.

The service provides a programme where clients learn strategies for maintaining their recovery and set goals. The length of programme is for a minimum of three months, with an option for a further three months.

Longreach has a large main house and adjacent cottage with gardens. The main house has 15 beds and the cottage has seven beds, which is not currently in use. Community drug and alcohol services and local authorities fund the majority of the clients. There were 13 clients at Longreach at the time of our inspection.

The service is registered to provide accommodation for persons who require treatment for substance misuse. At the time of our inspection, Longreach did not have a manager in post. However, a manager had been appointed and was applying to CQC for registration.

Longreach was last inspected by the CQC on 5 July 2018. This was a focussed inspection and was not rated at that time. The service had no outstanding requirement notices.

Our inspection team

The team that inspected the service comprised of three CQC inspectors, one with significant experience of working in substance misuse services.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme to inspect and rate substance misuse services.

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- Visited the location and looked at the quality of the environment and observed how staff were caring for clients
- Spoke to the chief executive (who is the current registered manager) and the deputy manager
- Observed a client group therapy session

Summary of this inspection

- Spoke with four members of staff
- Looked at seven client care and treatment records
- Looked at a range of policies, procedures and other documents related to running the service and
- Received feedback about the service from stakeholders.

What people who use the service say

We spoke with three clients. All clients were given an opportunity to speak to us if they wanted to. The clients we spoke with told us staff were supportive, caring and treated them with dignity. However, they felt that the levels of restriction were too high and they would like access to their mobile telephones and more community access. Clients also told us that their weekend food budget for the house was not big enough and it was difficult to purchase enough food for everyone.

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?

Inadequate

We rated safe as **inadequate** because:

- There was insufficient attention to safeguarding children and adults. The service did not adhere sufficiently to safeguarding principles. Staff did not consistently recognise or identify safeguarding concerns. Staff were not trained in child safeguarding.
- The service had blanket restrictions in place that impacted on client's freedom. Clients told us that the environment was too restrictive. There was no blanket restrictions policy in place and use of blanket restrictions was not recorded or reviewed.
- There was a lack of regard around infection control. Staff carried used urine specimen pots across the house to the clinic room for disposal. Staff could not wash their hands in the clinic room because there was no hand washing sink.
- Staff did not lock the door to the clinic room. This meant that clients could access sharps bins and medical equipment which could pose risks to themselves or others.
- The medicines reconciliation process put people at risk of harm. There was no process in place to ensure that the service had an up to date and accurate list of clients' medications.
- Staff did not complete crisis planning, including unplanned discharge plans, with clients. This meant there was no plan in place if a client's mental health deteriorated or they left treatment early.

However:

- A multidisciplinary team screened potential clients prior to admission to ensure the service could meet their needs and safely manage any risks.
- All care records contained an up to date risk assessment and risk management plan. Risk assessments were comprehensive and included physical health risks.

Are services effective?

Good

We rated effective as **good** because:

- Staff were provided with a comprehensive induction and had relevant qualifications to provide clients with effective care and treatment. Managers had appropriate qualifications to perform their role. Counsellors were qualified to deliver the therapeutic

Summary of this inspection

programme. For example counsellors had training in cognitive-behavioural therapy and had completed the provider's Advanced Practitioner Substance Misuse (APSM) handbook, which included training such as group facilitation.
- Staff considered physical health needs. We saw examples of physical health issues that had been planned for and were being monitored. For example, the provider had trained staff and clients to administer lifesaving treatment for a client with a nut allergy.
- All care records had a comprehensive assessment completed prior to admission. Staff completed personalised, holistic and collaborative care plans with clients shortly after admission.

However:

- The service did not quality assure their individual or group therapy programs. The service did not audit the program against NICE guidelines and did not monitor the efficacy of the therapeutic program.
- Staff did not regularly liaise with community services and there was a lack of interagency working.
- The service did not routinely supply take home naloxone to all clients and carers following treatment for opiate rehabilitation.

Are services caring?

Good

We rated caring as **good** because:

- Staff treated clients with kindness, dignity and respect. We observed staff interacting with clients in a respectful, caring and appropriate manner.
- Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards clients without fear of consequences.
- Clients were involved in their care. Staff ensured care plans were written in collaboration with the client and recorded client's goals in their words.
- The provider involved clients in the recruitment process of new staff.

Are services responsive?

Requires improvement

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

- The location of the clinic room compromised client's privacy, dignity and confidentiality. The clinic room formed the internal walkway into the dining room. A white board with clients' names and medication times written in dry-wipe marker was visible to all clients. This information could be easily amended

Summary of this inspection

by anyone walking through, and did not afford client privacy and dignity. The internal door to the dining room was locked if a client needed treatment or medication during meal times and a screen was pulled down across the window.
- Staff did not complete discharge planning with clients. Community staff completed a discharge plan prior to a client's admission but this was not revisited during the client's treatment.
- Several of the bedrooms were double rooms and were shared between two clients. We did not see documented risk assessments for sharing bedrooms and the provider did not have a policy in place.
- Clients had limited access to the community within the first four weeks of treatment. Clients were required to take a "senior peer" with them on family visits and visits in the community.

However:

- The provider did not have a waiting list. The service consistently met their target of admission within three weeks of referral.
- The service had clear referral criteria to ensure they could safely manage peoples care. Referrals were screened and assessed to check for suitability. Admissions were agreed at a weekly multidisciplinary team meeting.
- Staff supported clients to access and attend external support groups such as Alcoholics Anonymous.
- Clients had access to a local community project for women in recovery from addiction. The centre provided counselling, housing support, outreach, a therapeutic group program and parenting support.

Are services well-led?

Requires improvement

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

- Longreach had not had a manager in post since April 2018. The chief executive officer (CEO) held the registered manager position. However, staff told us that the CEO wasn't seen often on site.
- The service had 47% unplanned discharges in the last reported quarter. There was not any analysis in trends in reasons for discharge.
- The provider did not ensure robust risk monitoring of the service as there was no risk register in place.

However:

- Managers were developing a female only detoxification service on the Longreach site. This involved converting the cottage into a residential unit with a clinic room and observation bedrooms.

Summary of this inspection

- Staff reported that senior members of the organisation were approachable and supportive.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

The service had a policy on the Mental Capacity Act. Staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. The service did not accept clients who were subject to Deprivation of Liberty Safeguards (DoLS).

Staff had a good level of understanding of the Mental Capacity Act and how it related to their role.

Overview of ratings

Our ratings for this location are:

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

Requires improvement

Substance misuse services

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

Are substance misuse services safe?

Inadequate

Safe and clean environment

- The environment was clean and tidy. Living rooms were bright, spacious and well maintained. There was access to suitable rooms for individual therapy and group therapy. There was a large garden with seating and smoking shelters.
- Clients were responsible for maintaining the cleanliness of the environment, under the supervision of the housekeeper.
- Staff checked bedrooms monthly for safety concerns. This included checking electrical equipment, checking for signs of smoking and other fire hazards.
- The provider had not completed a comprehensive environmental risk assessment. However, following our inspection this was updated by the provider.
- The service had not completed a ligature risk assessment. A ligature point is anything that could be used to attach a cord, rope or other material for hanging or strangulation. There was no assessment of ligature points for the site. We raised this with the provider at the time and a ligature risk assessment was completed following the inspection. It did not contain documentation of specific actions to mitigate the risks identified. The service did not admit clients with a history of ligaturing. However, there were not risk management plans in place to manage this risk if it occurred.
- The door to the clinic room was left unlocked. The clinic room formed the internal corridor to the dining room and was unlocked to allow clients access to the dining room as the only other entrance to the dining room was from the garden. Clients could access sharps bins and medical equipment which could be used to cause harm to themselves or others.
- Staff did not always follow infection control principles. Staff carried used urine specimen pots across the house to the clinic room for disposal. Staff were unable to wash their hands in the clinic room because there was no hand washing sink. Two sharps bins were insecurely stored on a transportable trolley. However, we raised this with staff on the day and they were moved to a locked office.
- The clinic room was clean and staff cleaned the refrigerator and monitored its temperature daily. A first aid kit and spills kit was available.

Safe staffing

- At the time of our inspection there were five counsellors, nine support workers and three ancillary staff members. There was an overall vacancy rate of 20% which included the registered manager post. There was a sickness rate of 3.2%. Internal bank staff covered vacant shifts and staff from the local Broadreach and Closereach services were used to support with staffing if required.
- Support workers provided evening and night time support to clients. Support workers had access to an on-call counsellor and manager during the night for emergency support. Staff had access to personal alarms which contacted the on-call counsellor, manager and police when activated.
- The majority of staff had completed their mandatory training required by the provider. There was a system in place for identifying when training was due.

Assessing and managing risk to clients and staff

- All care records contained an up to date risk assessment and risk management plan. Risk assessments were comprehensive and identified physical and mental health risks. However, there was no evidence of crisis planning. Crisis plans should contain personalised information on what support is available during a deterioration of mental health and how the service would manage the risks of a deteriorating client (for example, risks of self-harm and suicide).
- Staff did not complete unplanned discharge plans with clients. Community staff completed a basic form prior to the start of treatment but this was not revisited by staff or clients on admission. Staff did not identify whether clients were at risk of an unplanned discharge.
- A multidisciplinary team screened potential clients prior to admission to ensure the service could meet their needs and safely manage any risks.
- The service had blanket restrictions in place. Blanket restrictions are rules or policies that restrict clients liberty and other rights, which are routinely applied to all clients without individual risk assessments to justify their application. For example; For example; clients had no access to mobile phones throughout treatment including when on community leave in the local area but were able to take mobile telephones on home leave and were unable to have unsupervised access to the community until week four of treatment. Clients had to seek approval from staff for their visitors and visitors with current substance misuse would not be approved. Staff witnessed all clients giving urine samples. The provider did not have a blanket restrictions policy in place and a log of their use was not kept. The provider did not consider restrictions on an individual basis or regularly review the use of blanket restrictions.

Safeguarding

- Staff and managers did not always recognise safeguarding concerns. Staff were trained in adult safeguarding but were not trained in child safeguarding. Managers kept a safeguarding log to monitor referrals that were made to the local authority. However, this had not been updated for over a year. Staff that we spoke with were unaware of any safeguarding referrals made this year. The quarterly managers report stated the service had made one referral in the last quarter. The service's safeguarding procedures contravened good safeguarding practice. Staff told us if they identified a safeguarding concern, they would tell a manager who would make the referral. Staff told us managers are not always available which could result in a delay to a safeguarding referral being made. We found an example where staff did not respond appropriately to an incident of potential abuse.
- There was not a suitable area for children to visit on site. Clients were encouraged to spend time with their children in the community. Staff told us children could visit their families on site but there was no policy or risk assessment in place for children visiting on site.

Staff access to essential information

- Staff kept paper and electronic client records. All staff had access to the paper records but not all staff had access to the electronic system. This was used to record triage and assessments prior to admission. Staff printed this off and stored it with the rest of the paper client records.

Medicines management

- Staff audited medication weekly for expiration date and amount. One staff member was responsible for ordering medication. This had been reviewed following incidents of running out of medication when staff were unclear who ordered medication.
- Staff monitored the temperature of the clinic room and medicines refrigerator to ensure medicines were stored at the correct temperature.
- The medicines reconciliation process put people at risk of harm. Community staff sent a GP summary, including a medication list, up to four weeks prior to admission. Clients brought in 28 days of medication with them and this was checked against the GP list. There was no process in place to ensure this was the most up to date and accurate list of medication.
- All staff had been trained in safe administration of medication. Staff returned medication to the community pharmacy for disposal and kept a log of returned medication. Two out of date items were found in the 'homely remedies'. These were removed by staff when informed.
- Staff audited drug charts weekly and staff reported drug errors to managers. Managers reviewed staff competencies to dispense medication following drug errors, in line with policy.

Track record on safety

Requires improvement

Substance misuse services

- The service reported 16 incidents in the past 12 months, four of which were serious incidents. Two were episodes of aggression from the same client which required police involvement, one incident where a client took an overdose of over the counter medication and an incident where staff left controlled drug keys in the cabinet.

Reporting incidents and learning from when things go wrong

- Staff knew which incidents to report and how to report them. Accidents were reported on separate forms. The manager kept logs to monitor incidents and accidents. Managers reviewed incidents in detail and shared learning with staff.
- Staff made improvements to the service following specific safety incidents. For example, following an incident where a kitchen knife was found in a client's bedroom staff added counting the knives to the evening handover with a picture of the knives so they could identify an exact knife if it were to be misplaced. The service also informed catering staff that if a client borrows a knife, to ensure it is returned before they finish their shift or hand it over to the evening support staff.

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

Good

Assessment of needs and planning of care

- All care records contained a comprehensive assessment completed prior to admission. Staff completed personalised, holistic and collaborative care plans with clients shortly after admission. Care plans contained the client's goals and had risk management plans for risks identified in client risk assessments.
- Staff considered physical health needs. We saw examples of physical health issues being planned for and monitored, including training other clients to administer adrenalin for a client with a nut allergy. However, not all clients had physical health included in their care plan. We received feedback that the provider did not support clients to maintain a healthy weight whilst in treatment.

Best practice in treatment and care

- Staff delivered the therapeutic timetable. This included therapeutic groups such as relapse prevention, relationships and trauma and complementary groups such as Tai Chi and arts and crafts. The therapeutic program was developed internally. The treatment manual references cognitive behavioural therapy, which is best practice in line with National Institute for Health and Care Excellence (NICE) guidelines. However, the service did not quality assure their individual or group therapy programs or have an embedded quality assurance process. The service did not monitor the efficacy of the therapy program.
- The provider did not supply take home naloxone to all clients or carers of people who were discharged after opiate rehabilitation. This is an essential injectable medication that can reverse opiate overdose. However, staff were trained to administer this medication and to train others how to use it.

Skilled staff to deliver care

- The staff team comprised of qualified counsellors and support workers.
- Staff were provided with a comprehensive induction and had relevant qualifications to provide clients with effective care and treatment. Managers had appropriate qualifications to perform their role. Counsellors were qualified to deliver the therapeutic programme. Counsellors had training in cognitive-behavioural therapy, motivational interviewing and had completed the provider's Advanced Practitioner Substance Misuse (APSM) handbook, which included training such as group facilitation. A comprehensive group manual was available to staff containing contents of each group in the program. However, there was no evidence that staff had their competencies to deliver the group therapeutic program assessed.
- Staff had access to regular supervision and annual appraisals. An external supervisor delivered clinical supervision and management supervision was delivered internally. All staff had had an appraisal within the past 12 months.

Multi-disciplinary and inter-agency team work

- Managers from all sites held a multidisciplinary team meeting each week. In attendance was the chief executive, managers and deputy managers of each

rehabilitation unit and supported housing, the GP, the psychiatrist and the admissions manager. In the meeting proposed admissions were discussed and accepted or rejected dependent on whether the client was suitable. Concerns with current clients and changes to care plans or funding were also discussed. Staff also discussed clients within supported living. Risks, physical health and mental health were covered in each of the clients discussed and management plans were devised between the medical staff and managers of the units. However, keyworkers of the clients and external professionals from community teams were not invited.

- Care managers and community teams were clearly documented in client's notes. We received mixed feedback from stakeholders about the amount of feedback they received from the service about their client.

Good practice in applying the MCA

- The service had a policy on the Mental Capacity Act. Staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards.
- Staff had a good level of understanding of the Mental Capacity Act and the guiding principles.

Are substance misuse services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

- Staff treated clients with kindness, dignity and respect. We observed staff interacting with clients in a respectful, caring and appropriate manner.
- Staff were hard working, caring and committed to delivering a good quality service. They spoke with passion about their work and were proud of what they did.
- Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards clients without fear of consequences.
- Staff maintained the confidentiality of information about clients and supported them to make choices about sharing information. However, not all client care records contained a confidentiality statement or contract.

Involvement in care

- Staff collected formal client feedback quarterly and held weekly house meetings for clients to raise any issues. However, feedback was not always acted on by the provider. Clients repeatedly raised that there are issues with the payphone and they would like access to mobile telephones, particularly on community leave for safety reasons. This had not been addressed by the provider and clients reported that they felt unsafe in the community.
- Clients were involved in their care. Staff ensured care plans were written in collaboration with the client and recorded client's goals in their words. Clients signed their care plans and staff provided clients with a copy of their care plan.
- The provider involved clients in the recruitment process of new staff. Potential employees worked a shadow shift and feedback from clients was sought prior to appointing new staff.

Are substance misuse services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Access and discharge

- The service had clear referral criteria to ensure they could safely manage peoples care. Referrals were screened and assessed to check for suitability. Clients deemed appropriate for the service were assessed prior to being offered a bed. Admissions were agreed at a weekly multidisciplinary team meeting.
- There was no waiting list for Longreach. The provider was consistently meeting their target of admitting clients within three weeks of receiving a referral.
- Staff did not complete discharge planning with clients. Community staff completed a discharge plan prior to a client's admission but this was not revisited during the client's treatment. There was no evidence of discharge planning meetings with community services or housing providers.
- Where relapse was identified in clients, staff tried to work with clients around their relapse or supported

them to transfer to another service before discharge. Discharging clients immediately following relapse is often normal practice within many substance misuse services.

The facilities promote recovery, comfort, dignity and confidentiality

- At the time of inspection, the location of the clinic room compromised client's privacy, dignity and confidentiality. The clinic room formed the internal walkway into the dining room. A white board with client's names and medication times written in dry-wipe marker was visible to all clients. This information could be easily amended by anyone walking through, and did not afford client privacy and dignity. The internal door to the dining room was locked if a client needed treatment or medication during meal times and a screen was pulled down across the window. Following the inspection, the provider informed us they had moved the clinic room.
- The service had one single bedroom. The remaining seven bedrooms were double rooms and were shared between two clients. A screen was provided to split the room in two and maintain privacy and dignity. When we spoke with clients, they did not raise sharing bedrooms as a concern. Clients consented to sharing bedrooms. We did not see documented risk assessments for sharing bedrooms and the provider did not have a policy in place. However, discussions took place at the weekly multidisciplinary team meeting about the allocation of beds based on risk and client preference.
- The service had a range of rooms for clients, including a large group room based in a separate building in the garden. This was light and airy and had kitchen facilities and an accessible toilet. There were other rooms for group and individual therapy. The living rooms were bright, spacious and well maintained. There was a dining room large enough for all the clients to eat together.

Clients' engagement with the wider community

- Staff supported clients to access and attend external support groups such as Alcoholics Anonymous.
- Clients had access to a local community project for women in recovery from addiction. The centre provided counselling, housing support, outreach, a therapeutic group program and parenting support.
- Clients had limited access to the community within the first four weeks of treatment. Clients were required to take a "senior peer" with them on family visits and visits in the community.
- Clients had limited contact with their family during treatment. There was one payphone between 15 clients which was not switched on until the evening, which meant telephone calls had to be short.

Meeting the needs of all people who use the service

- Wheelchair access to the building was limited. There were no bedrooms on the ground floor. Although there was a stair lift to the bedrooms and there was an accessible bathroom upstairs, the corridors between bedrooms were too narrow at points for a wheelchair to fit. The clinic room was not fully wheelchair accessible. However, we saw plans to convert a room in the cottage to a fully accessible bedroom and bathroom. The group room was also fully accessible.
- Clients were positive about the therapeutic program. However also told us they would like access to complementary therapies such as Tai chi and reflexology. This had been raised in the client evaluation feedback.
- There was no waiting list for Longreach. The service aimed to admit urgent referrals within two weeks and routine referrals within three weeks.

Listening to and learning from concerns and complaints

- Longreach received no formal complaints in the 12 months prior to our inspection.
- Staff gave clients information on the complaints procedure on admission. Information was available in their induction pack. An anonymous feedback book, suggestions box, house meetings and the quarterly client evaluations were also available to clients as a means of raising concerns. However, we saw that clients had raised issues in this way that had not been addressed by the provider. For example, access to mobile telephones.

Are substance misuse services well-led?

Requires improvement

Leadership

- Longreach had not had a manager in post since April 2018. A manager had been recently appointed but not yet started. The chief executive officer (CEO) held the registered manager position. However, staff told us that the CEO was not seen often on site. A deputy manager had been recently appointed. Staff spoke positively of the leadership shown by the deputy manager. The deputy manager was a qualified counsellor and provided the staff with therapeutic support and guidance as well as managerial support.

Vision and strategy

- Staff understood the vision and values of Longreach and the wider organisation. All staff had a job description and understood their roles in achieving the vision and demonstrating the values.
- Managers were developing a female only detoxification service on the Longreach site. This involved converting the cottage into a residential unit with a clinic room and observation bedrooms. Current staff, including staff already providing detoxification at Broadreach, had the opportunity to have input into the service development through a consultation.

Culture

- Staff reported that senior members of the organisation were approachable and supportive.
- Staff were aware of how to raise concerns including the whistle-blowing process and felt they could do so without fear of retribution.
- Staff told us that managers were compassionate and proactive about staff wellbeing. Managers held a quarterly wellbeing group to enable staff to share ideas that may improve staff wellbeing. A staff room was introduced at Longreach after it was raised through this meeting.

Governance

- The provider did not have governance processes in place to ensure sufficient oversight, quality assurance and risk management of the service. The provider did not have supervision of safeguarding practices within the staff team or offer child safeguarding training. The organisation did not hold a risk register for the service to ensure that all service risks are identified and managed. The provider did not have systems in place to monitor the effectiveness of their therapeutic program or have sufficient quality assurance processes in place. The provider did not have systems in place to ensure that client feedback was always acted upon.
- The service had 47% unplanned discharges in the last reported quarter and 53% in the previous quarter. There was not any analysis in trends in reasons for unplanned discharge.
- The deputy manager reported data quarterly to the CEO, including; safeguarding referrals, incidents, accidents and discharges. This was then reviewed by the CEO and board of trustees.
- Treatment outcome profiles were completed and submitted to National Drug Treatment Monitoring System via electronic client records. However, no data was available on client outcomes after completion of treatment.
- The service had employed two nurses on a consultancy basis. One nurse was part time and undertook clinical audits, including care planning and medicines management. The other nurse was full time and worked with management to address a shift in culture within the service and manage the resistance amongst the staff to any planned changes.

Management of risk, issues and performance

- The CEO and board of trustees maintained and regularly reviewed an organisational risk register. This was comprehensive and contained potential impact and steps to mitigate risks. However, there was no risk register for Longreach at a service level.
- There was a business continuity in place that contained relevant information to ensure safe running of the service in the event of an incident that threatened service delivery.

Information management

- All staff had access to clients' paper care records, this contained printed versions of assessments from the electronic care record. However, care records did not contain confidentiality statements or signed information sharing forms.
- The managers had access to information relating to incidents, safeguarding referrals, sickness and complaints. However, we did not see evidence that trends, learning and outcomes were discussed with staff on a regular basis.

Requires improvement

Substance misuse services

Engagement

- Clients had regular opportunities to give feedback about the service, including; house meetings, evaluation forms, suggestion box and a feedback book. The provider also gauged client's opinion the service through self-evaluation forms during and on completion of treatment. However, these were not always acted on or responded to. Carers feedback was not routinely sought.

Learning, continuous improvement and innovation

- The provider did not employ any specific improvement methodologies, participate in any national quality improvement programmes or give any examples of innovative practice.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that client's medication is checked against a current list of prescribed medication on admission. (Reg 12)
- The provider must review its approach to blanket restrictions and ensure the least restrictive options are placed on clients. The provider must review restrictions on an individual basis and regularly review blanket restrictions that are in place. (Reg 12)
- The provider must put in place appropriate systems to ensure oversight and quality assurance of risk management and safeguarding practices. (Reg 17)
- The provider must ensure that the clinic room maintains the privacy, dignity and confidentiality of clients. (Reg 10)
- The provider must ensure that the clinic room is locked at all times. (Reg 12)
- The provider must ensure that the service adheres to infection control principles regarding the disposal of specimen containers and the provision of hand washing facilities. (Reg 12)

Action the provider SHOULD take to improve

- The provider should audit and quality assure the therapeutic program to ensure it is in line with NICE guidelines and that the program is of high quality.
- The provider should update client's unplanned discharge plans to include personalised information on where they would go and how they would stay safe.
- The provider should ensure that clients have a crisis plan in place.
- The provider should ensure that they respond appropriately to client feedback and concerns.
- The provider should include physical health in all client's care plans, not just those with an identified health need.
- The provider should ensure that take home naloxone is available to all clients and carers.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The location of the clinic room compromised client's privacy, dignity and confidentiality. The clinic room formed the internal walkway into the dining room. The doors to the clinic room were not locked as the only other entrance to the dining room was from the garden. A white board with client's names and medication times written in dry-wipe marker was visible to all clients. This information could be easily amended by anyone walking through, and did not afford client privacy and dignity. The internal door to the dining room was locked if a client needed treatment or medication during meal times and a screen was pulled down across the window. This was a breach of regulation 10(1)(2)(a)

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment There was no process in place to ensure that client's medication was checked against the most up to date and accurate list of prescribed medication. Community staff sent a GP summary, including a medication list, up to four weeks prior to admission. Clients brought in 28 days of medication with them and this was checked against the potentially inaccurate GP summary. The service had in place many blanket restrictions on client's freedom. These were not assessed on an

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individual basis and were not reviewed by the provider. The service did not have a restrictive practice log or blanket restrictions policy which contained justification for the restrictive practices.

The door to the clinic room was left unlocked. Clients could access sharps bins and medical equipment which could be used to cause harm to themselves or others.

Staff did not always follow infection control principles. Staff carried used urine specimen pots across the house to the clinic room for disposal. Staff were unable to wash their hands in the clinic room as there was no hand washing sink.

This was a breach of regulation 12(2)(g)(h) (3)(a)

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have governance processes in place to ensure oversight, quality assurance and risk management of the service. The provider did not have supervision of safeguarding practices within the staff team or offer child safeguarding training. The organisation did not hold a risk register for the service to ensure that all service risks are identified and managed. The provider did not have systems in place to monitor the effectiveness of their therapeutic program or have sufficient quality assurance processes in place. The provider did not have systems in place to ensure that client feedback was always acted upon. This was a breach of regulation 17(1)(a)(b)