High View Residential Unit

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

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:

Summary of findings

- The environment was not fit for some clients who were at risk of falling due to their physical conditions and cognitive impairments, which can affect balance and coordination. The provider had not made reasonable adjustments to meet the needs of people using the service in order to ensure their safety. For example, there was no disabled access into the house. There were no panic alarms installed which meant that there was no means for staff or clients at the service to alert others to any emergency.
- Staff had not updated risk assessments after incidents and some clients were not assessed in relation to their physical health needs including risk of falls and self-administration of medication. For example, three clients were self-administering creams but this had not been risk assessed to ensure they were able to do so safely. Clients' risk assessments had not been updated as a result of incidents.
- The internal reporting system was not working effectively as some incidents were not reported appropriately and outcomes to incidents lacked detail. For example, two serious incidents had not been documented and reported internally. Incidents that required reporting to the CQC had not been appropriately reported.
- The service did not have appropriate systems and processes in place to ensure that the quality and safety of the care and treatment provided was continuously monitored and improved upon. The service did not have a risk register in place to address areas of risk.
- Client files were stored within the administration office and throughout our inspection the office door was seen open. Client names and details were on display to visitors and other clients. During the inspection, we observed a handover meeting whereby staff held the meeting in the lounge area with the door open whilst clients were present. Staff did not ensure that clients' confidentiality was protected.
- The service did not have infection control measures in place where medicines were administered. Staff had not documented when the area had been cleaned, so clients could not be assured that medicines were administered in a hygienic area. The service did not complete infection prevention and control audits. The key for the medicine cupboard was observed to be stored on a hook in the administration office and on a few occasions left in the medicine cupboard door. This did not ensure that the medicines were safely stored.
- The overall staff mandatory training compliance rate was 86%. However, not all staff had completed some mandatory training courses and additional specialist training which was required to support clients who had specific physical health needs. For example, staff were not trained in catheter care and how to administer medicines when a client was having a seizure. Fifty-five percent of staff required a refresher in the Mental Capacity Act.
- The service had not ensured they had obtained the correct information from staff prior to employment. For example, two out of seven staff had gaps in their employment history without an explanation and four out of seven staff including the registered manager who was also the managing director did not have two references.
- Throughout the building, there was a strong smell of urine around the bathrooms and toilets.
- As a result of the concerns identified in the report, we issued the registered manager, who was also the manging director and the provider with a warning notice under Section 29 of the Health and Social Care Act 2008. We took this action, as we believed people using the service might have been exposed to a serious risk of harm.

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

- Staff had been identified to be first aiders and fire marshals. The key persons were clearly visible on posters around the building.
- Five clients were subject to Deprivation of Liberty Safeguards (DoLS) authorisations and all of the relevant paperwork was correct and up-to-date. The service had a suitable DoLS policy in place. The Deprivations of Liberty Safeguards provide legal protection for those who are vulnerable and are

Summary of findings

aged 18 and over who are, or may become, deprived of their liberty in a hospital or care home. A child protection safeguarding policy was in place for when children visited the service.

- Staff had daily handover meetings to discuss clients and staff attended monthly reflective practice meetings in order to discuss and learn from complex cases.
- Staff were receiving regular supervision and annual appraisals.
- On a monthly basis, clients had a meeting where they were encouraged to raise their questions, concerns or comments. Keyworkers and the clinical psychologist met on a monthly basis to discuss clients' care plans and recovery.
- Clients had access to independent advocacy services. One client had used an advocate within the last 12 months.
- The registered manager who was also the managing director of the service attended regularly and knew all clients on an individual basis. The manager had a good knowledge of clients' backgrounds, histories and preferences.
- Staff we spoke with during the inspection told us that they enjoyed working at the service and felt supported.
- The service had a duty of candour policy in place, which explained the provider's responsibility when something went wrong.

Summary of findings

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Background to High View Residential Unit

High View Residential Unit is a seven-bedded unit that provides residential care to adults with acquired brain injury and histories of substance misuse. The service is set within a town house arranged over four floors. During the inspection, there were seven clients staying at the service who were all male. Residents were referred via local authorities' social service departments, clinical commissioning groups and community mental health teams.

High view residential unit is registered to provide the following regulated activities:

- Accommodation for persons who require nursing or personal care
- Accommodation for persons who require treatment for substance misuse

The service has been registered with the CQC since 2011. The service has been inspected twice; one was carried out in September 2012 and the other in August 2013. The service was meeting the CQC essential standards that were inspected. There is a registered manager in place, who is the managing director of the service.

The service does not provide a detoxification programme, as all of the clients are abstinent. Staff provide day-to-day support to clients in order to ensure clients have a good quality of life. The service employs a therapeutic team, which included neuro-rehabilitation coaches, literacy and numeracy coaches, counsellors and activities coordinators. The support workers and coaches work with clients on an individual and group basis. Staff facilitate social groups, which include taking clients out to the local café and for walks. Staff do not provide psychological therapies to clients.

Our inspection team

The team that inspected the service comprised of two CQC inspectors, an assistant inspector, an expert by experience, a specialist advisor (a psychiatrist with a background in substance misuse) and a pharmacy inspector who attended the inspection on 15 August only.

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?

Summary of this inspection

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:

- looked at the quality of the physical environment, and observed how staff were caring for clients
- spoke with five clients
- spoke with the registered manager who was also the managing director, business manager and team manager
- spoke with four other staff members employed by the service provider including support workers and neuro-rehabilitation coaches
- received feedback about the service from one independent advocacy service
- attended and observed a daily handover meeting for clients
- collected feedback using comment cards from two clients
- looked at seven 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 we spoke with described staff as being empathetic, enthusiastic and respectful. One client told us that staff helped them to visit their family. Two clients told us that they felt they received a good service; felt that their medicines were managed well and that the facilities were adequate.

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:

- The environment was not fit for some clients who were at risk of falling due to their physical conditions and cognitive impairments, which can affect balance and coordination. The provider had placed handrails up the stairway and on the ground floor corridor to help clients move around the building. However, the provider had not made other reasonable adjustments to meet the needs of clients using the service in order to ensure their safety. For example, there was no disabled access into the house, there were no lifts to help clients move easily around the building, clients had not been risk assessed in using the stairs and clients were unsupervised when using the stairs. There were no panic alarms installed which meant that there was no means for clients or staff at the service to alert staff to any emergency.
- Throughout the building, there was a strong smell of urine around the bathrooms and toilets.
- The service did not have infection control measures in place in the area where medicines were administered. There was no evidence to demonstrate that the area was cleaned regularly.
- The key for the medicine cupboard was observed to be stored on a hook in the administration office and on a few occasions left in the medicine cupboard. The office door was not closed throughout the inspection and there was a risk of the key going missing.
- The service offered a wide range of mandatory courses to staff. However, the service had not ensured that staff had completed all courses to support clients who had specific care needs. One member of staff had not completed any of the internal mandatory training programme.
- Risk assessments were not updated after incidents had occurred and some clients were not being assessed in relation to specific risks. For example, three clients were self-administering creams without an appropriate assessment to ensure that clients were able to apply creams safely. We

Summary of this inspection

reviewed ten incident reports and all ten risk assessments had not been updated as a result of the incidents. The lack of assessing and identifying risks meant that the service was unable to mitigate risks as they were unknown.

- Staff failed to ensure clients with epilepsy were safely managed. A client had been prescribed specific medicine in order to manage their epileptic seizures. However, staff had not completed specialist training in how to administer medicines rectally to a client during a seizure. A neurologist had recommended a change in medicine for the same client. However, the service had not completed a risk assessment to ensure that the client's treatment plan was sufficient and had not ensured the GP had reviewed the plan in a timely manner.
- The internal reporting system was not working effectively as some incidents were not being reported and investigated appropriately. A serious incident had not been reported internally and a separate incident involving a client absconding had not been reported. Lessons learned from incidents lacked detail and the system was not robust enough to ensure incidents were prevented. The service did not routinely complete statutory notifications to the CQC for incidents that required reporting.

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

- The service had a child protection safeguarding policy in place for when children visited the service.
- Staff had been identified to be first aiders and fire marshals. The key persons were clearly visible on posters around the building.
- The service had a duty of candour policy in place, which explained the provider's responsibility when something went wrong.
- The service did not use bank or agency staff and there was one vacancy at the time of inspection.
- Safeguarding monthly audits had been carried out for the past seven months and were up to date. Staff we spoke with understood how to raise a safeguarding concern and the correct procedure to follow.

Are services effective?

We do not currently rate standalone substance misuse services.

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

Summary of this inspection

- Staff were not always appropriately qualified and experienced in carrying out specialist tasks. A part of a client's catheter care plan was for staff to clean the catheter site and observe for signs of infection. However, staff had not received catheter care training in order to understand and identify signs of physical health deterioration. Sixty-three percent of staff had not completed specialist training in diabetes care, despite two clients staying at the service who had been diagnosed with the condition. Fifty-five (five) percent of staff required a refresher in the Mental Capacity Act (MCA).
- Individual client records were stored on a shelf in the administration office. However, the door was not locked and mostly kept open without staff supervision. This did not ensure the security of the office and client records could always be maintained.
- The service did not routinely monitor their performance or measure clients' health outcomes. This meant that the service was unable to demonstrate their clinical effectiveness as well as being able to monitor and improve upon the quality of the service provided.

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

- Five clients were subject to Deprivation of Liberty Safeguards authorisations and all of the relevant paperwork was correct and up-to-date.
- Staff attended monthly reflective practice meetings in order to discuss and learn from complex cases.
- Staff were receiving regular supervision and annual appraisals.
- Daily handovers took place between shifts and team meetings were held on a monthly basis, which incorporated client reviews. The service had built links with the local hospital and local GP practices.

Are services caring?

We found the following areas of good practice:

- Support workers facilitated outings for clients throughout the week. Clients enjoyed going for walks and attending the local cafes.
- On a monthly basis clients had a meeting where they were encouraged to raise their questions, concerns or comments. Keyworkers and the clinical psychologist met on a monthly basis to discuss clients' care plans and recovery.

Summary of this inspection

- Clients had access to independent advocacy services. Four clients had used an advocate within the 12 months.

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

- Client community meeting records demonstrated that the meetings were not taking place regularly. Between January and August 2016, six meetings had taken place. Meeting minutes did not demonstrate a structured agenda for staff to follow.

Are services responsive?

We do not currently rate standalone substance misuse services.

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

- During the inspection, we observed a handover meeting whereby staff held the meeting in the lounge area with the door open. Clients were coming in and out of the room during the handover and other members of staff were passing the door. Staff had not ensured that clients' privacy had been protected.

We found the following issues that the following areas of good practice:

- The service had a complaints policy and procedure in place. However, the service had not received any complaints in the past 12 months.
- Clients we spoke with felt able to make staff aware if they were concerned or unhappy.

Are services well-led?

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

- The service did not have appropriate systems and processes in place to ensure that the quality and safety of the care and treatment provided was continuously monitored and improved upon. The service did not have a risk register, which focused on clinical risks such as staffing and the environment.
- The service carried out internal audits, which included health and safety, care plans, and medicine audits. However, the audits were not robust as they had not identified poor areas of practice.
- Staff files were not all up-to-date and did not demonstrate the provider had obtained the correct information prior to employment to demonstrate that employees were of good

Summary of this inspection

character. Twenty-five percent of the files we reviewed demonstrated there were gaps in employment history without an explanation and 50% of files did not demonstrate the provider had gained two appropriate references. The registered manager's file did not demonstrate that two references had been obtained. The registered manager was also the managing director of the service.

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

- The registered manager who was also the managing director attended the service on a regular basis and knew all clients on an individual basis. The manager had a good knowledge of clients' backgrounds, histories and preferences.
- Staff we spoke with during the inspection told us that they enjoyed working at the service and had no concerns of bullying.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

- Five clients were subject to Deprivation of Liberty Safeguards (DoLS) authorisations and the acting manager was in the process of completing DoLS applications for two other clients. We reviewed six client records and found that 100% of records were up-to-date with capacity assessments, which were decision specific, and appropriate parties had provided input into the decision. The DoLS applications were completed appropriately and updated when expired. The service had a DoLS policy in place and was locally available. However, the policy did not formally include the recent change of case law in this area. The manager had added the new guidance into the front of the policy folder.
- The service provided staff with Mental Capacity Act (MCA) and DoLS training combined. Training records demonstrated that 45% of staff required a refresher of MCA training and 9% required a refresher of the DoLS training as it had expired three years ago. Staff we spoke with had a varied understanding of the main principles of MCA and one member of staff told us that capacity was the responsibility of the manager and the psychologist.However, staff told us that if they were concerned they would discuss it with their manager.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

- The service was located in a four-storey town house. The provider had placed handrails up the stairway and on the ground floor corridor to help clients move around the building. However, the provider had not made other reasonable adjustments to meet the needs of clients using the service in order to ensure their safety. For example, there was no disabled access into the house. During the inspection, we observed some clients using the stairs and some of them had an unstable gait. There were staircases throughout the house including a metal staircase down to the garden. The provider had not made reasonable adjustments to meet the needs of clients using the service in order to ensure their safety. For example, there was no disabled access into the house or other aids to help clients move easily around the building.
- The layout of the building meant that it was difficult for staff to observe all areas of the house. The service mitigated the risks by assessing clients risk prior to being accepted into the home and not accepting clients who had a history of self-harm using ligatures or who were actively suicidal.
- During the inspection, the service only had male clients living at the home. However, the service had accepted female clients in the past.
- There was a smell of urine throughout the hallways of the house, which we raised with the acting manager to rectify. Overall, the bathrooms and toilets were not clean and were in need of redecoration. The acting manager told us that the support workers deep cleaned two bedrooms each day in collaboration with the clients. This included moving furniture, cleaning floors, mopping and helping clients with their laundry. The cleaning duties were documented on the daily planning sheet.
- There was no clinical room available and the medicines cupboard was stored within a small, cramped administration office on the ground floor. The medicine key was kept on a hook in the office. The office door remained open throughout the inspection and at times, no members of staff were in the office, which meant the key could be removed. We observed the key left in the cupboard and the office door was open. The area where medicines were dispensed was not clean and was heavily cluttered. The daily cleaning sheet did not include the medicines administration area and there was no infection control regime in place for this, which meant the service could not ensure that the area was clean.
- The service did not have access to emergency life support equipment. For example, a defibrillator and oxygen supply. However, the service had an emergency protocol procedure in place, which advised staff how to respond in an emergency. Staff knew to call an ambulance and await support from emergency services. Ten members of staff were first aid trained and had access to first aid boxes.
- A specialist contractor carried out a fire safety assessment in October 2015 and raised several areas of concern that required action. The provider had completed the outstanding actions. Three members of staff were identified as fire wardens. Posters clearly demonstrated who the three fire wardens were. The service alternated fire alarm tests for each floor, therefore each floor would be tested every three weeks. The fire alarms had been tested for the past six months. The managers mostly carried out periodic health and

safety checks on a monthly basis. We checked six health and safety checklists from January to July 2016 and found the checklist for June and July had not been fully completed.

- The service carried out legionella tests, which included checking the water supply on an annual basis and routinely monitored the clinical fridge temperatures.
- Environmental risk assessments were not carried out for the building itself. However, clients had individual risk assessments, which included an assessment of some risks that the environment may present to them, for example, using equipment in the kitchen.
- There were no panic alarms installed within the building and staff did not wear personal panic alarms. This meant that there was no means for anyone at the service to alert staff to any emergency. Two clients within the service had epilepsy and seizures, which meant there was an increased risk of staff and clients not being able to raise an alarm when there was an emergency.

Safe staffing

- The service ensured that two support workers were on shift at all times and had the flexibility of moving staff from the provider's other locations in order to fill any gaps in staffing. In total, 11 staff were employed at the service during the inspection. The service encouraged staff to rotate across the providers other locations in order for staff to learn from different client groups. The shifts worked were early, late and night shifts. Staff were employed on a full-time and part-time basis. One member of staff worked on an ad-hoc basis and had been employed for many years. There was a vacancy for a deputy manager as the team manager was shared with another location.
- Over the past 12 months, staff sickness had been very low at 0.5%. Three members of staff had left within the past year.
- In total, we reviewed four weeks of the staff rota in July and August 2016. The rota demonstrated that some staff tended to work long days, which included working an early, and a late shift combined. This meant staff working from 7.30am to 9.15pm. Some staff preferred to do regular nights. The provider offered an opportunity for staff to opt-out of the 48-hour EU working directive. The rota demonstrated that on one occasion in July 2016, one support worker had worked a night shift alone. The manager told us that this was a very rare occurrence and the support worker had been reminded to read the provider's lone working policy, which provided guidance on working independently. The acting manager created some specific guidance in relation to a lone worker managing an emergency. Staff were advised to contact the on-call managers and also to contact another location for staffing assistance. At the weekends, the manager was rostered to be on-call in case of any emergencies and the registered manager who was also the managing director was always on-call and lived locally to the service.
- The service employed a clinical psychologist who managed the therapeutic team within the service. However, the clinical psychologist told us that they do not work directly with clients. The therapeutic team included rehabilitation coaches who were post-graduate psychology students. During the week, there was a therapeutic timetable in place where staff were allocated to attend the service to carry out tasks with clients. The managing director who was also the registered manager told us that the provider was trying to attract more graduates to the service.
- The service offered a wide range of mandatory courses to staff. However, the service had not ensured that staff had completed all courses to support clients who had specific care needs. One member of staff had not completed any internal mandatory training programme. Staff were provided with nine different mandatory training courses and the overall compliance rate was 86%. However, the service had not ensured that all staff had completed specific mandatory training courses to support clients who had specific health needs. The service had not ensured that one member of staff had not completed the internal mandatory training programme.

Assessing and managing risk to clients and staff

- The service did not use seclusion facilities and did not carry out physical interventions with clients. Staff told us that only verbal de-escalation was used to meet challenging situations with clients.
- Overall client risk assessments required further improvements. Most of the clients staying at the service

had physical health conditions, some were unstable on their feet and one client had a learning disability However, clients had not been risk assessed in using the stairs.

- A client had been diagnosed with epilepsy and was prescribed medication in order to manage the epileptic seizures. However, on three occasions staff had administered the medicine without being appropriately trained in administering medicines rectally during a seizure. This was unsafe practice and posed a risk to the client's safety.
- The service had a safeguarding policy in place. The service had made a safeguarding alert to the local authority after a member of staff made a serious allegation. Safeguarding monthly audits had been carried out for the past seven months and were up to date. Staff we spoke with understood how to raise a safeguarding concern and the correct procedure to follow. The service had a child protection policy and procedure in place for when children visited the home. The manager told us children rarely visited the service.
- Overall, medicines were not managed appropriately. The service was using medicine administration records (MARs) from a local pharmacy. However, staff had not received training in how to complete the MARs correctly, which had led to errors being made. For example, one client had been prescribed a medicine to treat epileptic seizures as and when required, which had not been transcribed onto the MAR. A member of staff had administered a medicine during the inspection and did not sign the MAR to demonstrate it had been given to the client. In addition to this, the medicine dose had recently changed and staff had not ensured the amended dose had been transcribed onto the record. Another client had epilepsy and was seen by a neurologist in June 2016, who recommended that a medicine dose should be altered and for another medicine to be introduced if required. However, the client's GP had not reviewed and amended the treatment plan to reflect the neurologist recommendations. The service managers had not recognised that the client's treatment plan required a review immediately, which meant that the service was failing to ensure safe management of a client with epilepsy. Monthly medicines management audits were completed but there was no system in place to check the balances of medicines not supplied in pre-prepared packs. This meant that the service was not monitoring medicine stock and ensuring that any stock discrepancies were investigated. However, arrangements were in place for obtaining medicines. Staff told us how medicines were obtained and we saw that supplies were available to enable clients to have their medicines when they needed them.

Track record on safety

- There had been one serious incident within the service. There had been a delay in reporting the incident via the internal reporting system. However, the incident was referred to the local safeguarding team and fully investigated.

Reporting incidents and learning from when things go wrong

- Staff were aware of the aggressive behaviours that some of the clients displayed and that the behaviour was related to clients having enduring mental health conditions and brain injury. There were frequent incidents of clients becoming aggressive with staff. Staff understood how to manage and defuse potentially aggressive incidents.
- The incident reporting system in place was ineffective as some incidents were not being reported and investigated appropriately via the internal process. We reviewed 10 incident reports and reviewed how incidents were managed. An incident had happened earlier in 2016, which related to a client going missing. However, staff had not documented this as an incident via the internal reporting process. There was no record of how the incident had been followed up to ensure lessons had been learned for the future. After the inspection, the team manager informed us that the service had reported the incident to Southwark Adult services, but this was not recorded in the client's care records. Another example of this related to an allegation that was made internally in March 2016. The incident report demonstrated that there had been a poor relationship between staff. There was no evidence to demonstrate how the service responded to this.
- Staff we spoke with informed us that staff meetings took place every month to discuss each client and any related incidents. Incidents were written in the

communication book for everyone to read. Staff were expected to read the communication book at the start of every shift and were aware of minutes from meetings from the provider's other locations.

Duty of candour

- The service had a duty of candour policy in place, which explained the provider's responsibility when something went wrong. The provider's accident and incident reporting procedure stated that the duty of candour should be referred to when an incident involved a client. Staff we spoke with were unaware of the term or its meaning. However, the provider had demonstrated that they were open and honest when an incident had happened. For example, a written apology letter was sent to the client involved and the client was invited to a meeting to discuss what action had been taken after the incident.

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

Assessment of needs and planning of care (including assessment of physical and mental health needs and existence of referral pathways)

- Senior managers at the service assessed clients before admission, which included a review of the client's physical and mental health. Care plans were put in place to ensure that client needs were supported during their stay at the service. We reviewed seven clients' care plans and found that care plans were reasonably detailed when completed and included some evidence of clients being involved. Records demonstrated that care plans were reviewed on a monthly basis. However, care plans were not routinely updated after an incident, or in place for specific physical health conditions such as catheter care or epilepsy.
- The service did not provide comprehensive physical health monitoring as clients routinely saw their GP and staff were able to book appointments for physical health checks.
- Keyworkers and the psychologist met on a monthly basis to review clients' care plans and their progress. Neuro-rehabilitation coaches also provided monthly psychology reports which provided information on clients' progress which was reviewed by the team.
- Individual client records were stored on a shelf in the administration office. However, the door was not locked and mostly kept open. The office was not always manned by a member of staff, which meant that the security of the office could not always be maintained and client' files and names were visible to others.

Best practice in treatment and care

- Staff administered medicines to clients, which had been prescribed by the local GP. Medicines prescribed followed national guidance. However, during the inspection we had found that the local GP had agreed to increase a client's medication in order to manage their distressed behaviour. However, there was no evidence of staff undertaking any assessments of the client's behaviour in order to monitor the effects of this medication. We did not see evidence to demonstrate that the service was jointly working with other community clinicians to review the client's current treatment plan. The client's care notes did not clearly demonstrate the reason for increasing the medication with sedative side effects.
- The service had a therapeutic team that visited on a timetabled basis, which consisted of neuro-rehabilitation coaches, a literacy and numeracy coach, activities coordinators and a counsellor. The neuro-rehabilitation coaches were psychology graduates who were on a paid placement from a London university. The clinical psychologist led the therapeutic intervention team and the coaches facilitated the activities, which ran Monday to Friday. The therapeutic team facilitated activities such as individual or group walks, visiting local coffee shops and social groups including a current affairs group. The clinical psychologist did not work directly with clients. The role included overseeing the coaches and providing support to them when they were confronted with challenging situations. The service provider advertised that they offered brain-injury rehabilitation, which included interventions such as guided mindfulness meditation, motivational interviewing and cognitive behavioural techniques. However, during the inspection we found little evidence to demonstrate that clients were receiving psychological therapies in order to improve their wellbeing.

- Staff monitored the clients' health and wellbeing. All clients were registered with a GP and some clients received specialist physical health care at the local hospital.
- The service did not routinely monitor their performance and did not measure clients' health outcomes. This meant that the service was unable to demonstrate their clinical effectiveness and was not able to monitor and improve upon the quality of the service provided.
- The managers had undertaken a range of audits including quality visits, care plans, risk assessments, safety and safeguarding. An external pharmacist attended the service to carry out annual medication audits. Some staff carried out audits that related to health and safety and fire. Senior managers had carried out quality assurance audits over the past six months, which included health and safety. However, the internal and external medicine audit had not highlighted the medicine concerns we found during the inspection, which demonstrated that the audit was not robust.

Skilled staff to deliver care

- The staffing group consisted of one team manager, seven support workers, three senior support workers, one counsellor, two neuro-rehabilitation coaches and one literacy and numeracy coach.
- Some staff had been in post for a long time and had previous healthcare experience. Staff were provided with specialist training in order to equip them to carry out the role of support worker. The neuro-rehabilitation coaches were permanent members of staff who worked at the service on a full-time basis. The registered manager who was also the managing director of the service and team manager were both registered social workers and had worked for many years in adult social care.
- Staff were provided with a comprehensive three-month induction. A part of the induction was for staff to spend time shadowing colleagues, completing necessary training and reviewing their progress. Staff who worked at the service during the inspection were not new to healthcare and had obtained a qualification in health and social care including some staff who were trained nurses. The service supported staff to complete the care certificate induction when required.
- Staff received supervision approximately every two months. We reviewed six supervision records, which were all up-to-date and annual appraisals had been completed for this year.
- Staff were offered a variety of specialist training which included epilepsy, diabetes, brain injury, challenging behaviour and alcohol misuse. However, 63% of staff had not been trained in diabetes care despite the service-accepting one client who was diagnosed with diabetes. Staff had not received specialist catheter care training although a client care plan indicated that it was staff responsibility to monitor the catheter for signs of infection. Staff could have missed signs of deterioration due to not being appropriately trained.
- The service did not have a robust system in place to ensure staff were suitably qualified and experienced when carrying out specific tasks. For example, staff were administering medication to a client without the appropriate training. This increased the risk of the procedure being carried out unsafely and the client's safety was compromised. The service had not recognised that this practice was unsafe.
- Staff performance was addressed and monitored in supervision meetings. The team manager told us that staff that were not performing were supported as much as possible by the senior managers.

Multidisciplinary and inter-agency team work

- Daily handovers took place between shifts and team meetings were held on a monthly basis, which incorporated client reviews. Monthly reflective practice meetings were held to discuss complex cases and at times, the neuro-rehabilitation coaches participated. Senior managers met on a monthly basis to discuss and review each client.
- The manager felt that the service had built good links with the local general hospital and GPs. Social workers from the local authority visited the service to carry out annual placement reviews. None of the clients were linked to community mental health teams .

Good practice in applying the MCA

- Five clients were subject to Deprivation of Liberty Safeguards (DoLS) authorisations and the acting manager was in the process of completing DoLS applications for two other clients. We reviewed six-client

records and found that 100% of records were up-to-date with capacity assessments, which were decision specific, and appropriate parties had provided input into the decision. The DoLS applications were completed appropriately and updated when expired.

- The service provided combined Mental Capacity Act (MCA) and DoLS training. However, completion records demonstrated that 45% (five) of staff required a refresher and 9% (one) of staff required an update in DoLS training as the training had expired three years ago. The provider expected staff to update their training on an annual basis. Staff we spoke with had a varied understanding of the main principles of MCA and one member of staff told us that capacity was the responsibility of the manager and the psychologist. However, staff told us that if they were concerned they would discuss it with their manager.
- A DoLS policy was in place and was locally available. The policy did not formally include the recent change of case law. However, the acting manager had added the new guidance into the front of the policy folder for staff to read.

Equality and human rights

- The service initially assessed clients' needs before they entered the service, including their religious and cultural needs.

Management of transition arrangements, referral and discharge

- Clients rarely moved and transitioned to other services.

Are substance misuse services caring?

Kindness, dignity, respect and support

- During the inspection, staff were observed to be caring and interacting well with clients. When clients needed assistance, staff were available to help.
- Clients we spoke with described staff as being very good, empathetic and enthusiastic. One client told us that staff helped them to visit their family and another told us that staff were respectful.
- All staff had a good knowledge of the clients' needs and support staff had spent time getting to know the clients very well including their family history, background and their day-to-day abilities.

The involvement of clients in the care they receive

- Support workers facilitated a community meeting involving the clients on a monthly basis. Staff encouraged clients to suggest ideas and raise any requests or concerns they may have. However, meeting minutes showed that between January and August 2016, six meetings had taken place. Meeting minutes did not demonstrate a structured agenda for staff to follow. Meetings covered topics such as activities and food. One meeting had an action plan. Clients met with their key worker, which gave clients an opportunity to raise any concerns or questions privately.
- Clients had accessed an independent advocate in the past six months. Staff were able to provide contact details for local advocacy services.
- Staff supported clients to see their families and carers when they were in contact with them.
- Clients were not involved in decisions to recruit staff.

Are substance misuse services responsive to people's needs?

(for example, to feedback?)

Access and discharge

- The service had been fully occupied (100%) over the past 12 months. The service accepted referrals from anywhere but most clients were from a London borough. The service had a waiting list of 12 months.
- The provider had clear criteria for which they would accept clients into the service. The criteria included clients who had an acquired brain injury or/and had a history of substance misuse. Some clients who were staying at the service also had learning disabilities and mental health conditions.
- The aim of the service was to move clients onto supported living where possible. However, there was no recovery pathway in place in order to promote clients to do this. Clients were rarely discharged from the service. For example, one client had been staying at the service

for 10 years. The placement teams from local authorities visited the clients in order to review individual cases. The service aspired to develop a transition service, which would create pathways for clients to transition easily into independent living.

The facilities promote recovery, comfort, dignity and confidentiality

- The service was located within a town house situated in a busy residential area. There was a lounge, dining room, kitchen and a recreation room, which included a pool table for client use.The communal dining room and lounge area was a large space and decorated to a good standard. Three bedrooms were located within the lower ground floor; two bedrooms were on the first floor and two bedrooms on the second floor. Bedrooms were well furnished with a chest of drawers, a bed and a wardrobe. The rooms were an adequate size and included a tiled shower area with a separate toilet. The service had a pleasant garden, which included a small hut for clients who smoked, as smoking was not permitted within the house.
- The service provided a comfortable and homely environment. Clients had unrestricted access to the large garden, which was well maintained. However, the layout of the building meant that staff did not have a dedicated space for one to one sessions or team meetings. Instead, staff had to use the lounge, recreation room or the garden. During the inspection, we observed a handover meeting whereby staff held the meeting in the lounge area with the door open whilst clients were present. This practice did not ensure clients' privacy. There was no access to a quiet room or a space for visitors. Visitors would need to visit in the lounge or the garden. Clients were able to make phone calls in a private space by using the office cordless phone.
- Clients had access to a kitchen to make hot and cold drinks. Staff carried out risk assessments on clients to ensure they were safe in making hot drinks. Clients were made aware of the rules of being at the service, which included no smoking and no alcohol allowed.
- Clients' bedrooms were personalised with personal photos and their belongings.
- Clients regularly participated in activities, which included outings to the local cafés, trips to the seaside and local parks. Activities took place throughout the week.

Meeting the needs of all clients

- Leaflets available for clients included a leaflet about the service, how to complain and easy read information about DoLS. No leaflets were available that included information about local services. Most of the leaflets were not available in easy read or in any other language apart from English.
- Clients were supported with their spiritual needs and each client had a care plan around this. The acting manager told us that clients had not expressed a desire to attend a religious place despite staff regularly reminding clients it was an option.
- Clients dietary requirements were recorded and they jointly agreed the food menu. For example, staff prepared a Ghanaian dish for one client on a weekly basis.

Listening to and learning from concerns and complaints

- The provider had an appropriate complaints, suggestions and compliments policy in place, which included that managers were required to provide an initial acknowledgement letter within 24 hours and for the matter to be investigated within 28 days. Complaints and compliments were supposed to be documented within a dedicated log.
- The service had not had received any complaints since 2011.
- Three clients were able to tell us that they knew how to complain and felt confident to raise any concerns. However, there was no written information available for clients describing how to make a complaint.

Are substance misuse services well-led?

Vision and values

- The service had a ' document available which included the vision and values for the service. The managers told us that the aim of the service was to provide continuous

rehabilitation and maintenance to clients at the service. The managers also told us that the therapeutic team had helped support workers to widen their knowledge of the client group.

- The registered manager who was also the managing director visited the service regularly and knew all of the clients individually.

Good governance

- The managers had undertaken a range of audits including quality visits, care plans, risk assessments, safety and safeguarding. A senior manager carried out quality assurance checks on a monthly basis. However, the quality checks were not working effectively as the concerns we had raised during the inspection had not been highlighted in the monthly checks.
- Staff received supervision every two months and appraisals had been completed for 2016.
- Team meeting minutes demonstrated that staff discussed clients and incidents on a regular basis. However, there was no evidence to demonstrate there had been shared learning between the provider's other locations in relation to incidents and the lessons learned.
- The service was unaware of notifiable safety incidents that were required to be reported to the CQC. During the inspection, we found that the service had not notified the CQC of DoLS authorisations and incidents that were reported to the police.
- The service did not have appropriate systems and processes in place to enable the service to identify where quality and safety was being compromised. This was because the service did not have a risk register or equivalent system for recording potential risks to the service, including clinical risks, and how these risks were being mitigated or managed. The acting manager told us that that the service did not have a risk register and was going to look at guidance on how to develop one. The service had a business continuity plan in place, which included specific events that could happen to the service for example disruption to the utilities supply and how the service would manage this. However, the risks did not demonstrate how potential clinical risks, staffing and the environmental risks were being managed.
- The service did not routinely monitor their performance and did not measure health outcomes. The service-collected information, which related to the overall costing's for each client who was placed with the service.
- The service had not carried out appropriate checks on staff prior to employment to demonstrate they were of good character and had the qualifications, competence, skills and experience necessary. Out of eight employment records we reviewed, 25% had gaps in employment history without an explanation. Fifty percent of records did not demonstrate the provider had gained two appropriate references for each staff member. For example, records showed the references were from a friend or a neighbour. This potentially put clients at risk from unsuitable staff.

Leadership, morale and staff engagement

- Overall, staff we spoke with enjoyed working at the service and had no concerns regarding bullying. The provider carried out a staff survey in May 2016. Five members of staff had completed the survey. The feedback included two members of staff feeling that they had not been trained, supervised and encouraged to raise concerns internally. A member of staff was unhappy that the survey was not anonymous and another member of staff disagreed that they felt respected by the team. During the inspection, staff we spoke with understood how to raise concerns and felt able to escalate concerns to their manager. The service had plans to introduce a new employee of the month initiative by October 2016. Staff were introduced to a new pay scale in order to promote and encourage staff to progress in their roles.
- The acting manager is a trustee of the British Institute of Brain Injury Social Work Group. The managers told us that staff were able to attend external courses which included training in leadership and management. The provider told us that staff attended specialist events to enhance their professional development.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that clients are comprehensively risk assessed and individual risk assessments are updated after incidents take place.
- The provider must ensure that the environment is fit for clients who have deteriorating physical health conditions. This includes ensuring clients are safe to use the stairs independently.
- The provider must ensure that staff are appropriately trained in carrying out specific tasks. This includes staff being trained in how to administer medicines to a client whilst having a seizure and in catheter care management.
- The provider must ensure that medicines are managed safely. This includes staff receiving the appropriate training in how to complete medicine administration records and that the medicine cupboard keys are stored in a safe place at all times.
- The provider must ensure that client needs are individually assessed and a care plan is formulated in order to ensure the client is receiving the correct support and treatment.
- The provider must ensure that there is a system in place that demonstrates that the provider has assessed the services' clinical risks.
- The provider must ensure that the service is routinely monitoring their performance and measuring health outcomes.
- The provider must ensure that staff respect clients' rights to confidentiality and protect the privacy and dignity of individuals by ensuring that clients' personal details are not discussed in front of others and individual care records are safely stored.
- The provider must ensure that all staff including the registered manager have all the necessary recruitment checks in place including two employment references from suitable referees and a full career history.
- The provider must ensure that all statutory notifications are reported appropriately to the CQC.

Action the provider SHOULD take to improve

- The provider should ensure that there are no strong odours or smells in any areas of the service for long periods.
- The provider should ensure that infection prevention and control audits are carried out and recorded to enable staff to learn from the results and make improvements to the service.
- The provider should ensure that all staff have completed mandatory training courses which include MCA and diabetes care training.
- The provider should ensure that the decoration in patient bathrooms and toilets are updated and the areas are kept clean at all times.
- The provider should ensure that health and safety checks are fully completed and documented accordingly.

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 nursing or personal care Accommodation for persons who require treatment for substance misuse	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The provider failed to establish and operate effective recruitment procedures in Schedule 3 of the Health and Social Care Act 2003 (HSCA). The provider had not conducted adequate checks on the employment history of staff. **This was a breach of regulation 19(1)(2)(3).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Accommodation for persons who require treatment for substance misuse	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider had not ensured that they had reported notifiable incidents to the CQC such as when clients sustained a serious injury, outcomes of DoLS applications, incidents reported to the police and any allegations of abuse. **This was a breach of regulation 18(1)(2).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Accommodation for persons who require treatment for substance misuse	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not ensured that the keys to the medicine cupboard were stored in a safe place.

This section is primarily information for the provider

Requirement notices

This was a breach of regulation 12(1)(2)(b)(h).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Accommodation for persons who require treatment for substance misuse	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The provider had not ensured that the privacy and dignity of clients was protected and their personal details remained confidential. **This was a breach of regulation 10(1)(2)(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 nursing or personal care Accommodation for persons who require treatment for substance misuse	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had failed to ensure that service users were safe because: The service had not assessed and identified associated risks in relation to clients falling. Risk assessments and care plans were not updated after incidents had taken place. The environment was not fit for some service users who were at risk of falling due to their physical conditions. This was because the provider had failed to make reasonable adjustments to meet the needs of people using the service. Service users had not been risk assessed to use the stairs. The service had not ensured that staff were appropriately trained in carrying out specific tasks. Staff had not received training in how to administer medicines to a service user whilst having a seizure. Staff were responsible to monitor and care for a service user who had a catheter. However, staff had not been trained in catheter care management. Medicines were not being managed safely and staff were not trained in how to complete medicine administration records which had affected the quality of record keeping. A service users medicine regime had not been reviewed following expert advice. Explanation for medication changes were not documented appropriately.

This section is primarily information for the provider

Enforcement actions

Care plans were not in place for service users who had physical health conditions. The lack of care planning did not ensure that service users were protected against preventable risks.

The service did not have a policy or procedure in place to support service users who had conditions such as epilepsy and frequent seizures.

The internal incident reporting system was ineffective and incidents were not being reported and investigated.

This was a breach of regulation 12 (1)(2)(a)(b)(c)(d)(g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Accommodation for persons who require treatment for substance misuse	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had not ensured that the service had effective systems and processes in place because: The service did not have a risk register in place, which focused on clinical risks. The service did not routinely monitor their performance or measure health outcomes. **This was a breach of regulation 17 (1)(2)(a)(b)(c)(d)(f).**