

THOMAS Drug & Alcohol Rehabilitation Unit







Quality Report

Witton Bank
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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	Good	
Are services safe?	Good	
Are services effective?	Good	
Are services caring?	Good	
Are services responsive?	Good	
Are services well-led?	Good	

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.

Summary of findings

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 rated T.H.O.M.A.S Drug and Alcohol Rehabilitation Unit as good because:

- The service delivered safe treatment. Staffing levels were sufficient to deliver safe care. Staff completed comprehensive risk assessments of clients and developed risk management plans. Systems were in place to protect clients from abuse. Staff followed appropriate medication management protocols. Policies and processes were in place to ensure the safety of the environment.
- Care and treatment was delivered in line with national guidance and best practice. Clients had their needs fully assessed. Care records were comprehensive, holistic and completed in a timely manner. Clients had physical health concerns managed appropriately. Staff were suitably skilled and supported to meet their roles and responsibilities.
- Staff treated clients with consideration and compassion. They demonstrated good knowledge of their individual needs. Clients were involved in decisions about their care and treatment.
- The service had clear process for the referral, admission and discharge of clients. Staff worked collaboratively with other services to facilitate these processes. Clients had access to a range of facilities to support their treatment.
- The service was well-led. There was a governance structure and processes to support quality assurance. Staff and clients spoke positively about the management of the service.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Residential substance misuse services	Good 	

Summary of findings

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Summary of this inspection

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Good



T H O M A S Drug & Alcohol Rehabilitation Unit

Services we looked at

Residential substance misuse services

Summary of this inspection

Background to T H O M A S Drug & Alcohol Rehabilitation Unit

T.H.O.M.A.S (Those On The Margins Of Society) Witton Bank is an inpatient drug and alcohol rehabilitation unit based in Blackburn, Lancashire providing 21 beds. The service provides residential psychosocial rehabilitation to men aged between 18 and 55. Clients who attend Witton Bank have already completed a detoxification programme, which means they are no longer actively using alcohol or illicit substances. Witton Bank provides a 26-week rehabilitation programme followed by the option of a further six months in a secondary community-based programme.

Witton Bank is one of three T.H.O.M.A.S services registered with the Care Quality Commission. It has been registered

since January 2011. The service is registered to provide accommodation for persons who require treatment for substance misuse and for the treatment of disease, disorder and injury.

The service has previously been inspected three times, in December 2012, October 2013 and June 2016. The service was found to be fully compliant with standards on all previous inspections.

There was a registered manager and nominated individual in place.

Our inspection team

The team that inspected T.H.O.M.A.S Drug and Alcohol Rehabilitation Unit comprised two CQC inspectors and a CQC assistant inspector.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited the service, looked at the quality of the environment and observed how staff were caring for clients
- spoke with five clients who were using the service
- spoke with the registered manager and nominated individual for the service
- spoke with four other staff members
- observed the delivery of a group session
- looked at four clients' care and treatment records
- carried out a specific check of the medicine management
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this inspection

This was an unannounced inspection, which means that the service did not know that we were coming.

What people who use the service say

We spoke with five clients during the inspection. Feedback from clients was positive. Clients spoke highly

of the service and staff. They felt that the treatment programme was appropriate, effective and was helping them to maintain and develop their recovery. Clients felt they were involved in decisions about their care.

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 rated safe as good because:

- Staff provided a safe environment for the delivery of care. Appropriate checks to ensure the safety of the building were in place.
- The service had sufficient staff to ensure client safety and engagement. Staff were up to date with mandatory training.
- Clients had up to date and comprehensive risk assessments. Risk management plans were in place and reflected the findings of risk assessments.
- Staff understood how to protect clients from abuse. Staff received safeguarding training and had clear safeguarding policies to follow.
- There were systems and processes to ensure the safe management of medicines.
- There was a process to report and learn from adverse incidents.

However:

- The décor of the building was old and tired.

Good



Are services effective?

We rated effective as good because:

- Clients received a comprehensive assessment. Care plans were personalised, holistic, recovery orientated and reflected the outcomes of assessments.
- Staff provided care and treatment suitable for the client group and in line with national guidance and best practice.
- Staff were supported in the delivery of care. Staff received regular supervision and annual appraisals. There was access to specialised training.
- There were good links with other services, support agencies and the local recovery network.
- Staff received training on mental capacity and the Mental Capacity Act. Mental capacity was considered as part of ongoing assessments.

Good



Are services caring?

We rated caring as good because:

- Staff treated clients with compassion and understanding. We observed positive interactions between staff and clients.
- Client feedback on staff and the service was positive.

Good



Summary of this inspection

- Staff involved clients in decisions about their care and treatment. Staff and clients worked collaboratively to develop care plans.
- Clients were able to give feedback on the service.

Are services responsive?

We rated responsive as good because:

- The service had clear admission criteria. There was a referral and admission process. Staff worked with referring agencies and the client to ensure they were prepared for admission.
- Clients had access to a range of facilities within the premises and the community to promote their recovery.
- Clients were supported to maintain relationships with loved ones. Staff supported clients to access and engage with the wider community.
- The service had assisted bedroom and bathing facilities. There was access to translation services. Clients religious, cultural and dietary needs were met.
- There was a complaints policy and process. Clients told us that they would be confident in raising any concerns.

Good



Are services well-led?

We rated well-led as good because:

- The manager had the skills, knowledge and experience to perform their role. Senior managers were a visible presence within the service.
- Staff knew and understood the provider's vision and values. These were applied in the delivery of care.
- Staff we spoke with described a positive and open culture. Staff morale was high.
- There was a governance structure to support the delivery of care. Staff had access to relevant policies and procedures.
- Staff had access to a risk register. Service performance was monitored. Business continuity plans were in place.
- Staff had access to the information and equipment required to carry out their roles.
- The service engaged with external organisations and played an active role within the local recovery network.

Good








Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff received training on the Mental Capacity Act although the service did not admit individuals without capacity. The provider had a mental capacity policy in place and referred clients to local GPs or mental health

services where concerns regarding capacity had been raised. Staff ensured clients consented to care and treatment and that this was assessed, recorded and reviewed promptly.

Residential substance misuse services

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

Are residential substance misuse services safe?

Good 

Safe and clean environment

T.H.O.M.A.S Witton Bank was located over four floors. There were 14 bedrooms. Seven bedrooms were single occupancy and seven bedrooms were dual occupancy. There were shared shower and bathing facilities. Clients were informed of these arrangements prior to admission.

The building was clean and well maintained. Clients joined a cleaning rota and took responsibility for the upkeep of the building and communal areas. Cleaning rotas we reviewed showed that the building was cleaned daily. However, the décor was old and tired. The service had recently begun the process of securing quotes to redecorate the premises and was waiting for a final decision to be made.

Staff maintained the safety of the building. Regular audits and maintenance checks were in place. This included monitoring of fire safety, prevention and detection systems, regular checks of water samples for the presence of legionella and an annual health and safety assessment. Staff adhered to infection control principles.

A ligature risk assessment and supporting policy was in place. This identified potential ligature risks within the building and identified actions to mitigate the risk for example through risk assessment and observation. The

service did not admit clients with high level mental health concerns or with active suicidal or self-harm behaviour. This was captured in referral documentation and through the assessment process.

Safe staffing

The service employed eight staff. These included the registered manager, four key workers, two group workers and administrative and technical support. The service was staffed 24 hours a day, seven days a week. Key workers worked 24-hour shifts. Key workers worked alone at night. There were appropriate lone working assessments, policies and protocols in place to support them. Group facilitators worked Monday to Friday from 9am until 5pm. There were sufficient staff to meet clients' needs and ensure the safe operation of the service. Clients we spoke with told us they had not experienced planned activities or group sessions being cancelled due to staffing numbers. Clients were able to have regular 1:1 time with staff.

The manager was able to increase staffing levels if required. The T.H.O.M.A.S organisation had its own bank staff who helped cover periods of sickness and leave. Bank staff had completed an induction and were familiar with the service and client base. The service did not use agency staff. There had been no staff turnover in the 12 months leading up to the inspection. Staff sickness for the same period was 1.8%.

Staff received and were up to date with mandatory training. This included training around safeguarding, first aid, health and safety, medicines management, information governance, infection control and blood borne viruses. The service manager kept a database of training compliance and ensured staff were booked onto or completed online training courses as required.

Assessing and managing risk to patients and staff

Residential substance misuse services

We reviewed four sets of care records. All had an up to date risk assessment that was started at the point of assessment with the client. All had a risk management plan for the early exit from the service if the client relapsed and used alcohol or drugs. This was because the client would risk losing their placement within the programme and become homeless. Management of risk included unexpected exit from treatment as well as protocols for dealing with unexpected exits from treatment. Risk management plans detailed the risk of unexpected exit from treatment.

On referral to the service, GPs provided a history of physical and mental health. These notes were not scanned onto the service's electronic notes system. However, risk assessment, risk management and care plans held the relevant information about clients' ongoing mental and physical health care and treatment. This included support from community mental health services; monitoring of treatment for blood borne virus; optical, dental and audiology appointments and referral from GPs for physical health checks. There was evidence that the service recognised and responded to deterioration in clients' health including referrals to external agencies.

Staff gave clients information about the risks of continued substance misuse and harm minimisation. Safety planning was an integral part of the care received within the service. This included risk management plans identifying clients at risk of opioid relapse following early exit from the service accessing naloxone kits. The early use of naloxone (a non-addictive, life-saving drug) can reverse the effects of an opioid overdose.

Individual client risks were discussed in the daily flash meetings and in response to a change in circumstances.

Staff adhered to best practice in implementing a smoke-free policy and during the inspection we saw staff enforcing this. The provider's smoking at work policy identified the building as a smoking free site. This included E-cigarettes and vaping. The service offered staff and clients access to smoking cessation education.

Safeguarding

Staff received training in safeguarding adults and children. Training was delivered both face to face and online. Training had recently been renewed for all staff. Staff we spoke with displayed a sound knowledge of safeguarding

principles and procedures. They were aware of different types of abuse and how to raise a concern. There was a safeguarding policy in place to support staff in managing and reporting safeguarding concerns.

The service had made no safeguarding alerts in the previous year. However, we saw evidence in records that staff considered safeguarding concerns and discussed two cases that staff had raised with the local safeguarding team but that had not required further action.

Children were allowed to visit the service as part of planned family visits. Management of child visits was covered within the safeguarding policy.

Staff access to essential information

Staff had access to an electronic system for client records as well as paper records. We saw all clients' paper records were scanned into the electronic system.

Medicines management

The service did not prescribe medicines. There were policies and procedures in place for staff to support clients who were on medicine. Clients could self-administer but staff also administered medicines. Staff assessed clients for their suitability to self-administer medicines. Medicine administration record sheets were in place and staff followed appropriate identification protocols including the use of client photographs.

The service had facilities for the storage of medicines including controlled drugs. However, the service was not storing any controlled drugs at the time of our inspection. The temperature of fridges used to store medicine was monitored daily. The Registered Manager completed monthly audits.

Track record on safety

There were no serious incidents at the service in the 12 months prior to inspection.

Reporting incidents and learning from when things go wrong

Staff recorded adverse incidents in client notes and in a separate adverse incident file. Adverse incidents were reviewed by the service manager. The managers completed incident reports where appropriate and these were

Residential substance misuse services

discussed in the provider's operational managers' meeting. Incidents and lessons learnt were a standing agenda item for team meetings. Staff we spoke with understood the type of incidents that should be reported and how to do so.

Are residential substance misuse services effective?

(for example, treatment is effective)

Good 

Assessment of needs and planning of care

We reviewed four sets of care records. The records we reviewed all contained assessments following a referral into the service and care plans. Care plans were holistic, person centred and personalised.

Care records including recovery plans were up to date and reviewed and contained all the essential information needed to support clients' care and treatment. For example the service completed assessment of risk to blood borne virus, drug and alcohol use and motivation to change.

Best practice in treatment and care

The service delivered care in line with the 12-step programme. The 12-step programme was developed by the alcoholics anonymous fellowship. It utilises principles of mutual aid and peer support as recommended in national guidance provided by the National Institute for Health and Care Excellence. Staff were also trained in and delivered psychosocial interventions including cognitive behavioural therapy and mindfulness. This was in line with Department of Health guidance that treatment for drug misuse should always involve a psychosocial component. Clients had access to a counsellor. Clients who had previously completed treatment at Witton Bank attended the service to act as peer mentors. The use of peer mentors to help make recovery a visible presence was recommended in the Strang Report (2012).

The service routinely offered blood borne virus testing and referred clients to the hepatitis services provided by the local NHS acute trust. Staff supported clients to live healthier lives for example in smoking cessation schemes, healthy eating advice and dealing with issues relating to

substance misuse. Staff supported clients by ensuring they were following the correct care pathway for example for chronic obstructive pulmonary disease (COPD) or Hepatitis B and C.

Staff undertook health and well-being assessments and used the treatment outcome profile (TOPS) a validated tool for checking the changes that occur during treatment for clients so that their needs were identified and addressed in the care plan. Clients completed outcome starts during their treatment journey.

Skilled staff to deliver care

Staff were experienced, qualified and had the right skills and knowledge to meet the need of clients. All staff completed an induction process and received an annual appraisal and regular supervision. Supervision took place every four to six weeks.

Staff had access to specialist training. Key workers were supported to complete a level three national vocational qualification in care and were able to apply to take level four and five qualifications. Additional training around psychosocial interventions, physical health, overdose prevention and the use of naloxone had also been delivered. Group facilitators were scheduled to receive dynamic intelligence learning training. Some staff had lived experience.

The provider was in the process of recruiting a volunteer coordinator. At the time of our inspection Witton Bank had one volunteer who was going through an indication process and shadowing staff.

Human resource support was provided by an external company. There were policies and procedures to manage staff performance and discipline. There were no staff on performance management at the time of our inspection.

Multi-disciplinary and inter-agency team work

The service ensured multi-agency input into clients' comprehensive assessments from mental health teams, GPs, social workers and criminal justice services.

The service had effective protocols in place for the shared care of clients which was evident on inspection when we spoke with staff and reviewed care records. Support workers acted as points of contact for shared care services, for example health and justice, probation, social services and mental health.

Residential substance misuse services

Recovery plans included clear care pathways to other supporting services. The service worked with health, social care and other agencies to plan integrated and coordinated pathways of care to meet the diverse needs of client groups. For example, there were clear pathways for hepatitis B, C and blood borne viruses.

Good practice in applying the MCA

The service had a policy on the Mental Capacity Act which staff were aware of and could refer to.

Clients were supported to make decisions where appropriate and staff knew how to access further support if they had concerns around capacity. The service did not use an assessment tool for capacity and if staff were concerned about a client's capacity to consent to care and treatment they referred them back to their GP or to mental health services for a capacity assessment.

Staff ensured clients consented to care and treatment and that this was assessed, recorded and reviewed promptly. This was seen in all care records we reviewed on inspection.

Are residential substance misuse services caring?

Good 

Kindness, privacy, dignity, respect, compassion and support

During our inspection we saw interactions between clients and staff. These were consistently positive, with staff always being polite and respectful. Client feedback on staff was positive. Clients considered staff to be compassionate and committed and felt they behaved appropriately towards them. Staff recognised and respected the totality of clients' needs. They always took personal, cultural, social and religious needs into account. Staff supported clients to understand and manage their difficulties.

Support workers co-produced recovery plans with clients. This was clear when we reviewed care records and spoke with clients and staff. Documentation included a risk and recovery assessment that considered client preferences and goals. Staff offered clients a copy of their recovery plan.

The service displayed and provided information for clients about other services and wider recovery networks. Clients were supported to access support services such as housing and benefit agencies.

The service had clear confidentiality policies in place that were understood and adhered to by staff. Staff maintained the confidentiality of information about clients.

Consent forms were seen in all care records we reviewed, and clients told us they were asked to consent to care and treatment. As part of the assessment process staff sought consent from clients as to who they could contact or share information with about their care and treatment.

Involvement in care

There was an admissions process to inform and orientate clients to the service. Clients received a welcome pack which included information on the service, house rules, complaint procedures and weekly activities. Clients attended a welcome group with other residents following their admission.

Clients we spoke with told us they were active participants in their care and in care planning.

We reviewed four sets of care records. All the records we reviewed evidenced client involvement. Staff worked with clients to help identify and develop their recovery capital. Clients' communication needs were considered at assessment prior to admission. Staff communicated effectively with clients and clients told us they understood their care and treatment.

Clients were able to give feedback on the service they had received in treatment exit surveys. In addition, there were monthly community meetings and a suggestions box in place. Clients we spoke with told us they were also able to feedback issues informally to staff on day-to-day basis.

Staff facilitated family involvement where appropriate and in line with client wishes. Clients completed a consequence letter that was sent to family members as part of their treatment. Clients and family members could access family mediation sessions.

Are residential substance misuse services responsive to people's needs? (for example, to feedback?)

Residential substance misuse services

Good 

Access and discharge

The service had documented admission criteria. Clients had to be abstinent from alcohol and illicit substances. Staff worked with referrers and clients to ensure that clients were prepared for the service and the rehabilitation programme prior to admission. Clients could visit the service as part of the referral and assessment process.

The service assessed referrals within seven working days of the referral being made. Referrals and referral assessments were discussed in weekly team meetings to ensure a quick response. At the time of the inspection the service did not have a waiting list for admissions.

Discharge and discharge planning was considered from the point of referral and admission. Clients were supported to create discharge plans. Staff worked with clients to identify and develop the recovery capital, resources and relationships required to support them in achieving their discharge objectives. There were policies in place should a client discharge themselves unexpectedly. Staff engaged with relevant services such as the referring agency, local drug service or probation. Clients were provided with information on reduced tolerance, overdose prevention and relevant support services. Staff were also able to offer naloxone packs where appropriate.

Clients moving to a second stage service provided by T.H.O.M.A.S had a structured pathway to follow as part of their transfer. Where clients were due to be discharged back into the community family visits and planned leave were increased as part of the discharge pathway.

The facilities promote recovery, comfort, dignity and confidentiality

The service had a range of rooms to support the delivery of treatment and care. These included three lounges, two group rooms, dining room, conservatory and a music room. Clients also had access to a gym. Seven bedrooms were single occupancy and seven bedrooms were dual occupancy. Clients were made aware of these arrangements prior to admission. New clients often roomed with clients who had been at the service for a while. This provided a buddy and peer support structure for

new clients. Clients we spoke with who were in a shared room were happy with the arrangement. Clients were able to personalise bedrooms by displaying photographs and posters. There was access to outdoor space.

Clients were able to store their possessions and valuables securely. Clients were able to make telephone calls in private. However, calls were not allowed in the first three weeks of treatment. Clients were informed of this prior to admission and it was recorded in the welcome pack and behavioural contract.

Clients' engagement with the wider community

Staff encouraged clients to develop and maintain relationships with people that mattered to them. Clients completed consequence letters that were shared with family members. Family visits were scheduled at specific times during the treatment programme. Visits could be arranged outside of this schedule if required.

Staff encouraged clients to access positive and meaningful opportunities in the community with social, recreational and educational activities. These included shopping trips, access to mutual aid groups, gym visits and walking groups. Clients in the second stage of treatment also accessed colleges, voluntary schemes and work opportunities. This included volunteering at the provider's charity shop and upcycling scheme.

Meeting the needs of all people who use the service

The service had a room that had been adapted for use by people with mobility needs, however the layout of the building did not lend itself to wheelchair use. Referrals for clients with mobility issues were considered on an individual basis and consideration given as to whether reasonable adaptations could be accommodated.

Communication needs were identified during the referral process and discussed with the referring agency. Clients were able to access translation services, including sign language where this had been agreed and funded by the referrer. The service met religious and cultural needs such as halal meat. Staff supported clients to access local places of worship.

Dietary requirements were identified during assessment and the service procured relevant produce. A choice of food

Residential substance misuse services

was available, and clients agreed weekly menus in advance. Clients were responsible for purchasing and cooking food for the residents. There was a rota in place to support this.

Listening to and learning from concerns and complaints

The service had a complaints policy and process. Information on how to complain was on display within the service and provided in the client welcome pack. Clients we spoke with were not always certain of the complaints process but told us that they would be confident in raising concerns with staff and management.

The service had not received any complaints in the 12 months prior to our inspection. However, the registered manager was able to describe the process for instigating a complaint investigation, the governance process to manage the complaint and how feedback and learning would be disseminated.

In the 12 months prior to our inspection the service had received 34 compliments. These were in the form of 29 thank you cards and five thank you letters from family members.

Are residential substance misuse services well-led?

Good 

Leadership

The service manager had the skills, knowledge and experience to perform their role. They demonstrated a good understanding of the client group and how the service could meet their needs. Senior managers from within the provider organisation were a visible presence and known to staff and clients. Staff and clients we spoke with were positive about the management of the service. The service manager had completed specialised leadership and management training.

Vision and strategy

The T.H.O.M.A.S organisation had a clear vision and a mission statement in place. These were underpinned by a set of values which were to:

- provide timely, reliable and targeted recovery services that are judged by their quality, their cost effectiveness and relevance to peoples' needs
- fulfil our obligation of building strong and durable recovery communities, protecting sustainable recovery and meeting our commitments to our partnership working
- attract, develop and retain the interest of our service users by making recovery an enjoyable journey of discovery
- value diversity and the unique contributions of each person, fostering a trusting, open and inclusive environment
- value the passion people have for transformation and we empower our service users to believe in change
- strive for success by pulling together
- treat each other and our differences with a high degree of respect, sharing ideas, failures and successes
- work in innovative ways, network in unexpected ways and make connections across disciplines.

Staff we spoke with understood the provider's vision, mission statement and values. We observed that care was delivered in line with these. Staff had the opportunity to contribute to discussions about the development and strategy of the service. This was through supervision, appraisal, team meetings and involvement in service improvement projects.

Culture

Staff we spoke with told us they felt respected and valued. They felt supported by management and were clear about their role and responsibilities. Staff were proud about the work they did and the level of care they provided.

Staff we spoke with described an open and honest culture. Staff understood the provider's whistleblowing policy and felt able to raise concerns without fear of retribution or victimisation.

Staff morale was positive. Staff worked well together and demonstrated a cohesive team approach to the delivery of care. There had been no bullying or harassment cases within the service during the 12 months prior to our inspection. Staff sickness and turnover were both low. Staff appraisals and supervision sessions included discussions about professional development. Staff were able to access additional training and experience as part of their development.

Residential substance misuse services

Governance

The service had an effective governance structure. Governance meetings were held at provider level to allow for shared learning with other sites. Team meetings followed a set agenda and there was a clear communication pathway with the provider's governance meetings. Staff had access to a suite of policies and procedures to guide them in the delivery of care. Policies and procedures were all in date and had been subject to regular review.

There were systems in place to ensure that the service was safe and clean, that treatment was effective and that clients and staff were appropriately supported. Staff participated in local audits and responded to the findings. Adverse incidents were reported and reviewed. Staff were completing relevant mandatory training and receiving regular supervision. Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of clients.

Management of risk, issues and performance

Staff had access to a risk register which was held at provider level. The risk register was discussed and reviewed in governance meetings at provider level. The risk register included concerns over financial pressures and reduced budgets within commissioning and referral services. Mitigating actions had been identified and there was no evidence that financial pressures had compromised care delivery. Senior managers showed a good understanding of the pressures and risks facing the service now and in the future.

The service monitored performance through compliance with national drug treatment monitoring service reporting arrangements. In addition the service had key performance indicators in place and produced quarterly performance reports for block purchasers of beds.

The service and provider had a business continuity policy in place. This outlined how the service could continue to operate in the event of a loss of use of the building, key services or in cases of adverse weather or high staff sickness.

Information management

Staff had access to the information and equipment required to carry out their roles and deliver treatment. Information needed to deliver care was in an accessible format and stored securely.

Staff felt confident using the systems in place and had completed information governance training. Staff were aware of the provider's policies in relation to confidentiality and the sharing of information with other bodies.

The service manager had access to information to support the management of the service. This included information on performance, staffing and client feedback.

Notifications and data were submitted to external bodies as required, including the CQC.

Engagement

Staff, clients and carers had access to up to date information about the work of the service. Information was available on noticeboards within the building, in leaflets and documentation provided by the service and on the service's website and social media platforms.

Clients had the opportunity to give feedback on the service they received. This occurred in 1:1 sessions, community meetings and through an exit survey once their treatment was completed. Staff had the opportunity to give feedback on the service during team meetings, in discussion with senior management and in an annual staff survey.

Staff engaged with external organisations such as commissioners, referral agencies and other services within the local treatment and recovery networks.

Learning, continuous improvement and innovation

Staff were encouraged to be creative and innovative in the delivery of care. Staff were encouraged to generate ideas for service improvement and development. These were discussed and developed during staff away days.

There were plans in place to develop research opportunities within the provider organisation.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **SHOULD** take to improve

- The provider should ensure that the programme to redecorate the premises is completed.
- The provider should ensure that consideration of mental capacity is recorded within client notes.