Grace House

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Overall summary

We do not currently rate independent standalone substance misuse services.

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

- Staff received induction training when they started at the service. However, there were gaps in specialist training around mental health, substance misuse and eating disorders. While some of this training was planned to take place in the future, there were people who used the service who had complex needs. The training provided did not support staff to work with people with complex needs.
- There had been a high turnover rate of staff, particularly at night. This meant that there had been a strong reliance on agency and bank staff so there had not been consistent staffing. This had improved with the recruitment of new staff to cover the service since January 2016.
- Some risk assessments were comprehensive. However, some did not include clear crisis management and relapse prevention plans. The provider has told us that since the inspection, the service has introduced separate relapse prevention planning and separate crisis planning documents that will be utilised with people who used the service.
- Staff were not clear about their responsibilities relating to the Mental Capacity Act. This was reflected by the policy which did not reflect the use of the Mental Capacity Act in a rehabilitation setting.

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

- The service had governance systems in place to ensure that information was fed up and across the organisation as a whole. Staff were positive about local leadership and management.
- The service had been newly refurbished. There were available sitting rooms and areas for therapy groups as well as an outdoor garden area which people could access. The service had a main house and a bungalow. The bungalow was used for people who were further on the road towards recovery.
- The service had implemented a buddying system which assisted people who arrived at the service to receive informal support from other people who were further along the recovery programme. This peer support was helpful to people who came to the service

Summary of findings

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Background to Grace House

Grace House is a residential rehabilitation service for up to 10 women. The provider is ARP Charitable Services which is a part of a wider organisation called Phoenix Futures. At the time of our inspection there were 5 women using the service. Women were funded either through health or social care services. However, two women had received bursaries on admission. The service opened in September 2015, having previously been a mixed detox unit.

The registered manager at the time of the inspection was no longer working in the service and another manager was in place with day to day responsibility for running the service. They had made an application to be the registered manager with CQC but this had not been completed.

The current service is registered to provide accommodation for persons who require treatment for substance misuse.

The previous service which was in the same location called Herbert Street had three inspections in May 2011, February 2013 and December 2013. While the registration remained the same, the service, staff team and management were different at Grace House and the service had been compliant with the relevant regulations at it's most recent inspection.

Our inspection team

The team that carried out the inspection consisted of two CQC inspectors, one specialist advisor who was a nurse with experience of working in substance misuse services, one CQC pharmacy inspector and the CQC Head of Mental Health policy.

Why we carried out this inspection

We inspected this service as part of our inspection programme to make sure health and care services in England meet fundamental standards of quality and safety.

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- Spoke with three people who used the service
- Reviewed five patient records including medication charts.

Summary of this inspection

- Spoke with four members of day and night staff.
- Spoke with the service manager as well as the regional operations manager, HR manager and Head of Quality as well as the service user involvement lead across the provider organisation.
- Received feedback from three commissioning organisations
- Requested additional information both before and after the inspection visit from the provider including policies, audits and data.

What people who use the service say

We spoke with three people who use the service. The feedback was very positive about the service and the staff. Some raised concerns about the turnover of staff but felt that this had improved over the two months prior to the inspection and told us that they felt listened to and involved in the service.

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 area in which the service needs to improve.

- People who used the service had pre-admission risk assessments and risk assessments which were completed through their admission at the service. These were comprehensive and identified key information. However, there were no clear crisis plans in the documentation. Since the inspection, the provider has told us that they have introduced separate relapse prevention planning and separate crisis planning documents that will be utilised with people who used the service.
- There had been significant changes in the staff since the service had opened as Grace House. This meant that people who used the service lacked consistency in staffing and they raised this as a concern to us, although stated it had improved in the two months leading up to the inspection.

However, We found the following areas of good practice:

- The environment was clean and well-kept. Health and safety checks such as legionella tests and electrical points testing was up to date, ensuring a safe environment.
- Staff were aware of how to report incidents and incidents were reported.
- Medicines were administered and stored safely.
- Staff had received safeguarding training relating to children and adults and were aware of procedures to raise concerns if they arose.

Are services effective?

We do not currently rate standalone substance misuse services.

We found the following areas the service needs to improve:

- There was no training which specifically met the specialist needs of people who use the service. Some of this specialist training was planned in the future for example, in eating disorders. However, the provider was admitting individuals with these specialist needs and staff had not received training to meet the specialist needs of clients..

Summary of this inspection

- Staff had received support and training regarding the use of the Mental Capacity Act. However, the policy on which the training was based, did not clearly explain the way the Mental Capacity Act and it's five principles would be used in a residential rehabilitation setting.

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

- The majority of recovery plans were comprehensive and holistic. In some of the plans we saw, it was evident to see people's involvement in their care planning. The service used 'outcome stars' which is a way of determining priorities and progress of people who use the service.
- People who used the service had access to a range of activities external to the service such as drama groups and local voluntary work.
- Staff had access to equality and diversity training. The service was specifically aimed at providing support to women and people who used the service told us that they found this positive.

Are services caring?

We found the following areas of good practice:

- People we spoke with who used the service were very positive about the support and kindness from the staff. They also told us that they felt safe and had been able to participate in their recovery planning.
- Regular forums for people who used the service enabled clients feedback about issues which they wished to raise. These forums were minuted and we were given examples of suggestions which had led to change.
- The provider had an organisation-wide service user involvement lead. Their role was to further embed user voice through all levels of the organisation using peer support provided by people who had used the service.

Are services responsive?

We found the following areas of good practice:

- Clear referall pathways ensured that relevant information was available before admission and there was a specific standard operating policy which clearly explained exclusions from the service.
- The service had been recently refurbished at the time of the inspection and provided well-maintained environment including some outside space in a garden. People were able to personalise their rooms over their stay if they chose to.

Summary of this inspection

- Therapy sessions and programmes were delivered during weekday mornings, based on CBT approaches with other activities available throughout the week and weekend.
- The service had a visible complaints policy and people who used the service told us that they knew how to make complaints.

However, we found the following areas that need to improve:

- There was a focus on discharge planning in the latter stages of rehabilitation. Sometimes due to external factors, discharges could not take place as planned and clear contingency plans were not evident. This meant that there was a risk that people who were not suitable to be supported within the service would remain at the service for longer than they needed as no alternatives could be quickly sourced.

Are services well-led?

We found the following areas of good practice:

- The provider had governance systems in place including support from a central organisation . Human resources information was accessible and the management within the organisation had access to information about how the service was operating.
- Staff within the service whom we spoke with told us that they felt supported by the service management and the organisation.
- A number of internal and external audits were undertaken by staff and the management team and there was a clear action plan which resulted from these. Feedback from service user forums and other sources ensured that the service had a clear understanding of where improvement could be made with attached timescales.

However, we found the following areas needed to improve:

- Staff turnover had been very high and although vacancies were low, there had been some recent appointments made. This meant that the cohesiveness of the team still required further embedding.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

- Grace House had been renovated in the year prior to the inspection. Communal areas such as lounge, kitchen, toilet and bathroom areas as well as bedrooms were clean and comfortable. There was a cleaning rota which involved both people who used the service and staff members and this ensured that cleaning was regularly undertaken.
- The service had an infection control lead and there were regular infection control audits which took place monthly. All staff received training specifically related to infection control during their induction period.
- Weekly checks of fire equipment such as alarms and extinguishers were logged and we saw the evidence of this being completed. We also saw that all electrical sockets had been tested for safety within the last year and this was recorded. There had been a specific test related to legionella from which actions had been identified. Those actions had been completed in a timely manner.
- The first aid box for the service was checked monthly to ensure that all the contents were present and up to date.
- All maintainance requests were logged centrally and so staff were able to track when broken or missing items would be fixed or provided. We saw that this was used in practice and repairs were carried out in a timely manner.

Safe staffing

- The full staff complement at the service was five working time equivalent therapy support workers (including one who is currently on sick leave) and two full time equivalent and one part time (0.5 time) member of waking night staff. There was also one manager who worked during the week on a supernumerary basis. At the time of the inspection, one therapy support worker had been appointed to post and was currently awaiting the completion of pre-employment checks and there was one vacancy for a part time waking night member of staff which was being recruited to. There were three shifts which were 8am – 4pm, 1.30pm– 9pm and 8.30pm – 8.30pm. There was one member of staff on duty at all times and during the night, there was waking night cover. A manager was also on duty between 8am and 4pm between Monday and Friday. All staff employed were female.
- There had been significant changes in the staffing since the service was established. Nine permanent full time members of staff had been worked in the service since it opened in September 2015 and four full time permanent members of staff had left. Between 1 February and 1 May 2016, 72 night shifts were covered by agency staff and 17 day shifts were covered by agency staff. People who used the service told us that staffing had been inconsistent, particularly at night. 80% of the agency staff used had been the same two members of staff to ensure consistency as much as possible.
- Additional staff could be provided if required, for example, if people need to go to appointments through staff working additional shifts, bank staff or agency staff. Therapy input was provided in the mornings with the afternoons reserved for outings, appointments, one to one sessions with keyworkers and leisure activities.
- The service had sought to mitigate inconsistencies in staffing by temporarily placing the area manager into the service to create greater stability. People who used the service reflected that this had been helpful and had made a positive difference.
- We checked the records of five members of staff who were permanently employed. Employment checks had

been carried out and staff had current DBS (disclosure and barring system) checks. The service had an assigned human resources manager who could provide support and advice to the manager on-site.

- Managers within the service acknowledged that the turnover rate of staff has been high for various reasons and that this has led to a lack of stability for people who used the service. This was reflected in our conversations with people who used the service. The high use of bank and agency staff had been a particular issue at night as there had been vacancies for permanent night staff. In the month prior to our inspection, two new members of night staff had been recruited.
- Outside office hours, there was a manager available on-call.
- Mandatory training included medicines management which all staff had completed as well as infection control and safeguarding training. Four members of staff had completed first aid training and the other staff were booked to complete training. However, there was no mandatory training related to substance misuse, mental health or eating disorders. This meant that there was a risk that staff did not have the skills to manage the complex needs of people who used the service.

Assessing and managing risk to people who use the service and staff

- We checked five sets of records for people who used the service. Risk assessments were completed prior to admission and on admission. Four of the risk assessments we checked were comprehensive and identified key risks clearly. One risk assessment did not have dates on it which means that while key risks were identified, it was not possible to see when it had been completed or updated since the person's admission.
- We saw that risk assessments were holistic and covered areas such as domestic violence and contact with children. For example, one risk assessment which had specifically been completed relating to children visiting the premises.
- Risk management plans were relevant to the risks identified. However, we saw one person who had an identified medical need on admission. They did not have crisis plan completed until two weeks after their admission. The standard operating policy for the service specified that crisis plans should be completed when people who use the service have expressed suicidal intent or have a history of suicidal ideation. This did not specifically cover the need for crisis plans to be considered more broadly on admission. This meant that there was a risk that crisis plans were not routinely completed and effective in ensuring that people's needs could be met when there were unexpected incidents.
- We did not see specific relapse prevention plans in place in the five records we looked at for people who used the service who may be at risk of relapse where they had been drug and alcohol free for a very short period (for example, one week) on admission. We saw that the risk assessment for one person who had been drug and alcohol free for one week did not include a relapse preventation plan.
- The provider has informed us that since the inspection, the service has introduced separate relapse prevention planning and separate crisis planning documents that will be utilised with people who use the service.
- Three members of staff had been trained in relation to safeguarding procedures and staff at the service worked with the local authority to make referrals when necessary. Staff we spoke with were aware of how to identify safeguarding concerns and knew the actions to take. However, two members of staff,who had joined the service two weeks prior to the inspection visit, were awaiting adult safeguarding training and there were no specific dates when this would be completed as it was externally arranged by the local authority.
- The service had a specific lone working policy. Out of hours, staff had a mobile phone to ensure that they could call for support.
- We checked medicines storage and medicines administration records for five people who used the service. Staff obtained medicines for people who used the service on prescription from a local pharmacy and stored them securely. Staff kept records of medicines received, stock levels and medicines for disposal. There was a controlled drugs cupboard available but no controlled drugs in stock.
- Although staff monitored the fridge temperature readings daily, we saw that the readings were out of range during this inspection. There was no impact on people who used the service as, at the time of the inspection, there were no medicines requiring refrigeration. However, there would be a potential risk if someone were admitted to the service who required medication which needed to be refrigerated. We advised

staff to seek guidance in this area. Staff monitored the room temperature and those of the cupboards where medicines were stored. The temperature readings were satisfactory.

- Staff administered medicines to people who used the service. Staff recorded administration on medicines administration record (MAR) sheets. Staff signed the MAR sheets to prove that they had given the medicines. All five MAR sheets had the allergy status and a picture of the person included. Staff supported people who used the service to self-administer certain medicines based on a risk assessment. For example, people were not allowed to self-administer medicines that contained alcohol.
- All staff received medicines training and competency assessments before they could give medicines to people. Staff told us that medicines competencies would be rechecked annually. The service undertook random drugs tests during people's admission at the discretion of the manager according to the policy and this information was provided to people who were admitted to the service.

Track record on safety

- In the period since the service reopened, there had been no serious incidents which require investigation.
- Forty three incidents had been reported internally between November 2015 and April 2016 which includes near misses and medication errors. The highest number of these were 15 medication errors . These had been picked up through medicines audits and the service had reviewed staff medicines competency. There was a robust reporting framework internally and that staff were aware of the need to report incidents so that learning can be established.

Reporting incidents and learning from when things go wrong

- Staff we spoke with were clear about how to report incidents and we saw that a proactive approach to incident reporting had been taken.
- Learning from incidents was discussed in weekly team meetings.
- Incidents were reported to the central head office as well as to regional managers and a consistent approach to follow up incidents was decided upon. This meant that the central organisation had oversight of all the incidents which were reported in the service.
- In some cases, learning from incidents did not fully explore potential learning on a broader level. For example, one incident occurred when someone who used the services was admitted to hospital in a crisis setting. The learning identified from this incident did not capture the preventative work that could have been done to access mental health support before a crisis or the need for additional training for staff in order to recognise mental health concerns.

Duty of candour

- Managers within the service and members of staff were aware of the requirements relevant to the duty of candour and the need to apologise to people who used services when errors were made.
- Staff told us about an example when a medication error had occurred relating to over the counter medication and the person who was involved in this was told that this had taken place.

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

Assessment of needs and planning of care

- We checked five recovery plans of people who used the service.
- The service used an 'outcome star' which is a model of working with people to identify priorities and progress in a holistic sense. In four of the care records we looked at, we saw that outcomes stars were used with people who used the service. However, in one of the records, this had not been completed without any indication in the records why.
- Care plans were comprehensive and covered important aspects of people's life and their rehabilitation pathways. In four of the five care plans it was clear that people had been involved in decisions about their care. It was not indicated on care plans that they had been given to people. However, people told us that they were aware of the contents of their care plans and knew what to expect from care within the service.
- Care records were completed in paper files. These files were stored in the staff office and was able to be locked.

Best practice in treatment and care

- The service used a model of care which had reflected the established evidence base of working assessing and planning care for this clients in this service. Staff in the service were clear about the model used and this was part of the services standard operationing procedure.
- Best practice guidance which was relevant to people who used the service was disseminated through the central quality team through policies and procedures, such as a focus on cognitive behavioural therapy (CBT) approaches in therapeutic groups. Groups were delivered by therapeutic staff.
- People who used this service accessed external activities and support such as local drama groups and counselling. Some people who used the service also were involved in volunteering in the local community. For example, assisting the local Salvation Army group.
- The service determines the effectiveness by using a treatment profile outcome (TOP) form which measures progress in specific domains, for example, drug and alcohol use and social functioning. This is used in conjunction with the outcome star tool which also looks at domains with people who use the service and was recorded on admission and discharge from the service. However, we looked at the TOP measurements in care records and some of the information in one of the domains had been recorded incorrectly.
- Internal audits and quality assurance visits took place regularly within the service. There were specific audits of health and safety, staff and service user files and medicines audits which took place as well as a 'mock inspection' from an external consultant which identified areas for improvement linking to the service's action plan.
- People who used the service had access to a Nature and Therapy service which involved tree-planting and horticulture days locally.
- The service had a pet cat where they took turns (if they wished to) to provide care. People who used the service told us that they found that this increased their wellbeing within the service and helped maintain a homely atmosphere.
- The service liaised with the local GP to ensure that physical health monitoring was undertaken. However, staff at the service did not provide any healthcare interventions. On admission, people who used the service were registered with a local GP.
- The service had a homely remedies policy. Homely remedies are over the counter medicines made available to people living in residential and nursing care settings or hospitals. They are for short term management of minor ailments, for example, mild pain. Staff gave medicines to people who used the service using this policy and kept appropriate records. The policy was supported by guidance from the GP. Staff contacted a GP if a person requested a remedy for longer than 48 hours.

Skilled staff to deliver care

- The service had been newly established at the time of our inspection. We checked the employment records of five members of staff and previous experience varied significantly. All staff had experience working in health and social care sectors but not necessarily within substance misuse. The team manager had experience working in a substance misuse setting in a prison.
- All permanent staff were required to complete an induction when they started to work at Grace House. This included training related to health and safety, equality and diversity, safeguarding adults and children and data protection. The induction period included shadowing other members of staff. We spoke to staff who had completed their induction and they told us that it prepared them for their roles. However, staff were not provided with specific training related to substance misuse, mental health or eating disorders when they started at the service. New therapy support workers facilitated therapeutic sessions. Support workers had experience of working in health and social care but there was no evidence that specific skills related to delivering therapeutic input was progressed. We checked the training records of staff and saw that one member of staff had an NVQ3 in Health and Social Care and another therapeutic worker had training in substance misuse and mental health. However, there was no evidence that seven members of staff, some of whom were new, had received specific training regarding specialist skills to deliver therapeutic programmes including understanding substance misuse, mental health and other areas such as eating disorders. We saw that some of this training was planned for the future.
- The service had weekly team meetings with a standard agenda which included discussions of specific pieces of work, complaints, incidents and feedback from management. Minutes were available in the staff office for those unable to attend.

- Staff had regular supervision monthly. The service had been running with new staff so some staff had not completed their appraisals. However, this was because they were not yet due.
- On call duty managers available if a manager was not available on site.

Multidisciplinary and inter-agency team work

- Grace House has a service level agreement with a local GP with whom all the people who use the service were registered on admission. Staff in the service told us that generally the primary medical care services are responsive.
- While no medical care is provided directly at Grace House, staff in the service liaised with secondary health care services as necessary, for example, when people who used the service needed to attend appointments at local acute hospitals.
- When people who used services were known to mental health services, the staff team liaised with these teams to ensure information was shared by contacting the relevant teams. We saw examples in case records where information had been shared with involved health and social care teams.

Good practice in applying the MCA

- One member of staff had completed training related to the Mental Capacity Act and Deprivation of Liberty safeguards.
- All staff had access to e-learning which related to the Mental Capacity Act. However, although this had commenced, it had not been completed.
- The service had a Mental Capacity Act and Deprivation of Liberty safeguards policy which was dated February 2016. This policy, which formed the basis of training which had taken place in a staff team meeting, did not clearly link the five principles of the Mental Capacity Act to the work that was carried out at a residential rehabilitation service. This meant that there was a risk that staff would not understand their own roles in assessing capacity when necessary.

Are substance misuse services caring?

Kindness, dignity, respect and support

- We spoke with three people who used the service. They were very positive about the setting, interventions and staff. One person described their rehabilitation journey at Grace House as an “amazing experience”.
- All the people who used the service that we spoke with told us that they felt safe at Grace House and were aware that they were able to leave when they wished. They told us that they knew the contract and limitations which they agreed to on admission. For example, that drugs and alcohol were not allowed in the premises.
- People who were admitted to the service were assigned buddies who had been at the service for more time to help them to settle in and to provide additional peer support and reassurance.
- Staff we spoke with had a good understanding of the individual needs of people who used the service.

The involvement of people in the care they receive

- Monthly forums for people who used the service enabled clients to provide feedback. This ensured that they could provide feedback and influence the running of the service.
- Consultations with people who used similar services and the name of the service, Grace House, as well as it’s scope as a female only residential rehabilitation service had been decided as a result of feedback from people who used the service
- The provider undertook two surveys annually for service users. The feedback from Grace House specifically had not been collated but would be included at the next survey as it was a new service.
- There was a suggestions box which was visible in the service and where people who used the service were able to make suggestions, comments and complaints anonymously if they chose to.

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

Access and discharge

- The rehabilitation programme is designed to run for around six months although there was scope for

different lengths of stay depending on individual circumstances. The standard operating policy for the service stated that people who used the service should have completed detoxification .

- Between September 2015 when the service opened and 29 February 2016, five people had been discharged from the service, including one unplanned discharge.
- The service's standard operating policy was clear about exclusions from the service which were severe mobility difficulties, acute or chronic mental ill-health with suicidal ideation, significant physical health care needs and significant cognitive impairment or learning disability.
- Referrals to the service came from community mental health teams, adult social care, the probation service or the prison service. People who used the service were funded either by health or social care organisations. Although they were also able to fund themselves.
- The service ensured that information provided on referral included medical reports from GPs and if appropriate, a psychiatrist.
- At the time of our inspection there was not a waiting list for the service. There were ten beds available and five were occupied. One person was admitted in the week prior to our inspection.
- While staff told us that discharge was planned when clients were admitted to the service, this was not clear in the clients care records that we looked at. The final four weeks of the full rehabilitation programme focused more specifically on moving on and plans for the future. As the provider had access to some additional housing support there was the possibility that this could facilitate discharge. However, we saw that when someone needed to be discharged speedily, for example, if they were not receiving benefit from the service or they had not respected the rules within the service, there was a risk that they would remain in the service for longer than it was appropriate.

The facilities promote recovery, comfort, dignity and confidentiality

- The service had been renovated in the year prior to our inspection.
- People who used the service had access to single and twin rooms. Twin rooms were used when people arrived at the service to encourage supportive peer relationships to develop. There was a kitchen with a dining area. People who used the service cooked for themselves and the was used as a social space and for therapeutical groups.
- There was a garden and additional lounge areas and quiet rooms providing space for different activities and room for people who used the service.

Meeting the needs of all people who use the service

- We heard from people who used the service that staff tailored their approaches to meet different needs such as tape recording people's life stories (as opposed to them being written) if literary was an issue for people who used the service.
- The service had a focus on equality issues and had promoted involvement in Pride and lesbian, gay, bisexual and transgender events.
- Staff had access to equality and diversity e-learning. This was part of the induction to the service. However, although this was available for staff, it had not been completed by any member of staff in the service.
- Staff and people who used the service described to us examples of how the service met the needs of people from different religions by facilitating and working with local churches and ensuring that therapeutic sessions allowed for prayer times for someone who used the service who was a practising muslim.
- The service was solely open to women and all staff employed and engaged permanently in the team were women. People who used the service and staff we spoke with were positive about the impact of a female-only atmosphere. Rooms in the service were named after influential female role models as chosen by people who used the service.
- The service did not exclude transgender women.
- There were bedrooms which were on the ground floor in the bungalow section of the property. This meant that people who had mobility difficulties could access the service. However, due to the layout and staffing, the service was not able to accept people who had significant mobility difficulties and would need additional support to manage personal care.

Listening to and learning from concerns and complaints

- There was information about how to complain about the service displayed in the house.

Substance misuse services

- The people who used the service whom we spoke with told us that they were aware of how to make complaints.
- One formal complaint had been logged in the service at the time of our inspection and it was lodged during the inspection so the response had not been tracked. There had been one informal complaint and five compliments which had been logged.

Are substance misuse services well-led?

Vision and values

- The values of the provider included a strong focus on recovery. We saw that staff were eager to demonstrate this.

Good governance

- Information relating to staffing, quality control and audit feedback, including complaints and incidents were fed to the regional and national quality committees. This meant that the senior managers in the organisation had oversight and that learning could be shared across the organisation.
- We saw that the service undertook internal audits including medication audits and audits of paperwork as well as conducting 'mock inspections' to ensure the quality of the service which was being provided. This fed into an action plan for the service which combined information from audits, mock inspections, incidents, complaints and other information which had been shared to ensure that improvement was driven on the back of this.
- Staff briefings were sent out with key information when it was picked up centrally for the purpose of learning, for example, about the Mental Capacity Act.
- Staff received supervision regularly with a standard agenda including performance, identifying training needs and support .Team meetings took place weekly.
- Staff reported incidents using an online system which could be used by permanent and agency staff.
- Staff received medicines alerts from the clinical governance committee and the GP.
- Managerial staff completed regular audits of medicine administration record sheets. Managers flagged any issues to staff giving medicines in email and in person as well as during supervision.
- Staff from the local pharmacy completed a medicines audit and there were plans to repeat this every six months.

Leadership, morale and staff engagement

- The provider's leadership programme provided some staff with additional support and promoted career development.
- While there had been a significant turnover rate of staff at this service, there was a small staff team and the impact of a few members of staff leaving or being absent had a significant impact on the culture within the service. Staff we spoke with told us that there was strong morale within Grace House and that they felt fully supported by the local management as well as more senior management within the provider.
- The provider offered leadership development training to managers within the service. The manager of the service told us that they had been supported to achieve a managerial role within the organisation.

Commitment to quality improvement and innovation

- The service was able to utilise programmes such as the Recovery through Nature programme which had been developed by the provider to encourage people who had been affected by substance misuse to participate in conservation projects. People who used the service at Grace House had been given the opportunity to participate in local projects in Greater London and Hertfordshire.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that the mandatory training identified is sufficient to support staff to carry out their roles safely, and that staff are provided with additional specialist training to meet the needs of clients in the service and job roles.
- The provider must ensure that all clients have clear crisis management plans which incorporate identified risks, information from other agencies involved in the client's care and preferences of the individual in the event of a crisis.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12 (2) (a) (b) By not completing crisis plans and relapse plans for all patients, the service had not ensured that they were doing everything reasonably practicable to mitigate against the risks to the health and safety of service users of receiving care and treatment.

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 18 HSCA (RA) Regulations 2014 Staffing 18 (2) (a) The provider had not ensured that all staff who supported people who used services had access to specialist training which enabled them to carry out their roles and to support the complex needs of people who used the service. For example, there had been a lack of training related to eating disorders, substance misuse and mental health needs.