Inadequate

Wellington Healthcare Limited

Lighthouse

Quality Report

44 Farrant Road
Manchester
M12 4PF
Tel: 0161 225 2777
Website: www.lighthousecare.org

Date of inspection visit: 13 and 14 November 2018
Date of publication: 13/02/2019

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-2042041405	Lighthouse		M12 4PF

This report describes our judgement of the quality of care provided within this core service by Wellington Healthcare Limited. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Wellington Healthcare Limited and these are brought together to inform our overall judgement of Wellington Healthcare Limited.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

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

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards
We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

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

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

Summary of findings

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Summary of findings

Overall summary

We are placing the service into special measures.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

We rated Lighthouse as inadequate because:

- Managers had not ensured that the building that accommodated the clients was safe. Staff did not risk assess the environment in relation to risks to clients, especially in relation to managing a mixed sex environment. Staff had not identified repairs that required to be made to the building to keep clients safe.
- Staff did not follow basic procedures to protect clients from risk. The service did not have a system for checking clients as they entered or left the building. This meant that, if there was a fire, staff would have no way of knowing who was still in the building. Managers had not ensured that staff had all the training required for their role, in relation to drug misuse, overdose awareness and how to administer emergency medicine. Records did not contain the completed documentation to keep clients safe. In the records we reviewed we found staff had not completed fully, physical identity forms and health action plans. This meant staff would not have the necessary information to share if a client went missing or to meet their healthcare needs. They did not have any risk management plans in the records we reviewed.
- The governance arrangements for the service were not effective. The service could not be assured that the oversight was in place to provide high quality services and keep clients safe. Lighthouse did not have a system to identify the number of staff required for each shift. There was no way of knowing if the service was under or over staffed. There was no system to monitor the compliance with health and safety checks of the environment. Policies did not comply with legislation and there was no system to review the policies and ensure they were relevant to the client group. There were policies from three different services in use. The provision of the therapy in relation to addictive behaviours was not being provided as marketed in the services literature and information to commissioners and clients.
- The registered manager was not following policies in relation to Duty of Candour, complaints and CCTV. The risk register did not capture current risks to the service in relation to governance and how staff would mitigate risks.
- Lighthouse breached Regulations 12 Safe care and treatment and 17 Good Governance of the Health and Social Care Act 2008, we have issued warning notices for these breaches. Lighthouse also breached Regulation 18 Staffing of the Health and Social Care Act 2018, we will issue a requirement notice in relation to this.

However:

- Feedback from clients, carers and care coordinators was positive. Clients were supported and encouraged to participate in activities within the local community.
- Staff received a comprehensive induction, regular supervision and annual appraisal.
- Staff worked in a person-centred way. They demonstrated an understanding of equality and diversity issues and working with clients belonging to vulnerable groups. Staff had developed a therapeutic programme tailored to the needs of clients with a dual diagnosis of substance misuse and mental health needs.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

Inadequate

We rated safe as inadequate because:

- There were concerns with the safety and maintenance of the environment. Repairs had not been identified and acted upon.
- The environment was not managed safely. Staff did not know which clients were in the building because there was no system in place to record clients entering and leaving the premises. Staff did not risk assess the allocation of bedrooms to clients. The service was mixed sex. There were no building risk assessments that assessed risk to clients in relation to allocation of bedrooms and environmental risks.
- There were no arrangements for staff to conduct observations of the building to assess and mitigate the potential risks to the health and safety of clients receiving care and treatment.
- Where the service had a system to assess and mitigate risks, these were not up to date. There were several building checks in use, however these had not been completed since September 2018.
- Staff did not receive training in drug misuse and overdose awareness including how to administer an emergency medicine for use in the event of a suspected overdose, which one of the clients was prescribed.
- Care records did not contain risk management plans, fully completed health action plans or physical identity forms.
- Lighthouse did not have a system to identify the number of staff required for each shift. There was no way of knowing if the service was safely staffed.
- Systems in place did not support staff to follow the requirements of the Duty of Candour and the policy did not reflect the Regulation.
- We have issued a warning notice for Regulation 12 Safe care and treatment.

However:

- Records confirmed and care coordinators told us that staff recognised and responded to warning signs and deterioration in client's health.
- Staff had a good understanding of and responded appropriately to safeguarding concerns.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

Summary of findings

- Two of the three support plans reviewed were not up to date and did not include recent incidents.
- Clients were not receiving effective care and treatment. The Lighthouse education activity programme was not being offered as advertised, with one out of the three sessions being provided per week.
- Mental Capacity Act training had been completed by half of the staff.
- The service was not measuring or reporting on any outcomes relating to clients' treatment. Care and treatment did not always reflect current evidence-based guidance, standards and best practice.
- Staff were not supported to participate in training and development which met their needs. Not all staff had the right qualifications, skills, knowledge and experience to do their job.
- Team meetings did not take place regularly.

However:

- Client records had comprehensive assessments in place.
- Staff at Lighthouse had developed a LEAP (Lighthouse education activity programme) and PRE- LEAP programme focusing on behaviour, addiction and mental health.
- Feedback from NHS care coordinators was positive, they felt their clients had made significant progress at Lighthouse.
- Staff received a comprehensive induction, regular supervision and annual appraisal.

Are services caring?

Good

We rated caring as good because:

- Staff treated clients with compassion and respect. Clients reported good relationships with staff and told us that someone was always available if they needed to talk.
- Carers told us they were welcomed into the service and said they felt comfortable talking to staff about any concerns they had.
- Support plans were person centred and clients told us staff explored their preferences with them.

Are services responsive to people's needs?

Requires improvement

We rated responsive as requires improvement because:

Summary of findings

- The complaints we reviewed did not follow the complaints procedure set out in the company's policy. Clients and carers said that they had not been given information on how to make a complaint. We did not see any information displayed on how people could give feedback about the service.
- There were no discharge plans in client's files and support plans did not contain information about preparing for discharge.
- Lighthouse did not meet the Accessible Information Standard.

However:

- The service had a range of well-equipped communal rooms where clients could participate in activities or have some quiet time to themselves.
- Staff supported clients to access other services in the community, including services that helped them with their recovery. Clients were supported and encouraged to participate in activities in the local community including engaging with local AA (Alcoholics Anonymous) and NA (Narcotics Anonymous) meetings, local substance misuse services and access to employment and training. There was an activity worker who facilitated days out.

Are services well-led?

Inadequate

We rated well led as inadequate because:

- The governance systems were not effective. There were no governance arrangements in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of clients, or to assess the quality of the service delivered in accordance with client's needs.
- There were no arrangements in place to monitor and review the quality of the policies to ensure that quality care was consistently delivered to meet the needs of clients.
- Systems were not sufficient to maintain securely an accurate, complete and contemporaneous record in respect of each client.
- The provision of the therapy in relation to addictive behaviours was not being provided as marketed in the services literature and information to commissioners and clients. Lighthouse was not involved in any peer review or research.
- The registered manager was not following policies in relation to Duty of Candour, complaints and CCTV. The Duty of Candour policy did not fully reflect the regulation.

Summary of findings

- There was no system available to staff at Lighthouse to oversee all staff's attendance at training and identify areas of low compliance.
- Lighthouse had a recently developed risk register which we reviewed. This failed to capture current risks to the service in relation to governance and how staff would mitigate risks.
- We have issued a warning notice for Regulation 17 Good Governance.

However:

- A set agenda was used for team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed.
- The service had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service.
- The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. Staff used applications on their smart phones to provide and receive updates in relation to maintenance and health and safety.
- Staff made notifications to external bodies as needed.

Summary of findings

Information about the service

Lighthouse provided accommodation and rehabilitation support to adults with a substance misuse need and associated needs including mental health. The service was a dual diagnosis service. Most referrals came from staff from NHS services who were care coordinators of people with mental health needs who also had substance misuse needs.

Lighthouse was based in a residential area of Manchester. The building had 44 bedrooms over two floors. At the time of the inspection there were 19 clients living there with another client having a phased introduction to the service. The registered manager advised that the maximum number of clients the service was willing to support at any one time was 35.

Lighthouse has been registered with CQC since 27 May 2015. It is registered for the following regulated activity: Accommodation for persons who require treatment for substance misuse.

Previously the service was registered for accommodation for persons who require nursing or personal care. This regulated activity was removed from the services registration in August 2017.

There was a registered manager at Lighthouse.

This was the second inspection of Lighthouse. This inspection was announced. Lighthouse was last inspected in September 2016. The service was not rated at that time and no requirement notices or enforcement actions were issued. This inspection was the first time of rating Lighthouse.

At the inspection in September 2016, there were two areas that the inspection team recommended Lighthouse should address. We found the service had made improvements in these areas. The inspection team suggested that mandatory training was monitored, we saw a training audit in place for mandatory training. That staff received training in equality and diversity, manual handling and effective behaviour management. Staff received training in these areas. The other area recommended was in relation to performance indicators. The service reported on vacancies within the service, sickness and training levels.

Our inspection team

The team that inspected the service comprised two CQC inspectors, one CQC assistant inspector and a specialist advisor with a variety of experience of working in substance misuse services. On the first day of the inspection, it was the whole team that inspected the service and on the second day, two inspectors inspected the service.

Why we carried out this inspection

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

How we carried out this inspection

To fully understand the experience of clients 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 client's needs?
- Is it well-led?

Summary of findings

Before the inspection visit, we reviewed information that we held about the location including the provider information return that the registered manager had submitted.

During the inspection visit, the inspection team:

- received a presentation from the registered manager, deputy manager and Lighthouse education activity programme coordinator;
- toured Lighthouse and looked at the quality of the environment and observed how staff were caring for clients;
- spoke with seven clients who were using the service;
- spoke with three carers;
- spoke with three project workers;
- spoke with the registered manager, deputy manager and the development manager;
- spoke with three care co-ordinators and received written feedback from two care coordinators;
- attended and observed a hand-over meeting and a client morning meeting;
- looked at four care and treatment records of clients:
- carried out a specific check of the medication management in the service; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

Clients we spoke with told us that staff were very supportive and they felt safe at Lighthouse and that they had made progress during their time at the service. Clients told us that staff were kind, supportive and non–judgemental. They said staff were always available day or night, if they needed to talk.

Clients reported staff supported them to engage in the local community including accessing services to meet health needs. Client's told us that staff supported them to access other services including GPs, dentists and college courses. They explained that staff would accompany them to services if they found it difficult to access them independently. We saw evidence that clients accessed other services to help them with their substance misuse including the local drug service and Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) which are mutual aid groups.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure they introduce a system to record which clients are in the building.
- The provider must ensure they risk assess the allocation of bedrooms and develop mitigation for managing a mixed sex environment safely.
- The provider must ensure the identified repairs have been acted upon and the environment is maintained to a safe level for clients. Including the completion of the building checks and food safety checks within the allocated frequency.
- The provider must ensure staff receive training in drug misuse and overdose awareness including how to administer an emergency medicine for use if a suspected overdose and that managers have an overview of staff training attendance at Lighthouse.
- The provider must ensure risk management plans are in place for clients with identified risks and ensure the documentation is completed fully to meet the health and safety needs of clients. Including health action plans and physical identity forms and that there is a contemporaneous record for each client at the service.
- The provider must develop a system to identify the staffing requirements for the service.
- The provider must ensure the Duty of Candour policy reflects the regulation and staff follow the policy.
- The provider must develop and implement governance arrangements to monitor the quality of the service provided and maintain the safety of clients. Including the risks to Lighthouse are identified and ways to mitigate these communicated to staff.
- The provider must ensure polices are adhered to in relation to complaints and CCTV.

Summary of findings

Action the provider SHOULD take to improve

- The provider should ensure that families and carers are informed of how to give feedback about the service including how to complain.
- The provider should ensure that support plans are regularly reviewed, including following an incident.
- The provider should ensure discharge planning is discussed with clients and recorded in their care record.
- The provider should ensure they provide the type and number of therapeutic sessions as advertised.
- The provider should explore which monitoring system they should be reporting to including National Drug Treatment Monitoring System and commence reporting.

Wellington Healthcare Limited

Lighthouse

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Lighthouse	Lighthouse

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not routinely receive training in relation to the Mental Capacity Act or Deprivation of Liberty Safeguards.

Staff we spoke with understood the concept of assuming capacity and that clients can make unwise decisions.

Records reviewed showed evidence of clients giving their consent to treatment and sharing of information. There were no examples where there were reasons to doubt a client's capacity and make decisions in their best interests.

Inadequate

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

Safety of the facility layout

Lighthouse had a secure entrance, with a reception area and then a further secure entrance. There was a room off the reception used for searching clients on return from accessing the community. Lighthouse was a large building over two floors, with a variety of rooms for activities and opportunities to have conversations in private.

Staff in the service had taken no action to ensure the sexual safety of clients in a service that accommodated both men and women; some of whom might be vulnerable to sexual exploitation. Men and women used bedrooms on the same corridor and had to pass opposite gender bedrooms to access the bathroom. Staff had not undertaken any assessment of the potential risk that this might pose or steps to ensure that the allocation of bedrooms mitigated this risk.

Also, staff had not undertaken assessment of risks that the environment might pose to clients at risk of self harm; for example, the presence of potential ligature anchor points. This is important for a service that admits clients with a dual diagnosis of substance misuse and mental health needs.

There was no system of monitoring which clients were in the building. Clients did not have to sign in and out of the building. As such there would be no way staff would know which clients were in the building at any time. Staff told us they would rely on their knowledge as to who was in the building. We observed a client missing an appointment with a visitor as staff thought they were out. There were no arrangements in place to assess the risks to the health and safety of clients in the event of a fire. Fire drills took place and there were personal emergency evacuation plans for clients with mobility needs. In the fire box there was also a list of clients and their bedroom numbers.

Maintenance, cleanliness and infection control

There were concerns with the safety and maintenance of the environment. Premises and equipment were not maintained to a standard that ensures the safety of clients.

We saw there was no hot water in one of the wash basins. A wood panel was coming away from the wall in one of the toilets which posed an infection control risk. A bath had the end panel which was cracked and had protruding screws, there was a risk of injury to clients. The library had a damp patch and paint peeling. We reviewed the maintenance log and found the only task reported was the paint in the library. We asked the administrator responsible for reporting repairs to escalate the damage to the bath as a matter of urgency.

Toilets did not have sanitary waste bins. There was no bodily fluid spills kit, however on the second day of the inspection, there was a bodily fluid spills kit in the service. We saw that within the toilets there were occasions when no paper towels or toilet paper were available.

On review of the food hygiene arrangements, we found that food fridge temperatures had not been checked since 21 October 2018. Measuring the temperature of meals had not been recorded since 16 August 2018. There was no action in place to recognise and mitigate the risk in relation to food hygiene for clients.

We saw there were several building checks in use which had not been completed recently and were out of date. On review of these we found the window restraints checks were last recorded as completed on 7 September 2018, exterior lighting checks were last recorded as completed on 29 August 2018, the passenger lift check had not been completed since September 2018, room temperature checks had not been completed since September 2018. Water temperature checks for baths, showers, sinks and wash hand basins were last completed on 7 September 2018. Fire extinguisher checks were last completed on 7 September 2018. Emergency lighting tests were last completed on 7 September 2018. First aid box checks were last completed on 7 September 2018.

We observed the communal areas of the service to be clean. However, the toilets required cleaning and some corners and window ledges required cleaning. Staff were cleaning the environment during the inspection. Feedback from a client's survey identified the cleanliness of the service as an area for improvement for 12.5% of the respondents.

Inadequate

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

Safe staffing

Staffing levels and mix

Lighthouse did not have a system to identify the number of staff required for each shift. The registered manager advised this would vary dependant on the number of clients they had, however this was not formalised or recorded. At the time of inspection there was 19 clients with three staff on the early, late and night shifts.

The service could not be assured there were enough skilled staff to meet the needs of clients as there was no plan in place.

The service did not use agency staff and relied on bank staff to cover for absences. From June 2018 to end of August 2018, bank staff worked at Lighthouse for 302 shifts. They used regular bank staff and rotas confirmed this.

Managers told us there should be two waking staff on a night shift, however a review of staff rotas from January to April 2018 showed 11 weeks with one waking night and a sleep-in member of staff.

Mandatory training

The service did not provide the appropriate training to ensure staff had the skills to meet the needs of clients. Lighthouse was a dual diagnosis service for clients with a substance misuse and mental health need. Training in substance misuse and overdose awareness was not provided.

At the last inspection, we identified that the service should ensure staff were compliant in respect of equality and diversity, manual handling and effective behaviour management. Of the three recommended courses, manual handling was mandatory. However, staff could access training in equality and diversity and challenging behaviour via the online training. Training compliance for the three courses was: 96% for manual handling, 83% for equality and diversity and 42% for challenging behaviour. Staff had completed mandatory health and safety awareness training.

Fifty percent of staff had completed training in the Mental Capacity Act 2005. Staff we spoke with in relation to the Mental Capacity Act understood their responsibilities in relation to the Act.

Assessing and managing risk to patients and staff

Assessment of client risk

We reviewed four care records and found they had detailed risk assessments in them, but they did not include risk management plans recording how the service would manage the identified risks. Risks included self harm, suicide and self neglect. Records did not advise staff how to respond if a specific risk presented.

Records confirmed and care coordinators told us that staff recognised and responded to warning signs and deterioration in client's physical and mental health.

Management of client risk

Staff had not received training in drug misuse and overdose awareness. There was no assurance that clients were made aware of the risks of continued substance misuse and harm minimisation. There were no risk management plans and some risks such as blood borne virus transmission and clients being vulnerable to exploitation were not addressed.

Support plans focused on engagement with external services. The Lighthouse education activity programme would cover part of this, however the behaviour group was the only group happening at the time of the inspection.

Clients could smoke in the grounds of the building and had unrestricted access to the grounds.

Use of restrictive interventions

The service worked in the least restrictive ways with clients. There were no inappropriate restrictions. Restrictions in relation to a secure entrance and searching were proportionate to the nature of the service.

Safeguarding

Staff could give examples of how to protect clients from harassment and discrimination, including those with protected characteristics under the Equality Act 2010.

Staff worked effectively within teams, across services and with other agencies to promote safety including systems and practices in information sharing

Staff implemented statutory guidance around adults at risk and children and young people safeguarding and all staff had attended safeguarding awareness training.

Staff knew how to identify adults and children at risk of, or suffering, significant harm. This included working in partnership with other agencies.

Inadequate

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

Staff access to essential information

Records were paper based. Documents including assessments and risk assessments were typed on the computer then printed off. However, we found in one record that the most recent risk assessment was not within the paper file, it was on the computer but not printed.

There were separate records for Lighthouse education activity programme and pre- Lighthouse education activity programme sessions, daily notes and clients care records. We observed staff found it difficult to locate the necessary information including evidence of key work sessions taking place.

We reviewed four records. One record was for a new admission and they did not have a risk assessment in place. We found two of the three risk assessments reviewed were not up to date.

Records were not completed fully. Physical identity forms were not fully completed with the photograph of clients, if they went missing the service would not be able to provide an accurate description to the police.

Medicines management

The controlled drugs policy for Lighthouse did not comply with NICE guidance, Controlled drugs: safe use and management [NG46] Published date: April 2016. The guidance states that the name and signature or initials of any witness to medicine administration should be recorded. However, Lighthouse policy advised that a second member of staff should sign as soon as possible. The policy was not clear for staff to follow and could be interpreted that staff would be signing to say they witnessed medicine administration which they did not witness. This would not be in line with best practice.

Medicines were in blister packs prepared by a local pharmacy. Controlled drugs records reviewed were up to date and accurate.

Staff reviewed the effects of medication on clients' physical health regularly and in line with NICE guidance, especially when the client was prescribed medication above the maximum dose recommended by the British National Formulary.

Staff were not competent to administer some of the medicines that had been prescribed. One of the clients was prescribed naloxone, an emergency drug to be used in the event of a suspected overdose. The registered manager confirmed by email that one member of staff had received training in how to administer this, if that member of staff was not present, staff would not be able to administer the emergency medicine.

Track record on safety

Lighthouse have had one serious incident (SIs) in the last 12 months. This incident met the threshold for Duty of Candour, but the Duty of Candour requirements were not followed, the registered manager did not keep a written record of the contact made with the family of the deceased nor did they write to the family to apologise or explain the actions to be taken. The Duty of Candour Regulation states that providers of services must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. The service did provide information to the police and CQC as requested.

Reporting incidents and learning from when things go wrong

All staff knew what incidents to report and how to report.

Staff were clear about their roles and responsibilities for reporting incidents, were encouraged to do so and reported in a consistent way. We observed clients raising a concern about the environment and this was recorded on the maintenance incident reporting system.

Systems in place did not support staff to follow the requirements of the Duty of Candour and the policy did not reflect the Regulation. However, minutes confirmed that health and safety and incidents were discussed at team meetings.

Are services effective?

Requires improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

We reviewed four care records and found staff completed a comprehensive assessment in a timely manner.

Staff developed support plans that met the needs identified during assessment in relation to care needs. However; of the four records reviewed, one was for a new admission, there was no support plan in place. Two of the three support plans were not up to date and did not include recent incidents.

The care record identified the person's key worker/care co-ordinator.

Although there were detailed risk assessments in place, staff did not develop risk management plan for clients identified as being at risk. One of the four records reviewed included a plan for unexpected exit from treatment.

Best practice in treatment and care

Lighthouse offered a LEAP (Lighthouse education activity programme) and a PRE-LEAP programme, developed by staff at Lighthouse. Information submitted by the service prior to the inspection advised the Lighthouse education activity programme consisted of 12 weeks of three sessions per week, one on behaviour, one on addiction and another on mental health. The focus of some of the sessions were cognitive behavioural therapy led. At the time of the inspection there was one weekly session taking place which was on behaviour. This did not meet the three sessions per week which should have been in place.

Staff provided a range of care and treatment interventions suitable for the client group. The interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence.

Staff supported clients to live healthier lives. For example, through participation in smoking cessation schemes, healthy eating advice, exercise and dealing with issues relating to substance misuse.

Three staff were trained in cognitive behavioural therapy which is a therapy recommended by the National Institute for Health and Care Excellence. There was no formal cognitive behavioural therapy group or sessions, however staff used their skills in one to one sessions with clients.

Monitoring and comparing treatment outcomes

Care coordinators visited the service to be involved in the reviews of care provided. Feedback from the five care coordinators we had contact with was positive, they felt the clients they were care coordinator for had made significant progress at Lighthouse.

Lighthouse did not contribute to the national drug treatment monitoring system or the drug outcome monitoring study. The service were not measuring or reporting on any outcomes relating to client's treatment.

Skilled staff to deliver care

Lighthouse staff team consisted a registered manager, deputy manager, project workers, support workers, an administrator, domestic staff and a chef. Lighthouse provided all staff with a comprehensive induction, managers completed an induction checklist with staff.

Service provided and ensured that all staff have completed mandatory training. Staff inputted staff details including the training completed on the national minimum dataset for social care (NMDS-SC). The NMDS-SC is an online database which holds data on the adult social care workforce.

Managers did not provide all the necessary training staff required for their role. Managers had not identified substance misuse and overdose awareness training as a learning need for staff. However, managers enabled staff to access courses provided by a local recovery college.

We reviewed eight staff files and found staff received regular supervision and yearly appraisal from appropriate professionals.

Multi-disciplinary and inter-agency team work

The service ensured multidisciplinary input into client's comprehensive assessments from, for example, community mental health teams, GPs, Children and Family Services, social workers and criminal justice services.

NHS care coordinators were clearly identified and there was evidence in records of regular communication with clients' care coordinators to provide updates and share concerns identified. Care coordinators described a very positive working relationship with Lighthouse and reported their clients had made progress there.

Are services effective?

Requires improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

The service was not holding regular team meetings. Staff had regular team meetings from January to March 2018 and then a gap till October 2018, there had not been a team meeting since 9 October 2018.

Good practice in applying the Mental Capacity Act

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

Staff could access electronic training in relation to the Mental Capacity Act, but only 50% of staff had completed the training.

Records that we reviewed recorded that staff had ensured that clients had consented to care and treatment.

There were no examples where there were reasons to assess a client's capacity and make decisions in their best interests.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

Kindness, dignity, respect and support

During our visit, we saw staff treat clients with compassion, dignity and respect. Clients told us that staff were kind, supportive and non–judgemental. They said staff were always available day or night, if they needed to talk.

Two clients told us about how they had been involved in creating their support plans. We looked at four client files. Two support plans showed evidence of the clients' views and two clients had a copy of their support plan.

Clients told us staff took time to talk to them about their care and explained anything they did not understand. Clients attended a daily support group and four clients attended the structured programme offered by the service. Clients also had one to one sessions, although the recording of these sessions suggested that they did not take place regularly. Clients had an individualised weekly planner which helped them to structure their week.

Client's told us that staff supported them to access other services including GPs, dentists and college courses. They explained that staff would accompany them to services if they found it difficult to access them independently. We saw evidence that clients accessed other services to help them with their substance misuse including the local drug service and Alcoholics Anonymous and Narcotics Anonymous which are mutual aid groups.

The service had a clear confidentiality policy in place. We saw evidence of signed confidentiality agreements and consent forms in all clients' files.

The involvement of people in the care that they receive

Involvement of clients

Staff helped clients to identify and develop their recovery capital as part of their support plan.

We spoke with seven clients. Staff communicated well with clients and clients reported having good relationships with them. Staff told us that they had thought about the language they should use in the Lighthouse education activity programme and kept it simple and easy to understand. The Lighthouse education activity programme is a twelve week structured recovery programme designed by the service. It focuses on a different topic each week.

Staff told us they would support clients with literacy difficulties by looking for alternative ways of communicating, such as using pictures.

One client's file stated that they had a mild learning disability. We did not see evidence of this being explored further and there was no evidence of consideration given to communication needs.

Clients told us that advocacy was available to them if they needed it. Most clients said they felt supported by the staff and had not requested independent advocacy.

Clients told us they felt listened to by staff, and staff told us they worked with clients and considered their views when planning and meeting support needs. If a client did not want to do an activity staff explored this with them to understand the reasons why.

We saw evidence that staff held monthly meetings where clients could give feedback about the service. We also saw a client feedback questionnaire in which clients had given feedback on aspects of their care and support.

Involvement of families and carers

We spoke with three carers. They told us that they could visit regularly and they felt welcomed at the service. They said that communication was good and they could discuss any concerns they had with staff over the phone or in person.

Carers told us they had not been asked for feedback about the service. However, they felt they could address any feedback to the manager and that it would be taken seriously.

When asked, carers told us that they had not been offered any support as a carer including a carers assessment.

Are services responsive to people's needs?

Requires improvement

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

Access, waiting times and discharge

Lighthouse has a clear referral pathway in place. The manager told us that potential clients must have or have had a substance misuse problem to be accepted into the service.

We could not find evidence of a standard timeframe from referral to triage to comprehensive assessment or from assessment to treatment/care. Staff told us this could vary depending on the client's needs. They said they would not accept a client before they had been to the service to look around.

Lighthouse was not full and did not have a waiting list and was therefore able to see urgent referrals quickly.

Discharge and transfers of care

We saw support plans that were detailed and person centred. Complex needs were identified in the risk assessment. We saw a contract in one out of the four records reviewed. The contract included targets in relation to accepting support with budgeting, substance misuse, impulsive behaviour and mental health.

We did not see discharge plans in clients' files and support plans did not show evidence of preparing clients for discharge. We only saw one file with a plan for the client leaving treatment unexpectedly. Some of the clients told us they felt it was too soon to be looking at discharge. Clients also said they were pleased that they did not have to leave after a set time.

Staff supported clients during transfers between services for example, if they required treatment in hospital.

The facilities promote recovery, comfort, dignity and confidentiality

Clients had their own bedrooms and had keys to their rooms. The building was secure and clients felt safe. We did not see consideration of privacy and dignity when staff allocated rooms to clients. Although a few rooms contained a toilet, most toilets and showers were located on the corridors. Corridors contained both men and women's bedrooms which meant that men and women had to walk past each other's bedrooms to get to the shower or toilet.

There was plenty of communal rooms including a large lounge and smaller lounges that could be used for activities. A variety of activities were available including a gym, art materials and a pool table and musical instruments. Activities included engaging with local Narcotics Anonymous or Alcoholics Anonymous meetings, local substance misuse services and access to employment and training. There was an activity worker who facilitated days out, on our first day of inspection a group had visited a local market. The activity worker had completed a summary report of activities pursued which showed a variety of activities including the photography group facilitated twice a week at Lighthouse.

There was also a prayer / quiet room which contained bibles and a large cross. Staff told us they would support clients who practiced other religions to find a suitable room to pray in.

Clients' engagement with the wider community

Clients and carers told us that contact with family and loved ones was supported. Carers said they felt welcomed at Lighthouse. Clients' children could visit their parents at Lighthouse. Carers told us that regular contact was supported either through visits or on the telephone.

The service had a minibus and staff took clients out on regular trips into the community. These included countryside walks, trips to local attractions and trips to the local snooker club and to attend football matches.

Clients attended mutual aid groups in the community and attended groups at the local drug service. Staff supported some clients to access voluntary work. Staff also told us they supported clients to access educational courses in the community.

The clients also had the opportunity to take part in a photography project. Clients would be supported to access the local community and take photographs which were personally relevant to them.

Staff supported clients to access other services in the community to address individual needs and would accompany clients to hospital and GP appointment if they needed extra support.

Meeting the needs of all people who use the service

Staff demonstrated an understanding of the potential issues facing vulnerable groups. Staff told us they had

Are services responsive to people's needs?

Requires improvement

By responsive, we mean that services are organised so that they meet people's needs.

supported clients from the lesbian, gay, bisexual, transgender, plus community. Staff helped them to access local support groups in the community and directed them to online groups.

Lighthouse had a Christian value base and worked closely with a Pastor who facilitated some of the groups. Staff demonstrated an understanding of other faiths and explained how they would support clients with faith needs. They told us they could meet religious dietary requirements by ordering in food and would support clients to find a quiet space to pray. Staff said that they would support clients of any faith and look at how they could meet the specific needs of individual clients.

The building was accessible to clients with mobility needs. It contained a lift which was serviced regularly and the corridors were wide enough to accommodate clients using a wheelchair.

Lighthouse did not meet the Accessible Information Standard because they were not identifying, recording, flagging, sharing and meeting individuals' information and communication support needs.

There was no information about the service in other languages than English. Managers told us they would access translation services if required.

Listening to and learning from concerns and complaints

Clients and carers said that they had not been given information on how to make a complaint but would feel comfortable making a complaint if they needed to.

One client told us they had made a complaint and that it had been dealt with formally. They said a meeting had been held to discuss the complaint, minutes had been taken and they felt as though the complaint was taken seriously.

We looked at two complaints. One complaint was resolved and the other was in progress. For the resolved complaint, the registered manager did not follow the complaints policy. We found no evidence of a letter sent to the client in response to the complaint. There was also no record of what actions had been taken in response to the complaint in the clients file.

Are services well-led?

Inadequate

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Leadership

Leaders were visible in the service and approachable for clients and staff. However, managers spent most of their time responding to client and staff need, including processing new referrals to the service.

We reviewed a grievance investigation and found that the registered manager believed they had resolved it informally however the records did not reflect the action taken.

Vision and strategy

Staff knew and understood the vision and values of the service and organisation and what their role was in achieving that. They were aware the service was based on a Christian ethos, but would welcome clients with a different faith or no faith.

The development manager had been working alongside the registered manager to develop the service with the aim of additional services being developed by the provider.

Culture

The provider recognised staff success within the service, for example, through staff awards. Staff felt positive and proud about working for the service.

Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. Staff had started as bank staff, then progressed to becoming permanent support workers and leads in facilitating Lighthouse education activity programme.

Good governance

The governance systems were not effective. They were not sufficient to assess, monitor and mitigate the risks relating to the health, safety and welfare of clients. Health and Safety checks and audits within the building had not been completed since September 2018. This was not in line with the frequencies required by the provider's policies.

There were no arrangements in place to monitor the quality of the policies to ensure that quality care was consistently delivered. Policies examined and confirmed by staff as in use at Lighthouse were from three different organisations. Conflicting and out of date information was in place in these policies. Examples include; policies were tailored to residential care for older people and were not specific or relevant to clients with substance misuse needs accommodated within Lighthouse. The controlled drugs policy for Lighthouse did not comply with NICE guidance. The confidentiality policy referred to the health and social corporation act 2008.

Systems were not sufficient to maintain securely an accurate, complete and contemporaneous record in respect of each client. Of the four records examined, they were not accurate and current records. Health action plans were blank in two of the records reviewed and had one question completed in the other two records reviewed. This prevented clients from having robust arrangements in place for meeting their healthcare needs. Records showed limited evidence of key work sessions being completed. Two files had evidence of one key work session, another file had evidence of seven key work session in three years.

Systems and processes to seek and act on feedback to evaluate and improve services were not robust or monitored. There were no governance arrangements in place to assess the quality of the service delivered in accordance with clients' needs. Client monthly meetings focused on what they had not done and there was no evidence of actions taken and progress made.

The provision of the therapy in relation to addictive behaviours was not being provided as marketed in the services literature and information to commissioners and clients. There were three clients on the PRE-LEAP package and four clients on the LEAP (Lighthouse education activity programme). There should have been three group sessions per week, one on behaviour, another on mental health and a third on addictions. Records examined confirmed a weekly session was taking place regarding behaviour. There were no sessions for mental health and addictions.

CCTV was in place in communal areas but there were no signs within the building to advise clients that CCTV monitoring was in place. There were no systems in place to assess and monitor that the service was delivered.

The Duty of Candour policy did not fully reflect the regulation, it did not include that an apology would be given and that it would be in writing and there would be a written record of all attempts to contact the relevant person and retain copies of correspondence.

The training matrix in place did not show all training that staff had accessed. Managers were unable to assure

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themselves of all the training that staff had completed. Following the last inspection, the inspection team advised that the provider should ensure that mandatory training is monitored, and staff are compliant in respect of equality and diversity, manual handling and effective behaviour management. The training matrix provided as part of the provider information return and viewed on site did not include equality and diversity and effective behaviour management and these were not classed as mandatory training. Other courses relevant to their role including substance misuse were not offered. Training information was held centrally. There was no system available to staff at the Lighthouse to oversee all staff's attendance at training and identify areas of low compliance.

A set agenda was used for team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. However regular team meetings were not taking place. There had been a gap from March 2018 till October 2018, there had not been a team meeting since 9 October 2018.

Staff had implemented recommendations from a review of a death, incidents, complaints and safeguarding alerts at the service. An example was the level of assistance staff provide in relation to budgeting.

Data and notifications were submitted to external bodies as required. The registered manager submitted CQC notifications appropriately.

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the clients.

Management of risk, issues and performance

There was no clear quality assurance management and performance frameworks in place that were integrated across all organisational policies and procedures.

Lighthouse had a recently developed risk register which we reviewed. This failed to capture current risks to the service in relation to governance, including staffing levels and retention and provision of the Lighthouse education activity programme. The risk register did not include how to mitigate the risk should it arise. There was no mechanism to provide assurances that the risk register was being reviewed and progress made.

The provider monitored sickness and absence rates.

Information management

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. The service used applications on their smart phones to provide updates in relation to maintenance and health and safety. The electronic sign in system for staff could be accessed remotely too.

Managers had access to information to support them with their management role. This included information on the performance of the service, in relation to vacancies and incidents.

The registered manager had completed a manager report for the directors, which included referrers, pathways for recovery, aims of increasing occupancy, activities and feedback from clients.

Client information needed to deliver care was not available to all staff, when they needed it. Information was stored in a variety of files. Not all staff understood the filing system in relation to Lighthouse education activity programme. Paper versions of client's assessments were not the most current. We found that for one record we reviewed, the paper risk assessment was out of date, a more recent version was saved on the computer.

Staff ensured service confidentiality agreements were clearly explained including in relation to the sharing of information and data. Clients signed the consent to share information.

Engagement

Staff completed a survey, we reviewed the results which were positive, there were three areas for improvement identified which was to have two waking nights on each shift, improved communication and longer shifts. However, we could not see any action taken in relation to these suggestions.

Clients had completed a feedback questionnaire, we reviewed the results and found all were very or extremely satisfied with their care. Overall the feedback was very positive.

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Senior managers visited the service regularly. The development manager was facilitating the alpha course, a series of interactive sessions that explored the basics of the Christian faith.

We observed mangers talking with clients and listening to their views and feedback.

Learning, continuous improvement and innovation

The organisation encouraged creativity and innovation to ensure up to date evidence based practice was implemented. The LEAP (Lighthouse education activity programme) was created by Lighthouse staff to tailor a recovery model for clients with a dual diagnosis of substance misuse and mental health needs. However, this was not being facilitated as advertised.

Staff had had appraisals. All staff had objectives focused on improvement and learning.

Lighthouse was not involved in any peer review or research. Staff did not participate in local clinical audits.

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 18 HSCA (RA) Regulations 2014 Staffing There was no staffing system in place, therefore you could not tell if the service was over or under staffed. This was a breach of regulation 18 (1)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (b) (c) (d) (h), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have issued a warning notice in relation to this regulation.

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (1) (2) (b) (c) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have issued a warning notice in relation to this regulation.